



December 2017

policy update **bulletin**

UnitedHealthcare Medicare Advantage Coverage Summary Updates

UnitedHealthcare respects the expertise of the physicians, health care professionals, and their staff who participate in our network. Our goal is to support you and your patients in making the most informed decisions regarding the choice of quality and cost-effective care, and to support practice staff with a simple and predictable administrative experience. The Policy Update Bulletin was developed to share important information regarding UnitedHealthcare Medicare Advantage Coverage Summary updates.*

*Where information in this bulletin conflicts with applicable state and/or federal law, UnitedHealthcare follows such applicable federal and/or state law

Overview

This bulletin provides complete details on UnitedHealthcare Medicare Advantage Coverage Summary updates. The inclusion of a health service (e.g., test, drug, device or procedure) in this bulletin indicates only that UnitedHealthcare has recently adopted a new policy and/or updated, revised, replaced or retired an existing policy; it does not imply that UnitedHealthcare provides coverage for the health service. In the event of an inconsistency or conflict between the information provided in this bulletin and the posted policy, the provisions of the posted policy will prevail. Note that most benefit plan documents exclude from benefit coverage health services identified as investigational or unproven/not medically necessary. Physicians and other health care professionals may not seek or collect payment from a member for services not covered by the applicable benefit plan unless first obtaining the member's written consent, acknowledging that the service is not covered by the benefit plan and that they will be billed directly for the service.



A complete library of Medicare Advantage Coverage Summaries is available at UHCprovider.com > [Menu](#) > [Policies and Protocols](#) > [Medicare Advantage Policies](#) > [Coverage Summaries](#).

Tip for using the Policy Update Bulletin:

- From the table of contents, click the policy title to be directed to the corresponding policy update summary.
- From the policy updates table, click the policy title to view a complete copy of a new, updated, or revised policy.

Policy Update Classifications

New

New coverage guidelines have been adopted for a health service (e.g., test, drug, device or procedure)

Updated

An existing policy has been reviewed and changes have not been made to the coverage guidelines; however, items such as the definitions or references may have been updated

Revised

An existing policy has been reviewed and revisions have been made to the coverage guidelines

Replaced

An existing policy has been replaced with a new or different policy

Retired

An existing policy has been retired because national and local coverage determinations from the Centers for Medicare and Medicaid Services (CMS) are no longer available or the applicable coverage guidelines are documented in another policy

Note: The absence of a policy does not automatically indicate or imply coverage. As always, coverage for a health service must be determined in accordance with the member's benefit plan and any applicable CMS, federal, or state regulatory requirements. Additionally, UnitedHealthcare reserves the right to review the clinical evidence supporting the safety and effectiveness of a medical technology prior to rendering a coverage determination.

In This Issue
Coverage Summary Updates
Page
TAKE NOTE

- Annual CPT® and HCPCS Code Updates 4

UPDATED

- Foot Care Services 4
- Hearing Aids, Auditory Implants and Related Procedures 4
- Hyperbaric Oxygen Therapy 4
- Ostomy Supplies 4
- Positron Emission Tomography (PET)/Combined PET-CT (Computed Tomography) 4
- Services While Confined/Incarcerated 4
- Vertebral Artery Surgery 4

REVISED

- Family Planning (Birth Control) 5
- Prostate: Services and Procedures 5
- Radiologic Therapeutic Procedures 5
- Spine Procedures 6
- Vision Services, Therapy and Rehabilitation 6

Coverage Summary Updates

TAKE NOTE

Annual CPT® and HCPCS Code Updates

Beginning Jan. 1, 2018, all applicable Medicare Advantage Coverage Summaries will be modified to reflect the 2018 Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) code additions, revisions, and deletions. Refer to the following sources for information on the 2018 code updates:

- [American Medical Association. Current Procedural Terminology: CPT® 2018](#)
- [Centers for Medicare & Medicaid Services. Healthcare Common Procedure Coding System: HCPCS Level II](#)

Complete details on impacted policies and corresponding code edits will be provided in the January 2018 edition of the Medicare Advantage Coverage Summary Update Bulletin.

| Policy Title | Approval Date | Summary of Changes |
|---|---------------|---|
| UPDATED | | |
| Foot Care Services | Nov. 20, 2017 | <ul style="list-style-type: none"> • Routine review; no content changes |
| Hearing Aids, Auditory Implants and Related Procedures | Nov. 20, 2017 | <ul style="list-style-type: none"> • Routine review; no content changes |
| Hyperbaric Oxygen Therapy | Nov. 20, 2017 | Attachments <ul style="list-style-type: none"> • Updated Local Coverage Determination (LCD) Availability Grid to include the applicable LCDs for <i>Hyperbaric Oxygen (HBO) Therapy</i> |
| Ostomy Supplies | Nov. 20, 2017 | <ul style="list-style-type: none"> • Routine review; no content changes |
| Positron Emission Tomography (PET)/ Combined PET-CT (Computed Tomography) | Nov. 20, 2017 | <ul style="list-style-type: none"> • Routine review; no content changes |
| Services While Confined/ Incarcerated | Nov. 20, 2017 | <ul style="list-style-type: none"> • Replaced references to "<i>intermediary, A/B MAC, DME MAC, or carrier</i>" with "<i>A/B MAC (A), (B), or (HHH), or DME MAC</i>" |
| Vertebral Artery Surgery | Nov. 20, 2017 | <ul style="list-style-type: none"> • Routine review; no content changes |

