United Healthcare Medicare Advantage

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Coverage Summary Update Bulletin: May 2024

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Surgical Procedures	Jun. 1, 2024	**Surgical procedures are covered when Medicare criteria are met.** **Note:** The medical necessity criteria referenced in this Coverage Summary applies to a surgical procedure regardless of the approach, unless noted otherwise. **Appendectomy (CPT Codes 44950, 44960, and 44970)** Medicare does not have a National Coverage Determination (NCD) for appendectomy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. **For coverage guidelines**, refer to the InterQual® CP: Procedures, Appendectomy. Click here to view the InterQual® criteria. **Note**: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines. **Colectomy (CPT Codes 44140, 44141, 44143, 44144, 44145, 44146, 44147, 44160, 44204, 44205, 44206, 44207, and 44208)** Medicare does not have a National Coverage Determination (NCD) for colectomy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. **For coverage guidelines**, refer to the InterQual® CP: Procedures, Colectomy, Left and InterQual® CP: Procedures, Colectomy, Right. Click here to view the InterQual® criteria. **Note**: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines.

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Policy Title	Effective Date	Coverage Guidelines
Surgical Procedures (continued)	Jun. 1, 2024	**Hernia Repair Procedures** ***Inguinal or Femoral Hernia Repair (CPT Codes 49505, 49507, 49520, 49521, 49525, 49550, 49553, 49555, 49557, 49650, 49651, and 49659)*** Medicare does not have a National Coverage Determination (NCD) for inguinal or femoral hernia repair. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. **For coverage guidelines**, refer to the InterQual® CP: Procedures, Herniorrhaphy, Inguinal or Femoral. Click here to view the InterQual® criteria. **Note**: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines. ***Umbilical Hernia Repair (CPT Codes 49591, 49592, 49593, 49594, 49595, 49596, 49613, 49614, 49615, 49616, 49617, and 49618)*** Medicare does not have a National Coverage Determination (NCD) for umbilical hernia repair. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. **For coverage guidelines**, refer to the InterQual® CP: Procedures, Herniorrhaphy, Umbilical. Click here to view the InterQual® criteria. **Note**: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines. ***Hiatal Hernia Repair (CPT Codes 43192, 43201, 43210, 43211, 43212, 43235, 43236, 43254, 43257, 43266, 43280, 43281, 43282, 43283, 43284, 43325, 43327, 43328, 43332, 43333, 43334, 43335, 43336, 43337, 43338, and 43499)*** Medicare does not have a National Coverage Determination (NCD) for hiatal hernia repair. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

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Policy Title	Effective Date	Coverage Guidelines
Surgical Procedures (continued)	Jun. 1, 2024	**For coverage guidelines**, refer to the InterQual® CP: Procedures, Antireflux Surgery or Hiatal Hernia Repair. Click here to view the InterQual® criteria. **Note**: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines. **Laparotomy or Exploratory Laparotomy (CPT Codes 44050, 49000, 49010, 49013, 49014, 49020, 49040, and 49060)** Medicare does not have a National Coverage Determination (NCD) for laparotomy or exploratory laparotomy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. **For coverage guidelines**, refer to the InterQual® CP: Procedures, Laparotomy or Exploratory Laparotomy. Click here to view the InterQual® criteria. **Note**: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines. **Laparoscopy, Diagnostic (Abdomen or Pelvic) (CPT Code 49320)** Medicare does not have a National Coverage Determination (NCD) for diagnostic laparoscopy (abdomen or pelvic). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. **For coverage guidelines**, refer to the InterQual® CP: Procedures, Laparoscopy, Diagnostic (Abdomen) or InterQual® CP: Procedures, Laparoscopy, Diagnostic (Pelvic). Click here to view the InterQual® criteria. **Note**: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines.

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Policy Title	**Effective Date**	**Coverage Guidelines**
Surgical Procedures (continued)	Jun. 1, 2024	**Lymphedema Surgical Treatments (CPT Codes 15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15847,15876, 15877, 15878, 15879, 38999 [when used to report lymphedema surgical treatments], and 49906)** Medicare does not have an NCD for lymphedema surgical treatments. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. **For coverage guidelines**, refer to the UnitedHealthcare Commercial Medical Policy titled Surgical Treatment of Lymphedema. **Note**: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines. **Nephrectomy** ***Nephrectomy, Simple (CPT Codes 50220, 50225, 50230, 50234, 50236, 50300, 50320, 50546, 50547, and 50548)*** Medicare does not have a National Coverage Determination (NCD) for simple nephrectomy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. **For coverage guidelines**, refer to the InterQual® CP: Procedures, Nephrectomy, Simple. Click here to view the InterQual® criteria. **Note**: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines. ***Nephrectomy, Partial (CPT Codes 50240 and 50543)*** Medicare does not have a National Coverage Determination (NCD) for partial nephrectomy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. **For coverage guidelines**, refer to the InterQual® CP: Procedures, Nephrectomy, Partial.

