Computerized Dynamic Posturography

Policy Number: MMP258.10
Last Committee Approval Date: October 9, 2024
Effective Date: November 1, 2024

➲ Instructions for Use

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Related Medicare Advantage Medical Policy

- Hearing Services and Devices

Coverage Rationale

Overview

Computerized dynamic posturography (CDP), also known as moving platform posturography or dynamic posturography, uses a platform device for evaluating a patient's ability to maintain balance. CDP has been used to measure a patient's ability to maintain balance under varying conditions when the usual cues that one relies upon to remain upright, vision, proprioception, and vestibular function, are manipulated. The goal of testing is to isolate vestibular symptoms to a specific cause that can often be treated. Standard diagnostic tests include electronystagmography and rotational chair tests, which evaluate eye movements, in response to a number of different stimuli including the position and rotation of the head.

Computerized dynamic posturography is a quantitative method for assessing balance functioning under various simulated tasks. Protocols are designed to test the sensory, motor and biomechanical components of balance individually and in concert. Computerized dynamic posturography may assist with lesion localization, identifying adaptive strategies and functional capabilities.

CMS National Coverage Determination (NCD)

Medicare does not have a National Coverage Determination (NCD) for Computerized Dynamic Posturography.

CMS Local Coverage Determinations (LCDs) and Articles

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Computerized Dynamic Posturography.

For coverage guidelines for states/territories with no LCDs/LCAs:

- Diagnostic audiologic testing (including hearing and balance assessment services) is considered reasonable and necessary when performed by a physician or a qualified audiologist. An individual with a master's or doctoral degree in audiology and is licensed as such by the relevant State is considered to be a qualified audiologist. In addition to required licensure, audiologists are encouraged to obtain a Certificate of Clinical Competence from the American Speech-Language-Hearing Association (ASHA).
- Dizziness is a reasonable and necessary indication for hearing tests in the initial otolaryngologic evaluation of patients in whom general medical causes (anemia, cardiovascular, metabolic, etc.) have been excluded. However, since dizziness is a vague complaint, a diagnosis of dizziness alone does not qualify for coverage for vestibular function testing (VFT).
- It is very rarely necessary to conduct the entire battery of vestibular function tests. Previous workup, history, and exam will be carefully scrutinized to ensure that exhaustive test batteries are justified and appropriate to the patient's

history and symptoms. It is not necessary to conduct additional tests once the problem and its diagnosis have been determined or identified.
- The medical record must contain documentation demonstrating that the vestibular testing is likely to contribute directly to the patient's therapy of the condition. In those instances, full audiometric evaluation can be a critical part of a full vestibular evaluation.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service; however, language may be included in the listing below to indicate if a code is non-covered. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
92548	Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (i.e., eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report;
92549	Computerized dynamic posturography sensory organization test (CDP-SOT), 6 conditions (i.e., eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report; with motor control test (MCT) and adaptation test (ADT)

Diagnosis Code	Description
D33.3	Benign neoplasm of cranial nerves
H81.01	Meniere's disease, right ear
H81.02	Meniere's disease, left ear
H81.03	Meniere's disease, bilateral
H81.11	Benign paroxysmal vertigo, right ear
H81.12	Benign paroxysmal vertigo, left ear
H81.13	Benign paroxysmal vertigo, bilateral
H81.21	Vestibular neuronitis, right ear
H81.22	Vestibular neuronitis, left ear
H81.23	Vestibular neuronitis, bilateral
H81.311	Aural vertigo, right ear
H81.312	Aural vertigo, left ear
H81.313	Aural vertigo, bilateral
H81.391	Other peripheral vertigo, right ear
H81.392	Other peripheral vertigo, left ear
H81.393	Other peripheral vertigo, bilateral
H81.4	Vertigo of central origin
H81.8X1	Other disorders of vestibular function, right ear
H81.8X2	Other disorders of vestibular function, left ear
H81.8X3	Other disorders of vestibular function, bilateral
H81.91	Unspecified disorder of vestibular function, right ear
H81.92	Unspecified disorder of vestibular function, left ear
H81.93	Unspecified disorder of vestibular function, bilateral
H82.1	Vertiginous syndromes in diseases classified elsewhere, right ear
H82.2	Vertiginous syndromes in diseases classified elsewhere, left ear
H82.3	Vertiginous syndromes in diseases classified elsewhere, bilateral