Coverage Summary Updates

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|-----------------------------------|---------------|---|
| REVISED | | |
| Family Planning (Birth Control) | Nov. 20, 2017 | <p>Guideline 1 (Office Visits for General Education, Counseling, and Instruction on Birth Control Methods)</p> <ul style="list-style-type: none"> Added instruction to refer to the Medicare Benefit Policy Manual, <i>Chapter 15, § 20.1 – Physician Expense for Surgery, Childbirth, and Treatment for Infertility</i> <p>Guideline 2 (Routine Pregnancy Testing)</p> <ul style="list-style-type: none"> Added instruction to refer to the Medicare Benefit Policy Manual, <i>Chapter 15, § 20.1 – Physician Expense for Surgery, Childbirth, and Treatment for Infertility</i> |
| Prostate: Services and Procedures | Nov. 20, 2017 | <p>Guideline 4 [Prostatic Urethral Lift (e.g., UroLift®)]</p> <ul style="list-style-type: none"> Removed reference link to the UnitedHealthcare Medical Policy titled <i>Omnibus Codes</i> Added reference link to the National Government Services LCD for <i>Prostatic Urethral Lift (PUL) (L36601)</i> |
| Radiologic Therapeutic Procedures | Nov. 20, 2017 | <p>Guideline 2 [Proton Beam Therapy (PBT)]</p> <ul style="list-style-type: none"> Revised language pertaining to states with no LCDs: <ul style="list-style-type: none"> Updated list of diagnoses requiring individual consideration when referring to the UnitedHealthcare Medical Policy titled <i>Proton Beam Radiation Therapy</i> for applicable coverage guidelines: <ul style="list-style-type: none"> Removed: <ul style="list-style-type: none"> Unresectable extremity sarcoma Added: <ul style="list-style-type: none"> Unresectable breast tumors in proximity to the heart Acoustic neuromas Pituitary neoplasms Unresectable benign or malignant central nervous system tumors to include but not be limited to primary and variant forms of astrocytoma, glioblastoma, medulloblastoma, craniopharyngioma, benign and atypical meningiomas, pineal gland tumors <p>Guideline 5 [Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT)]</p> <ul style="list-style-type: none"> Revised language pertaining to states with no LCDs: <ul style="list-style-type: none"> Added list of diagnoses for SBRT requiring individual consideration when referring to MCG™ Care Guidelines, 21st edition, 2017, for <i>Stereotactic Body Radiotherapy ACG: A-0694 (AC)</i> for applicable coverage guidelines: <ul style="list-style-type: none"> Primary or metastatic pancreatic cancer Primary or metastatic renal cancer Primary or metastatic adrenal gland cancer <p>Attachments</p> <ul style="list-style-type: none"> Updated LCD Availability Grid to include the applicable LCDs for: <ul style="list-style-type: none"> <i>Proton Beam Therapy/Proton Beam Radiotherapy</i> <i>Intensity Modulated Radiation Therapy (IMRT)</i> <i>Stereotactic Computer Assisted Volumetric and/or Navigational Procedure</i> |

Coverage Summary Updates

| Policy Title | Approval Date | Summary of Changes |
|---|---------------|--|
| REVISED | | |
| Spine Procedures | Nov. 20, 2017 | <p>Guideline 4 [Interspinous Process Decompression (IPD®) (X STOP® and Coflex® Interlaminar Technology)]</p> <ul style="list-style-type: none"> Updated reference link to <i>FDA Approval Information for X STOP® Interspinous Process Decompression System</i> <p>Guideline 8 {Percutaneous Image-Guided Lumbar Decompression (PILD) [Includes Minimally Invasive Lumbar Decompression (Mild®)]}</p> <ul style="list-style-type: none"> Removed language pertaining to the Centers for Medicare & Medicaid Services (CMS) Decision Memo for <i>Percutaneous Image-guided Lumbar Decompression for Lumbar Spinal Stenosis (CAG-00433R)</i> <p>Attachments</p> <ul style="list-style-type: none"> Updated LCD Availability Grid to include the applicable LCDs for: <ul style="list-style-type: none"> Arthrodesis, Pre-Sacral Interbody Technique Decompression Procedure, Percutaneous of Nucleus Pulposus Percutaneous Minimally Invasive Fusion |
| Vision Services, Therapy and Rehabilitation | Nov. 20, 2017 | <p>Guideline 3.b.1 (Pair of Eyeglasses or Contact Lenses)</p> <ul style="list-style-type: none"> Added instruction to refer to National Coverage Determination (NCD) for <i>Refractive Keratoplasty (80.7)</i> <p>Guideline 25 [Visual Field Assessment, e.g., ForeseeHome AMD Monitoring Program (CPT codes 0378T and 0379T)]</p> <ul style="list-style-type: none"> Added applicable coverage guidelines (new to policy) |