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Surgical Procedures (continued)	Jun. 1, 2024	Click here to view the InterQual® criteria. **Note**: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines. ***Nephrectomy, Radical (CPT Codes 50230 and 50545)*** Medicare does not have a National Coverage Determination (NCD) for radical nephrectomy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. **For coverage guidelines**, refer to the InterQual® CP: Procedures, Nephrectomy, Radical. Click here to view the InterQual® criteria. **Note**: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines. **Sacrocolpopexy (CPT Codes 57280, 57282, 57283, and 57425)** Medicare does not have a National Coverage Determination (NCD) for sacrocolpopexy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist. **For coverage guidelines**, refer to the InterQual® CP: Procedures, Sacrocolpopexy. Click here to view the InterQual® criteria. **Note**: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines. **Small Bowel Resection (CPT Codes 44120, 44121, 44125, 44126, 44127, 44128, 44202, and 44203)** Medicare does not have a National Coverage Determination (NCD) for small bowel resection. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

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Policy Title	Effective Date	Coverage Guidelines
Surgical Procedures (continued)	Jun. 1, 2024	**For coverage guidelines**, refer to the InterQual® CP: Procedures, Small Bowel Resection. Click here to view the InterQual® criteria. **Note**: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines.

Revised

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Policy Title	Summary of Changes

Cardiovascular Diagnostic and Therapeutic Procedures	**Coverage Guidelines**
	• Removed content/language addressing:
	  ○ Computerized tomography (CT scan)
	  ○ Aquapheresis (ultrafiltration) [CPT code 37799 when used to report aquapheresis (ultrafiltration)]; refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Omnibus Codes* for applicable coverage guidelines
	  ○ Peripheral vascular angiography (CPT codes 75710 and 75716)
	• Revised notation pertaining to prior authorization requirements to indicate cardiology imaging prior authorization programs exist for some plans for cardiac imaging; reference materials are available at UHCprovider.com > Cardiology Prior Authorization and Notification
	• Removed notation pertaining to members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements

Durable Medical Equipment (DME), Prosthetics, Orthotics (Non-Foot Orthotics), Nutritional Therapy, and Medical Supplies Grid	**Notice of Revision**: The following summary of changes has been modified. Revisions to the previous policy update announcement are outlined in red below. Please take note of the additional updates to be applied on **May 1, 2024**. **Template Update** • Updated *Instructions for Use* **DME, Prosthetics, Orthotics, and Medical Supplies Grid** • Removed content/language addressing artificial limbs (addition to lower limb prosthesis, vacuum pump) (HCPCS codes L5781 and L5782) ***Air-Fluidized Bed (HCPCS Code E0194)*** • Added list of applicable HCPCS codes to item heading

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Policy Title	Summary of Changes
Durable Medical Equipment (DME), Prosthetics, Orthotics (Non-Foot Orthotics), Nutritional Therapy, and Medical Supplies Grid (continued)	***Alternating Pressure Pads and Mattress (HCPCS Codes E0277 and E0373)*** • Added list of applicable HCPCS codes to item heading ***Artificial Limbs – Lower Limb (HCPCS Codes L5301, L5856, L5968, L5981, and L5987)*** • Added list of applicable HCPCS codes to item heading • Revised language to indicate: ○ [Artificial limbs, lower limb prosthetics are] covered when criteria are met; refer to the DME Medicare Administrative Contractor (MAC) Local Coverage Determination (LCD) for *Lower Limb Prostheses (L33787)* for coverage guidelines ○ For determination of when an artificial limb, lower limb microprocessor is reasonable and necessary as required by the DME MAC LCD for *Lower Limb Prostheses (L33787)*, refer to the UnitedHealthcare Commercial Medical Policy titled *Lower Extremity Prosthetics* ○ UnitedHealthcare uses the criteria noted above: ▪ To supplement the general Medicare criteria regarding artificial limbs, lower limb microprocessors ▪ In order to ensure consistency in reviewing the conditions to be met for coverage of artificial limbs, lower limb microprocessors, as well as reviewing when such services may be medically necessary Use of this criteria to supplement the general provisions noted provides clinical benefits by helping ensure artificial limbs, lower limb microprocessors are not incorrectly denied when medically appropriate for a particular patient nor incorrectly approved when not reasonable and necessary for a patient ○ The criteria considers the patient's day to day needs and the technological differences in the prosthetic knees, and helps ensure that the individual receives a prosthesis that allows the member to ambulate more safely and efficiently ▪ For example, patients obtaining a microprocessor prosthesis instead of a mechanical prosthesis may receive a component that is too heavy, not appropriate for member's activities, and that requires higher maintenance; this can negatively impact members quality of life and functional status ▪ Further, highly active users and athletes may not opt for a microprocessor as they have more limitations than mechanical systems; examples of the limitations of microprocessors include: – The ability to kneel can be very important for most activity levels, however, some microprocessor knees make it difficult for the individual to kneel; – The microprocessor computer uses sensors and complex algorithms to interpret its environment and react, which can slow response time and consistency and can numb the feedback to the user and negatively impact proprioception; – Servicing is required on every submersion and showering is contraindicated; – Operating temperatures of microprocessors are limited; and – Contraindications exist for activities with impact and increased loading ▪ The potential clinical harms of using this criteria may include inappropriately denying an artificial limb, lower limb microprocessor when it is otherwise indicated which could lead to complications for the patient, such as suboptimal use or the member may not