Diagnosis Code	Description
H83.01	Labyrinthitis, right ear
H83.02	Labyrinthitis, left ear
H83.03	Labyrinthitis, bilateral
H83.11	Labyrinthine fistula, right ear
H83.12	Labyrinthine fistula, left ear
H83.13	Labyrinthine fistula, bilateral
H83.2X1	Labyrinthine dysfunction, right ear
H83.2X2	Labyrinthine dysfunction, left ear
H83.2X3	Labyrinthine dysfunction, bilateral
H83.8X1	Other specified diseases of right inner ear
H83.8X2	Other specified diseases of left inner ear
H83.8X3	Other specified diseases of inner ear, bilateral
H83.91	Unspecified disease of right inner ear
H83.92	Unspecified disease of left inner ear
H83.93	Unspecified disease of inner ear, bilateral
H90.0	Conductive hearing loss, bilateral
H90.11	Conductive hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side
H90.12	Conductive hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side
H90.3	Sensorineural hearing loss, bilateral
H90.41	Sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side
H90.42	Sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side
H90.6	Mixed conductive and sensorineural hearing loss, bilateral
H90.71	Mixed conductive and sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side
H90.72	Mixed conductive and sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side
H90.A11	Conductive hearing loss, unilateral, right ear with restricted hearing on the contralateral side
H90.A12	Conductive hearing loss, unilateral, left ear with restricted hearing on the contralateral side
H90.A21	Sensorineural hearing loss, unilateral, right ear, with restricted hearing on the contralateral side
H90.A22	Sensorineural hearing loss, unilateral, left ear, with restricted hearing on the contralateral side
H90.A31	Mixed conductive and sensorineural hearing loss, unilateral, right ear with restricted hearing on the contralateral side
H90.A32	Mixed conductive and sensorineural hearing loss, unilateral, left ear with restricted hearing on the contralateral side
R42	Dizziness and giddiness

Centers for Medicare and Medicaid Services (CMS) Related Documents

After checking the table below and searching the Medicare Coverage Database, if no NCD, LCD, or LCA is found, refer to the criteria as noted in the Coverage Rationale section above.

NCD	LCD	LCA	Contractor Type	Contractor Name
Computerized Dynamic Posturography				
N/A	L34537 Vestibular Function Testing	A56497 Billing and Coding: Vestibular Function Testing	Part B	Palmetto**

Medicare Administrative Contractor (MAC) With Corresponding States/Territories	
MAC Name (Abbreviation)	**States/Territories**
CGS Administrators, LLC (CGS)	KY, OH
First Coast Service Options, Inc. (First Coast)	FL, PR, VI
National Government Services, Inc. (NGS)	CT, IL, ME, MA, MN, NH, NY, RI, VT, WI
Noridian Healthcare Solutions, LLC (Noridian)	AS, AK, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY
Novitas Solutions, Inc. (Novitas)	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX, VA**
Palmetto GBA (Palmetto)	AL, GA, NC, SC, TN, VA**, WV
Wisconsin Physicians Service Insurance Corporation (WPS)*	IA, IN, KS, MI, MO, NE
Notes	
*Wisconsin Physicians Service Insurance Corporation: Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers. **For the state of Virginia: Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction.	

Other

CY 2023 Physician Fee Schedule Final Rule, Audiology Services (CMS)
Audiology Services (Novitas Solutions, Inc.)
CMS LCD / LCA - L34427 (Outpatient Occupational Therapy / A53064 Billing and Coding: Outpatient Occupational Therapy)
CMS LCD / LCA - L34428 (Outpatient Physical Therapy / A53065 Billing and Coding: Outpatient Physical Therapy)