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Durable Medical Equipment (DME), Prosthetics, Orthotics (Non-Foot Orthotics), Nutritional Therapy, and Medical Supplies Grid (continued)	obtain the prosthesis at all, which could adversely affect functional performance, activity level including community participation and quality of life, and overall health of the prosthesis user ▪ The clinical benefits of using this criteria are highly likely to outweigh any clinical harms, including from inappropriate denials, because the criteria is unlikely to lead to inappropriate denials and will provide numerous clinical benefits in helping ensure an appropriate prothesis for the patient; in addition, use of the criteria may decrease inappropriate denials by creating a consistent set of review criteria ○ Also refer to the *Medicare Benefit Policy Manual, Chapter 15, §130 – Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes* ***Artificial Limbs – Upper Limb*** Myoelectric (Upper Limb) (HCPCS Codes L6026, L6611, L6621, L6629, L6632, L6677, L6680, L6682, L6686, L6687, L6688, L6694, L6695, L6696, L6697, L6698, L6715, L6880, L6881, L6882, L6883, L6884, L6890, L6925, L6935, L6945, L6955, L6975, L7007, L7008, L7009, L7045, L7180, L7181, L7190, L7191, L7259, L7360, L7364, L7366, L7367, L7368, L7400, L7401, L7403, L7404, and L8465) *(new to policy)* • Added language to indicate: ○ Medicare does not have a National Coverage Determination (NCD) for myoelectric upper limbs ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Upper Extremity Prosthetic Devices* ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines ***Commode Chair with Seat Lift Mechanism (HCPCS Codes E0170 and E0171)*** (new to policy) • Added language to indicate coverage criteria apply; refer to the DME Medicare Administrative Contractor (MAC) LCD for *Commodes (L33736)* ***Continuous Positive Airway Pressure (CPAP) Devices (HCPCS Code E0618)*** • Added list of applicable HCPCS codes to item heading ***Hospital Beds and Accessories (HCPCS Codes E0302, E0304, E0316, E0328, and E0329)*** • Added list of applicable HCPCS codes to item heading ***Lifts*** Hydraulic (Hoyer) Lift/Patient Lift (HCPCS Codes E0635, E0636, E0639, E0640, E1035, and E1036) • Added list of applicable HCPCS codes to item heading

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Durable Medical Equipment (DME), Prosthetics, Orthotics (Non-Foot Orthotics), Nutritional Therapy, and Medical Supplies Grid (continued)	***Light Therapy Box (HCPCS Codes E0692, E0693, and E0694)*** • Added list of applicable HCPCS codes to item heading ***Mobility Assistive Equipment (MAE)*** Power Mobility Device (PMDs) (HCPCS Codes E0984, E0986, E0988, E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1009, E1010, E1017, E1230, E1239, K0801, K0806, K0808, K0831, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0843, K0848, K0849, K0850, K0851, K0852, K0854, K0855, K0856, K0857, K0858, K0859, K0860, K0861, K0863, K0864, K0877, K0884, K0890, K0891, K0898, and K0899) • Added list of applicable HCPCS codes to item heading Wheelchairs (Manual) (HCPCS Codes E1161, E1232, E1233, E1234, E1235, E1236, E1237, and E1238) • Added list of applicable HCPCS codes to item heading ***Other Non-Covered Items (HCPCS Codes E0761 and E1399)*** • Added list of applicable HCPCS codes to item heading ***Pneumatic Compression Devices (HCPCS Codes E0651, E0652, and E0667)*** • Added list of applicable HCPCS codes to item heading ***Pumps, Including Medications and Necessary Supplies*** Infusion (HCPCS Code E0784) • Added list of applicable HCPCS codes to item heading ***Speech Generating Device (HCPCS Code E2510)*** • Added list of applicable HCPCS codes to item heading ***Vacuum Assisted Closure Device (VAC) or Negative Pressure Wound Therapy Pump (HCPCS Codes E2402, A6550, and A7000)*** • Added list of applicable HCPCS codes to item heading