Clinical Evidence

Doğaner and Algun conducted a prospective, single center study to evaluate the effects of individualized treatment with Computerized Dynamic Posturography (CDP) on balance in patients who had experienced a single stroke with and without a history of chronic hemiplegic falls. The study included 40 patients with chronic hemiplegia (time post-stroke: 8-18 months) between 40 and 70 years of age who were divided into two groups, with Group 1 including patients with a falling history (n=20; 11 males; mean age 59.45 ± 8.42 years) and Group 2 including patients with no falling history (n=20; 7 males; mean age 57.85 ± 11.24 years). Patients with shoulder pain, those using an orthosis and those with respiratory distress were excluded. All participants were included in a traditional rehabilitation program for one hour, five days a week for five weeks. The participants in Group 1 also received individualized CDP treatment for 20 minutes, three days a week for five weeks. All patients were evaluated with a Sensory Organization Test (SOT) and a Berg Balance Scale (BBS). The same physical therapist performed every participant's evaluation on the first and the last day of the treatment. The authors reported that patients in Group 1 who received individualized CDP treatment showed no statistically significant difference between BBS, SOT 1, SOT 2, SOT 3, SOT 4, and SOT 6 scores before and after therapy; however, the post-therapy SOT 5 score (75.46 ± 9.28) improved significantly compared with the pre-therapy SOT 5 score. In Group 2, the authors reported that there was no statistically significant difference between the scores of SOT 1, SOT 2, SOT 3, SOT 4, and SOT 5 before and after therapy but the BBS and SOT 6 scores after therapy improved significantly compared with pre-therapy BBS and SOT 6 scores. However, the authors reported that there was no statistically significant difference in improvement between the two groups. This study was limited by the single-center design, the small number of participants, and the lack of a comparison group of patients with a history of falling who received traditional therapy only. The authors concluded that more participants and longer duration of individualized CDP therapy studies may be more reflective of improvements in SOT and BBS parameters measured in patients with chronic hemiplegia and a history of falls.

The Hayes Evolving Evidence Review (2022, updated 2023) on computerized dynamic posturography (CDP) for diagnosing vestibular disorders focused primarily on the clinical validity (in terms of diagnostic performance) and clinical utility (in terms of impact on diagnostic decision-making) of CDP; however, they did not identify any clinical studies that met this inclusion criteria. The review did identify one systematic review published in 1996 that did not indicate any potential benefit or advantage of CDP to the patient for diagnosing vestibular disorders, and two clinical practice guidelines with weak support based on expert opinion rather than from review of published, peer-reviewed studies.

Rossi-Izquierdo et al. (2022) conducted a prospective cross-sectional study in two tertiary facilities to assess postural stability with different posturographic techniques in essential tremor (ET). The study included 11 patients diagnosed with essential tremor (mean age of 73 ± 11.78, 82% female) and 12 gender and age matched healthy controls (mean age of 72.25 ± 4.02; 75% female). Each study participant underwent balance assessment with the sensory organization test (SOT) and limits of stability (LOS) of the computer dynamic posturography (CDP), results of free-field body sway analysis with mobile posturography (Vertiguard®), modified timed up and go test (TUG), Dizziness handicap inventory (DHI) and activities-specific balance confidence scale (ABC). The authors reported that patients with ET showed poorer scores in the SOT than controls for composite balance and somatosensory input, and that they also performed worse in LOS tests, with a higher risk of falling based on the Vertiguard results. The authors reported that there were no differences in the modified TUG. Conclusions by the authors include that posturography assessment with CDP and Vertiguard was more accurate in showing balance impairment in ET patients than clinical evaluation with the TUG test and that balance deficits could be included into future diagnostic criteria. The study was limited by the small sample size and the authors recommended further prospective studies with larger number of patients to validate the findings.