Molecular Pathology/ Molecular Diagnostics/ Genetic Testing	**Title Change**
	• Previously titled *Genetic Testing*
	Coverage Guidelines
	• Removed content/language addressing:
	  ○ Tumor markers
	  ○ Cytogenetic studies
	  ○ Next generation sequencing (NGS)

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Policy Title	Summary of Changes
Molecular Pathology/ Molecular Diagnostics/ Genetic Testing (continued)	○ Pharmacogenomic testing for warfarin response (CYP2C9 and VKORC1) (HCPCS code G9143 and CPT codes 81227 and 81355) ● Added language to indicate molecular pathology and molecular diagnostics are covered when Medicare coverage criteria are met ● Revised list of *Molecular Diagnostic Tests Included in the Palmetto MolDX Program*: ○ Added: ▪ Molecular biomarker testing to guide targeted therapy selection in rheumatoid arthritis ▪ Next-generation sequencing for solid tumors ▪ Next-generation sequencing lab-developed tests for myeloid malignancies and suspected myeloid malignancies ▪ Proteomics testing ○ Removed: ▪ Cystatin C measurement ▪ FDA approved CLL companion diagnostic test ▪ Urine drug testing ○ Updated descriptor/heading for: ▪ "4q25-AF risk genotype testing" (previously listed as "4q25-AF risk genotype coding") ▪ "Minimal residual disease testing for cancer" (previously listed as "minimal residual disease testing for solid tumor") ▪ "Targeted genomic sequence analysis panel, solid organ or neoplasm" (previously listed as "targeted genomic sequence analysis panel, solid organ or hematolymphoid neoplasm") **Supporting Information** ● Updated lists of applicable *Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs)* to reflect the most current information: ○ Modified reference information for: ▪ 4kscore® assay ▪ Abbott RealTime IDH1 and IDH2 testing for acute myeloid leukemia (AML) ▪ ABL1 gene analysis ▪ Afirma™ Assay by Veracyte ▪ Apoe genotype ▪ Aspartoacylase 2 deficiency (ASPA) testing ▪ ATP7B gene tests ▪ BCKDHB gene test ▪ BCR-ABL ▪ Negative myeloproliferative disease ▪ BDX-XL2 ▪ Biomarkers in cardiovascular risk assessment

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Policy Title	Summary of Changes
Molecular Pathology/ Molecular Diagnostics/ Genetic Testing (continued)	▪ Lab: bladder/urothelial tumor markers ▪ BLM gene analysis ▪ Blood product molecular antigen typing ▪ Breast cancer assay: Prosigna ▪ Breast Cancer Index® (BCI) gene expression test ▪ CDH1 genetic testing ▪ CHD7 gene analysis ▪ EndoPredict breast cancer gene expression test ▪ FDA-approved BRAF tests ▪ FDA-approved EGFR tests ▪ FDA-approved KRAS tests ▪ GBA genetic testing ▪ Germline testing for use of PARP inhibitors ▪ GlycoMark® testing for glycemic control ▪ HBB gene test ▪ HLA testing for transplant histocompatibility ▪ Hypercoagulability/thrombophilia (Factor V Leiden, Factor II Prothrombin, and MTHFR) ▪ LKBKAP genetic testing ▪ Immunohistochemistry (IHC) indications for breast pathology ▪ Lab-developed tests for inherited cancer syndromes in patients with cancer ▪ MCOLN1 genetic testing ▪ Melanoma risk stratification molecular testing ▪ MGMT promoter methylation analysis ▪ Microsatellite instability-high (MSI-H) and mismatch repair deficient (DMMR) biomarker for patients with unresectable or metastatic solid tumors ▪ Minimal residual disease testing for cancer ▪ Molecular biomarkers to risk-stratify patients at increased risk for prostate cancer ▪ Molecular syndromic panels for infectious disease pathogen identification testing ▪ Molecular testing for detection of upper gastrointestinal metaplasia, dysplasia, and neoplasia ▪ Molecular testing for solid organ allograft rejection ▪ NRAS genetic testing ▪ PAX6 gene sequencing