Kamieniarz et al. (2021) conducted a prospective, cross-sectional, single-center study to quantify balance changes in early and moderate stage Parkinson's Disease (PD) and compare the values to healthy controls (HC) using clinical assessments of balance and posturography. Study participants included 15 adults with early PD (PD-II, mean age 61.9 ±8.6 years), 15 adults with moderate PD (PD-III; mean age 70.7 ± 4.5 years) and 15 age matched healthy controls (HC; 63.5 ± 4.3 years). PD patients were tested during the "ON period" of their usual anti-parkinsonian medication (at least one hour after they took their medication) and none of the patients exhibited any dyskinesia or dystonia signs during testing. A clinical assessment and clinical tests of balance on a force platform were done. The authors quantified the spatiotemporal parameters of the center of pressure (COP), the sample entropy and power spectral density (PSD) of the COP. The authors reported that the PSD of the COP differentiated PD-II from HC from 0-0.5 Hz and PD-II from PD-III from 0.5-1 Hz. Specifically, PD-II and PD-III manifested greater power than HC from 0-0.5 Hz, whereas PD-III exhibited greater power than PD-II and HC from 0.5-1.0 Hz. However, there were no significant differences between PD-II and HC in all clinical tests and in spatiotemporal parameters of the COP. Although the sample entropy was significantly lower in the PD groups, entropy failed to differentiate PD-II from PD-III. The authors concluded that the low-frequency modulation of the COP differentiated early PD from HC and from moderate PD, and show that there are early balance deficits in PD. This study is limited by a small number of participants, the single center design, the cross-sectional comparison of early PD with moderate PD and HC and that the two subtypes of PD (postural instability and gait difficulty, and excessive tremor) which were not differentiated in the study.

In their prospective, single-center pilot study to evaluate whether the Biodex Balance System™ could produce clinically meaningful measures and elicit postural motor learning in patients with Parkinson's Disease (PD), Raethjen et al. (2020) enrolled 40 adult moderately affected patients with PD (mean age 72; 65% male) in a general neurology outpatient clinic who complained of postural instability. Antiparkinsonian medications were not changed during the study, and physical therapy (PT) sessions, if applicable, were kept constant during the study and only patients with stable PT frequency and intensity within the last 3 months were included in the study. Each participant underwent six training sessions once weekly for about 30-35 minutes over six weeks where they practiced shifts and stabilization of the center of pressure (COP) in a low intensity dynamic posturographic training. The authors reported that participants performed best (small deviations) when the COP position and its evolution over time was displayed on the screen, significantly worse when the COP position was not displayed but with eyes open, and even worse with eyes closed. The authors concluded that posturographic performance was significantly better with eyes open than closed and more so with explicit visual feedback of COP position and that the posturography procedures yielded clinically valid measures when COP position was visible and directional shifts from the base of support center were quantified.

In a single-center, non-randomized, prospective study to assess stroke patients' balance performance, Parsa et al. (2019) evaluated correlations between balance assessment as examined by the Biodex Stability System (BSS) and the clinical Berg Balance Scale (BBS) in post-stroke hemiparesis. The study included 25 stroke survivors (mean age of 57 ± 14 years, 14 males and 11 females) and 25 healthy age-sex matched adults (mean age of 57 ± 13 years, 14 males and 11 females). All subjects underwent assessment with BSS for 3 days, with a 24-hour interval, and a clinical evaluation with the standard BBS. The authors reported that there was significant moderate negative correlation between the Biodex overall indices and the BBS scores in the stroke group and in the healthy cohort, and that the correlation between the Biodex mediolateral stability indices and the BBS scores was moderate to low in both groups. The authors concluded that moderate negative correlation between the stability indices of the BSS and the BBS scores indicated that dynamic balance status of the participants partially reflects their functional balance status. Limitations of the study include the small sample size, the non-randomization, and the single-center design.

Mallinson et al. (2019) conducted a single-center, retrospective study to evaluate if Computerized Dynamic Posturography (CDP) results would correlate with Vestibular Evoked Myogenic Potential (VEMP) abnormalities in patients with chronic