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Policy Title	Summary of Changes
Molecular Pathology/ Molecular Diagnostics/ Genetic Testing (continued)	▪ Percepta® bronchial genomic classifier ▪ Pharmacogenomics testing ▪ HLA testing for transplant histocompatibility ▪ Pigmented lesion assay ▪ PIK3CA gene tests ▪ Plasma-based genomic profiling in solid tumors ▪ Prognostic and predictive molecular classifiers for bladder cancer ▪ Promark® risk score ▪ Prometheus IBD SGI Diagnostic® policy ▪ Prostate cancer genomic classifier assay for men with localized disease ▪ Repeat germline testing ▪ SEPT9 gene test ▪ STAT3 gene testing ▪ Targeted genomic sequence analysis panel, solid organ, or neoplasm
Omnibus Codes	**Coverage Guidelines** • Revised language to indicate: ○ This UnitedHealthcare Medicare Advantage Coverage Summary is intended to be used when there are no Medicare coverage criteria or other UnitedHealthcare Medicare Advantage Coverage Summaries that include omnibus codes ○ For coverage guidelines for items and services not listed in this policy, first search the Medicare Coverage Database to confirm no applicable Medicare coverage guidelines exist ○ After searching the Medicare Coverage Database, if no National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA) is found, then search for a UnitedHealthcare Medicare Advantage Coverage Summary that specifically addresses the service/code; if none is found, refer to the table [in the policy] ○ The guidelines in this Coverage Summary are for specific services only; for services not addressed in this Coverage Summary, refer to the Medicare Coverage Database to search for applicable coverage policies (NCDs, LCDs, and LCAs) • Added list of applicable CPT/HCPCS codes with corresponding coverage criteria ○ Added instruction to refer to the NCD for *Hair Analysis (190.6)* for coverage criteria for HCPCS code P2031 ○ Added instruction to refer to the listed LCD/LCA for coverage criteria for CPT codes 0075T, 0076T, 0333T, 0525T, 0526T, 0527T, 0528T, 0529T, 0530T, 0531T, 0532T, 0640T, 19294, 43206, 43252, 94011, 94012, and 94013; for coverage guidelines for states/territories with no LCDs/LCAs, refer to the United Healthcare Commercial Medical Policy titled *Omnibus Codes* ○ Added language to indicate the following CPT/HCPCS codes are **unproven**; refer to the United Healthcare Commercial Medical Policy titled *Omnibus Codes*: 0061U, 0163U, 0174T, 0175T, 0207T, 0208T, 0209T, 0210T, 0211T, 0212T, 0234T, 0235T, 0236T,

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Omnibus Codes (continued)	0237T, 0247U, 0266T, 0267T, 0268T, 0269T, 0270T, 0271T, 0272T, 0273T, 0330T, 0331T, 0332T, 0335T, 0338T, 0339T, 0347T, 0348T, 0349T, 0350T, 0351T, 0352T, 0353T, 0354T, 0358T, 0397T, 0408T, 0409T, 0410T, 0411T, 0412T, 0413T, 0414T, 0415T, 0416T, 0417T, 0418T, 0444T, 0445T, 0469T, 0472T, 0473T, 0485T, 0486T, 0506T, 0507T, 0510T, 0511T, 0515T, 0516T, 0517T, 0518T, 0519T, 0520T, 0521T, 0522T, 0559T, 0560T, 0561T, 0562T, 0563T, 0567T, 0568T, 0571T, 0572T, 0573T, 0574T, 0575T, 0576T, 0577T, 0578T, 0579T, 0580T, 0581T, 0583T, 0594T, 0600T, 0601T, 0607T, 0608T, 0614T, 0615T, 0616T, 0617T, 0618T, 0631T, 0647T, 0651T, 0658T, 0659T, 0664T, 0665T, 0666T, 0667T, 0668T, 0669T, 0670T, 0692T, 0694T, 0695T, 0696T, 0735T, 0766T, 0767T, 0859T, 0861T, 0862T, 0863T, 19105, 31634, 37799, 53451, 53452, 53453, 53454, 63268, 76999, 80145, 80230, 80280, 80299, 81599, 84999, 86849, 88375, 90999, 93998, 97799, A4542, C1839, E0734, E1399, K1007, K1030, L2999, L8608, and L8699 ○ Added language to indicate CPT codes 99174 and 99177 are **proven in certain circumstances**; refer to the United Healthcare Commercial Medical Policy titled *Omnibus Codes* **Supporting Information** ● Added list of applicable *Medicare Administrative Contractors (MACs) with Corresponding States/Territories*
Radiologic Diagnostic Procedures	**Coverage Guidelines** ● Removed notation indicating radiology prior authorization programs exist for some markets for MRIs, MRAs, PET scans, and nuclear medicine studies ● Removed content/language addressing: ○ Diagnostic x-rays ○ X-ray, radium, and radioactive isotope therapy ○ Bone (mineral) density studies/mass measurements ○ Beta amyloid positron emission tomography in dementia and neurodegenerative disease ***Computerized Tomography (CT Scan)*** ● Revised language to indicate: ○ For coverage guidelines, refer to the National Coverage Determination (NCD) for *Computerized Tomography (220.1)* ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable; these LCDs/LCAs are available in the Medicare Coverage Database ○ For states/territories with no LCDs/LCAs, for determination of when a CT scan is reasonable and necessary as required by the NCD for *Computerized Tomography (220.1)*, refer to the applicable nationally recognized guidelines (i.e., InterQual® CP: Imaging) ○ UnitedHealthcare uses the criteria in the InterQual® guidelines to supplement the general Medicare criteria regarding when a computerized tomography (CT) scan is reasonable and necessary