vestibular disease. The study included chart reviews of 180 patients (111 trauma patients and 69 non-trauma patients) who were referred to a tertiary care neuro-otology unit who did not have neurologic, orthopedic, or musculoskeletal involvement. All patients had extensive histories taken, and underwent caloric testing, CDP, Cervical VEMP (CVEMP) and Ocular VEMP (OVEMP) testing, and Subjective Visual Vertical (SVV). Patients were categorized as "normal" or "abnormal" for each modality, using the standardized assessment protocols for calorics, and using the normative database for CVEMP and OVEMP amplitudes and latencies that were used in their facility. CDP results were then divided into three categories: normal, vestibular abnormality patterns, and nonspecific abnormality patterns. The authors reported there were no differences in test results between trauma and non-trauma patients or male and female patients and that there were 102 patients (57%) with normal CDP results, 53 patients (29%) with nonspecifically abnormal results and 25 patients (14%) with results that showed a vestibular abnormality pattern. When the authors looked at each CDP abnormality group, they reported that there was a high rate of CVEMP and OVEMP abnormalities, but the rate of abnormalities was almost identical in both CDP abnormality groups (vestibular and nonspecific) and in the normal CDP group. Limitations of the study include the retrospective, single-center design, and the lack of generalized standard assessment protocols for the tests performed. The authors concluded that CDP was able to simulate verbalized complaints in many patients who had subtle non-vertiginous vestibular symptoms and that it was a sensitive vestibular assessment, but that it was not able to detect site-specific pathology and that CVEMP and OVEMP abnormalities did not correlate with CDP findings.

Clinical Practice Guidelines

American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS)

AAO-HNS recognizes that the following tests or evaluation tools are medically indicated and appropriate in the evaluation or treatment of certain persons with suspected balance or dizziness disorders:

- Static platform posturography.
- Computerized static platform posturography.
- Computerized dynamic platform posturography.
- Dynamic (or moving) platform posturography.

In 2017, an AAO-HNS Clinical Practice Guideline on benign paroxysmal positional vertigo (BPPV) listed computerized posturography as one of the diagnostic tools to consider when diagnosing BPPV; however, there was no additional supportive information included in the guideline (Bhattacharyya, et al., 2017).

References

Bhattacharyya N, Baugh RF, Orvidas L, et, al. Clinical Practice Guideline: Benign paroxysmal positional vertigo (Update). Otolaryngology Head and Neck Surgery. March 2017; 156(3S) S1-S47. Available at: https://www.entnet.org/quality-practice/quality-products/clinical-practice-guidelines/bppv/. Accessed April 24, 2024.

Doğaner I, Algun ZC. Treatment of balance with Computerised Dynamic Posturography therapy in chronic hemiplegic patients. S Afr J Physiother. 2023 Sep 18;79(1):1918.

Hayes, Inc. Hayes Evolving Evidence Review. Computerized dynamic posturography (CDP) for diagnosis of vestibular disorders. Lansdale, PA: Hayes, Inc.; December 7, 2022. Updated October 24, 2023.

Kamieniarz A, Michalska J, Marszałek W, et al. Detection of postural control in early Parkinson's disease: Clinical testing vs. modulation of center of pressure. PLoS One. 2021 Jan 12;16(1): e0245353.

Mallinson AI, Kuijpers ACM, Van Zwieten G, et al. Computerized Dynamic Posturography does not detect measured CVEMP and OVEMP abnormalities. Gait Posture. 2019 Jan; 67:248-250.

Parsa M, Rahimi A, Dehkordi SN. Studying the correlation between balance assessment by Biodex Stability System and Berg Scale in stroke individuals. J Bodyw Mov Ther. 2019;23(4):850-854.

Raethjen J, Raethjen P, Schmalbach B, Wasner G. Dynamic posturography and posturographic training for Parkinson's disease in a routine clinical setting. Gait Posture. 2020 Oct;82:281-286.

Rossi-Izquierdo M, Franco-Gutiérrez V, San-Román-Rodríguez E, et al. What could posturography tell us about balance in essential tremor? Gait Posture. 2022 Jul; 96:338-342.