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Radiologic Diagnostic Procedures (continued)	○ UnitedHealthcare uses the criteria noted above in order to ensure consistency in reviewing the conditions to be met for coverage of a CT scan, as well as reviewing when such services may be medically necessary ○ Use of this criteria to supplement the general provisions noted above provides clinical benefits by helping ensure CT scans are not incorrectly denied when medically appropriate for a particular patient nor incorrectly approved when not reasonable and necessary for a patient ○ The potential clinical harms of using this criteria may include inappropriately denying a CT scan when it is otherwise indicated, which could lead to diagnostic and treatment errors ○ The clinical benefits of using this criteria are highly likely to outweigh any clinical harms, including from delayed or decreased access to services, because the criteria is unlikely to lead to circumstances where CT Scans are inappropriately denied ○ In addition, use of the criteria may decrease inappropriate denials by creating a consistent set of review criteria; further, use of the criteria should limit the circumstances where CT Scans are incorrectly approved, which itself provides benefits because performing the test when it is not indicated can lead to false positive findings requiring otherwise unnecessary testing and or procedures and downstream complications ○ Additionally, unnecessary exposure to radiation may modestly elevate a person's lifetime risk of developing cancer ○ The administration of intravenous contrast commonly used to highlight both normal anatomy and pathologic conditions may have untoward effects including: ▪ Allergic reactions ▪ Leakage around the vein causing tissue damage ▪ Injury to the kidneys ***Computed Tomography (CCT) and Coronary Computed Tomography Angiography (CCTA)*** ● Removed language pertaining to states/territories with no LCDs/LCAs in regions involved in the Radiology Prior Authorization Program ● Modified language pertaining to plans not involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program; added instruction to refer to the applicable nationally recognized guidelines (i.e., InterQual® CP: Imaging) ***Single Photon Emission Computed Tomography (SPECT) (CPT Codes 78071, 78072, 78451, 78452, 78469, 78494, and 78803)*** ● Modified language pertaining to plans not involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program; added instruction to refer to the applicable nationally recognized guidelines (i.e., InterQual® CP: Imaging) ***Magnetic Resonance Imaging (MRI) & Magnetic Resonance Angiography (MRA) (MRI for Blood Flow)*** ● Modified service heading ● Revised language to indicate: ○ For coverage guidelines, refer to the NCD for *Magnetic Resonance Imaging (220.2)*

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Approved for Immediate Implementation

Policy Title	Summary of Changes
Radiologic Diagnostic Procedures (continued)	○ LCDs/LCAs exist and compliance with these policies is required where applicable; these LCDs/LCAs are available in the Medicare Coverage Database ○ For states/territories with no LCDs/LCAs, for indications of MRI/MRA not specifically addressed by the National Coverage Determination (NCD) for *Magnetic Resonance Imaging (220.2)*, refer to the applicable nationally recognized guidelines (i.e., InterQual® CP: Imaging) ***Positron Emission Tomography (CPT Codes 78429, 78430, 78431, 78432, 78433, 78434, 78459, 78491, 78492, 78608, 78811, 78812, 78813, 78814, 78815, and 78816)*** ● Added language to indicate: ○ For regions/states/territories involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program, refer to the Medicare Advantage Radiology & Cardiology Clinical Guidelines at UHCprovider.com > Radiology Prior Authorization and Notification ○ For plans not involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program, refer to the nationally recognized guidelines (i.e., InterQual® guidelines) ***Other Nuclear Medicine (CPT Codes 78012, 78013, 78014, 78015, 78016, 78018, 78070, 78071, 78072, 78075, 78099, 78199, 78226, 78227, 78299, 78399, 78499, 78579, 78580, 78582, 78597, 78598, 78599, 78699, 78799, 78800, 78801, 78802, 78804, 78830, 78831, 78832, and 78999)*** ● Modified language pertaining to plans not involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program; added instruction to refer to the applicable nationally recognized guidelines (i.e., InterQual® CP: Imaging) ***3D Rendering (CPT Codes 76376 and 76377)*** ● Modified language pertaining to plans not involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program; added instruction to refer to the applicable nationally recognized guidelines (i.e., InterQual® CP: Imaging) **Supporting Information** ● Added list of applicable *Medicare Administrative Contractors (MACs) with Corresponding States/Territories* ● Updated lists of applicable *Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs)* to reflect the most current information: ○ Added notation to indicate the Wisconsin Physicians Service Insurance Corporation (WPS) Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers ○ Modified reference information for *Positron Emission Tomography (PET) (FDG) for Oncologic Conditions* ○ Updated *References* section

Coverage Summary Updates

Revised

Approved for Immediate Implementation

Policy Title	Summary of Changes

Skilled Nursing Facility, Rehabilitation, and Long-Term Acute Care Hospital	**Coverage Guidelines**
	Outpatient Rehabilitation Therapy (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) (CPT Codes 92507, 92521, 92522, 92523, 92524, 92526, 92605, 92606, 92607, 92608, 92609, 92610, 93797, 93798, 94625, 94626, 96105, 96125, 97014, 97035, 97110, 97112, 97113, 97116, 97124, 97129, 97130, 97140, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97530, 97535, 97537, 97542, 97760, and 97763)
	Conditions of Coverage
	• Updated language pertaining to members in states that participate in the Outpatient Therapy Utilization Management Program:
	  ○ Added language to indicate additional criteria may exist through the Optum Physical Health Outpatient Rehabilitation Therapy Program; reference materials are available at myoptumhealthphysicanhealth.com > Clinical Policies
	• Removed instruction to refer to the InterQual® LOC: Outpatient Rehabilitation & Chiropractic
	Long Term Acute Care Hospital (LTACH)
	• Revised language to indicate:
	  ○ Medicare does not have a National Coverage Determination (NCD) or Local Coverage Determinations (LCDs) for determining medical necessity for long term acute care hospitalization
	  ○ UnitedHealthcare may utilize InterQual®, an evidence-based clinical decision tool to make medical necessity determinations, if there is no NCD, applicable LCD/LCA, or Medicare manual guidance on coverage, or where the existing guidance provides insufficient clinical detail; refer to the InterQual® LOC: Long-Term Acute Care
	  ○ Also refer to the:
	  ▪ Medicare Benefit Policy Manual Chapter 1 - Inpatient Hospital Services Covered Under Part A
	  ▪ Medicare.gov Long Term Hospital Care Coverage Website
	  ▪ Medicare Claims Processing Manual, Chapter 3 - Inpatient Hospital Billing §150 - Long Term Care Hospitals (LTCHs) PPS
	  ▪ Medicare Program Integrity Manual, Chapter 6, Section 6.5 – Medical Review of Inpatient Hospital Claims for Part A Payment
	  ▪ Centers for Medicare and Medicaid Services Medicare Learning Network, Long-Term Care Hospital Prospective Payment System (MLN6922507)

Revised

Approved for Future Implementation

Policy Title	Effective Date	Summary of Changes
Glaucoma & Other Ophthalmic Surgical Treatments	Jun. 1, 2024	**Title Change** • Previously titled *Glaucoma Surgical Treatments*