Policy History/Revision Information

Date	Summary of Changes

11/01/2024	**Title Change/Template Update**
	• Previously titled *Posturography*
	• Reformatted and reorganized policy; transferred content to new template
	• Changed policy type classification from "Policy Guideline" to "Medical Policy"
	• Added *Clinical Evidence* and *References* sections
	• Updated *Instructions for Use*
	Coverage Rationale
	Overview
	• Added language to indicate:
	  ○ Computerized dynamic posturography (CDP), also known as moving platform posturography or dynamic posturography, uses a platform device for evaluating a patient's ability to maintain balance
	  ○ CDP has been used to measure a patient's ability to maintain balance under varying conditions when the usual cues that one relies upon to remain upright, vision, proprioception, and vestibular function are manipulated
	  ○ The goal of testing is to isolate vestibular symptoms to a specific cause that can often be treated
	  ○ Standard diagnostic tests include electronystagmography and rotational chair tests, which evaluate eye movements, in response to a number of different stimuli including the position and rotation of the head
	CMS National Coverage Determination (NCD)
	• Added language to indicate Medicare does not have a National Coverage Determination (NCD) for computerized dynamic posturography
	CMS Local Coverage Determinations (LCDs) and Articles
	• Added language to indicate:
	  ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable; for specific LCDs/LCAs, refer to the table [in the *Centers for Medicare & Medicaid (CMS) Related Documents* section of the policy]
	  ○ For coverage guidelines for states/territories with no LCDs/LCAs, refer to the coverage guidelines below
	Coverage Guidelines
	• Revised language to indicate:
	  ○ Diagnostic audiologic testing (including hearing and balance assessment services) is considered reasonable and necessary when performed by a physician or a qualified audiologist
	  ▪ An individual with a master's or doctoral degree in audiology and is licensed as such by the relevant State is considered to be a qualified audiologist
	  ▪ In addition to required licensure, audiologists are encouraged to obtain a Certificate of Clinical Competence from the American Speech-Language-Hearing Association (ASHA)
	  ○ Dizziness is a reasonable and necessary indication for hearing tests in the initial otolaryngologic evaluation of patients in whom general medical causes (anemia, cardiovascular, metabolic, etc.) have been excluded; however, since dizziness is a vague complaint, a diagnosis of dizziness alone does not qualify for coverage for vestibular function testing (VFT)
	  ○ It is very rarely necessary to conduct the entire battery of vestibular function tests
	  ▪ Previous workup, history, and exam will be carefully scrutinized to ensure that exhaustive test batteries are justified and appropriate to the patient's history and symptoms
	  ▪ It is not necessary to conduct additional tests once the problem and its diagnosis have been determined or identified
	  ▪ The medical record must contain documentation demonstrating that the vestibular testing is likely to contribute directly to the patient's therapy of the condition; in those instances, full audiometric evaluation can be a critical part of a full vestibular evaluation

Date	Summary of Changes

	Centers for Medicare & Medicaid (CMS) Related Documents
	• Updated list of documents available in the *Medicare Coverage Database* to reflect the most current information
	• Added list of applicable *Medicare Administrative Contractors (MACs) With Corresponding States/Territories*
	• Added notation to indicate:
	  ○ The Wisconsin Physicians Service Insurance Company (WPS) Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers
	  ○ For the state of Virginia: Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction
	• Removed reference link to:
	  ○ Position Statement: Posturography American Academy of Otolaryngology – Head and Neck Surgery
	  ○ Title XVIII of the Social Security Act § 1833(e), § 1861(ll)(3), (ll)(4)(B), and § 1862(a)(1)(A)
	Supporting Information
	• Archived previous policy version MPG258.09

Instructions for Use

The Medicare Advantage Policy documents are generally used to support UnitedHealthcare coverage decisions. It is expected providers retain or have access to appropriate documentation when requested to support coverage. This document may be used as a guide to help determine applicable:

- Medical necessity coverage guidelines; including documentation requirements, and/or
- Medicare coding or billing requirements.

Medicare Advantage Policies are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates. This Policy is provided for informational purposes and does not constitute medical advice. It is intended to serve only as a general reference and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes this policy. For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.

Medicare Advantage Policies are developed as needed, are regularly reviewed, and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policies at any time by publishing a new version on this website. Medicare source materials used to develop these policies may include, but are not limited to, CMS statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. The information presented in this Policy is believed to be accurate and current as of the date of publication. Where there is a conflict between this document and Medicare source materials, the Medicare source materials apply. Medicare Advantage Policies are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing certain items or services referenced in this Medical Policy have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, in these circumstances, UnitedHealthcare applies internal coverage criteria as referenced in this Medical Policy. The internal coverage criteria in this Medical Policy was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the

evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Providers are responsible for submission of accurate claims. Medicare Advantage Policies are intended to ensure that coverage decisions are made accurately. UnitedHealthcare Medicare Advantage Policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate's requirements need to be followed.