Coverage Summary Updates

Revised

Approved for Future Implementation

Policy Title	Effective Date	Summary of Changes

Glaucoma & Other Ophthalmic Surgical Treatments (continued)	Jun. 1, 2024	**Coverage Guidelines**
		• Removed content/language addressing:
		  ○ Canaloplasty (CPT codes 66174 and 66175)
		  ○ Viscocanalostomy
		Implantation of Glaucoma Drainage Devices (e.g., ExPRESS™ Mini Glaucoma Shunt, Molteno Implant, Baerveldt Tube Shunt, Krupin Eye Valve, or the Ahmed Glaucoma Valve Implant) (CPT Codes 66179, 66180, and 66183 and HCPCS Code L8612)
		• Updated list of applicable CPT/HCPCS codes; removed C1783
		Dexamethasone Intracanalicular Ophthalmic Insert (e.g., Dextenza®) (CPT Code 68841 and HCPCS Code J1096)
		• Updated list of applicable CPT/HCPCS codes; added J1096
		• Revised language to indicate:
		  ○ Medicare does not have a National Coverage Determination (NCD) for dexamethasone intracanalicular ophthalmic insert
		  ○ 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 *Supporting Information* section of the policy]
		  ○ For coverage guidelines for states/territories with no LCDs/LCAs for HCPCS code J1069, refer to the UnitedHealthcare Commercial Medical Benefit Drug Policy titled *Intracanalicular and Intravitreal Corticosteroid Implants*
		  ○ CPT code 68841 (insertion of drug-eluting implant, including punctal dilation when performed into lacrimal canaliculus, each) is covered when used in combination with J1096, when criteria is met for J1096
		  ○ After checking the table [in the *Supporting Information* section of the policy] and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines
		Supporting Information
		• Added list of applicable *Medicare Administrative Contractors (MACs) with Corresponding States/Territories*
		• Updated lists of applicable *LCDs/LCAs* to reflect the most current information; added notation to indicate the Wisconsin Physicians Service Insurance Corporation (WPS) Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers
		• Removed *Clinical Evidence* and *References* sections

Coverage Summary Updates

Revised

Approved for Future Implementation

Policy Title	Effective Date	Summary of Changes
Hospital, Emergency, and Ambulance Services	Jun. 1, 2024	**Template Update** • Updated *Instructions for Use* **Coverage Guidelines** ***Inpatient Hospital Services*** • Updated language pertaining to appropriateness of coverage under Medicare for an inpatient admission; replaced language indicating "the documentation must clearly support the member's severity of illness and intensity of service to warrant the need for inpatient medical care" with "the documentation must clearly support the *medical necessity of the* member's *inpatient admission, as evidenced by* severity of illness and intensity of service to warrant the need for inpatient medical care" • Removed reference to the *Federal Register Volume 88 No.22191* Additional Considerations Supporting Inpatient Stay • Added language to indicate use of the criteria [noted in the policy] to supplement the [general Medicare criteria regarding inpatient admissions] provides clinical benefits by helping ensure inpatient admissions are not incorrectly denied when medically appropriate for a particular patient nor incorrectly approved when not reasonable and necessary for a patient ○ The potential clinical harms of using the criteria may include inappropriately denying an inpatient admission when it is otherwise indicated, which could lead to potential medical complications by not being closely monitored in the hospital ○ The clinical benefits of using the criteria are highly likely to outweigh any clinical harms, including from delayed or decreased access to services, because the criteria is unlikely to lead to circumstances where inpatient admissions are inappropriately denied ○ In addition, use of the criteria may decrease inappropriate denials by creating a consistent set of review criteria; further, use of the criteria should limit the circumstances where patients are inappropriately admitted as inpatient, which itself provides benefits because it prevents unnecessary development of adverse events (e.g., falls, pressure ulcers, medication complications, venous thromboembolism) ○ Additionally, unnecessary exposure to the hospital may decrease the risk for developing a hospital acquired infection ○ Use of this criteria will also further the Centers for Medicare & Medicaid (CMS) goal of reducing inpatient admission errors • Replaced language indicating "UnitedHealthcare uses InterQual® as a source of medical evidence to support medical necessity and level of care decisions" with "*as described in the UnitedHealthcare Commercial Medical Policies*

Coverage Summary Updates

Revised

Approved for Future Implementation

Policy Title	Effective Date	Summary of Changes
Hospital, Emergency, and Ambulance Services (continued)	Jun. 1, 2024	*referenced [in the policy],* UnitedHealthcare uses InterQual® as a source of medical evidence to support medical necessity and level of care decisions" ***Ambulance Services (HCPCS Codes A0430, A0431, A0435, and A0436)*** • Updated list of applicable HCPCS codes; removed A0425, A0426, A0427, A0428, A0429, A0432, A0433, and A0434 **Supporting Information** • Added list of applicable *Medicare Administrative Contractors (MACs) with Corresponding States/Territories* • Updated list of applicable *Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs)* to reflect the most current information; added notation to indicate the Wisconsin Physicians Service Insurance Corporation (WPS) Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers • Updated *References* section

Retired

The following Coverage Summary has been retired effective Apr. 10, 2024:

- Vision Services

General Information

The inclusion of a health service (e.g., test, drug, device, or procedure) in this bulletin indicates only that UnitedHealthcare is adopting 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. 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.

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 changes to our Medicare Advantage Coverage Summaries. When information in this bulletin conflicts with applicable state and/or federal law, UnitedHealthcare follows such applicable federal and/or state law.

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.

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

The complete library of UnitedHealthcare Medicare Advantage Coverage Summaries is available at **UHCprovider.com** > Policies and Protocols > Medicare Advantage Policies > Coverage Summaries.