Coverage Summary

Non-Covered Services
(Including Services/Complications Related to Non-Covered Services)

Approved by: UnitedHealthcare Medicare Benefit Interpretation Committee  Last Review Date: 02/18/2020

Related Medicare Advantage Policy Guidelines:

- Category III CPT Codes
- Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)

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The benefit information in this Coverage Summary is based on existing national coverage policy, however, Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

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I. COVERAGE

Coverage Statement: Medicare does not cover items and services unless the item or service is a defined benefit (Section 1861 of the Social Security Act), not statutorily excluded, and is reasonable and necessary for the diagnosis or treatment of an illness or injury or for the improvement in the functioning of a malformed body member (Section 1862 (a)(1) of the Social Security Act).

(Accessed January 31, 2020)

Note: Depending on the member’s plan, members may have supplemental benefit. Refer to the member’s Evidence of Coverage (EOC) or contact the Customer Service Department to determine coverage eligibility for supplemental benefit.
Guidelines/Notes:

1. Non-covered Items and Services

Medicare does make payment under either the hospital insurance or supplementary medical insurance program for certain items and services, when the following conditions listed below exist. See the following sections of the Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage for a-o. (Accessed January 31, 2020)

   a) Not reasonable and necessary (see §20)
   b) No legal obligation to pay for or provide (see §40)
   c) Paid for by governmental entities (see §50); also see the Coverage Summary for Services While Confined/Incarcerated and the Coverage Summary for Veteran Administration (VA) and Indian Health Services (IHS)
   d) Not provided within United States (see §60); also see the Coverage Summary for Emergent/Urgent Services, Post-Stabilization Care and Out-of-Area Services.
   e) Resulting from war (see §70)
   f) Personal comfort (see §80)
   g) Routine services and appliances (see §90)
   h) Hearing Aids and Auditory Implants (see §100); also see Coverage Summary for Hearing Aids, Auditory Implants and Related Procedures.
   i) Custodial care (see §110)
   j) Cosmetic surgery (see §120); also see the Coverage Summary for Cosmetic and Reconstructive Procedures.
   k) Charges by immediate relatives or members of household (see §130)
   l) Dental services (see §140); also see the Coverage Summary for Dental Services, Oral Surgery and Treatment of Temporomandibular Joint (TMJ).
   m) Services Reimbursable Under Automobile, No Fault, Any Liability Insurance or Workers’ Compensation (see §150)
   n) Nonphysician services provided to a hospital inpatient that were not provided directly or arranged for by the hospital (see §170)
   o) Excluded foot care services and supportive devices for feet (see §30); also see the Coverage Summary for Foot Care Services.

   Also see the Coverage Summary for Experimental Procedures and Items, Investigational Devices and Clinical Trials.

Example include, but is not limited to:

Category III Codes (T-Codes): Category III codes will be automatically denied as investigational unless specifically addressed as covered in another LCD or Local Article. These codes are temporary codes created to track the utilization of emerging technologies, services, and procedures. Refer to the LCD/LCA Availability Grid (Attachment A) for state-specific LCDs/LCAs.

2. Services Related to and Required as a Result of Services which are Not Covered under Medicare

   a) Medical and hospital services arising from non-covered services are covered when determined to be reasonable and necessary.
(1) When a member is admitted to the hospital for a non-covered service:
   (a) Complications of non-covered procedures develop after the member has been formally discharged from the hospital providing the non-covered service.
       Example: A member undergoes a non-covered cosmetic procedure and, following discharge, develops an infection at the surgical site. Services to treat the infection are covered. This includes subsequent inpatient stays or outpatient treatment ordinarily covered under the member’s health plan.
   (b) A complication develops that did not arise from a non-covered service or was not related to the non-covered service received by the member.
       Example: A member hospitalized for non-covered service breaks a leg while in the hospital. Services in connection with the broken leg are covered.

(2) When a member is admitted to the hospital for a covered service and obtains a non-covered procedure unrelated to the admission diagnosis, the services related to the admitting diagnosis would continue to be covered.

b) Medical and hospital services arising from non-covered service that are related to the non-covered service are not covered.

(1) When a member is admitted to the hospital for a non-covered service:
   (a) Complications that arise from, or are related to, a non-covered service before the member is formally discharged from the hospital providing that service
   (b) A covered service which is in preparation for a non-covered service
   (c) A covered service that is part of a treatment regimen for a non-covered service that requires a series of postoperative visits to a surgeon

(2) When a member is admitted to the hospital for a covered service and obtains a non-covered service during the same hospital stay, the non-covered service will not be covered.

If, on the basis of the services and a comparison of the date, they are received with the date on which the member is identified as a candidate for a non-covered service, the services reasonably attributed to preparation for the non-covered service will not be covered.


For a list of non-covered services, coding and claims payment guidelines, refer to the LCD/LCA Availability Grid (Attachment A). Compliance with these policies is required where applicable.

II. DEFINITIONS

None

III. REFERENCES

See above
### Attachment A – LCD/LCA Availability Grid

**Category III Codes/Non-Covered Services**

CMS website May 15, 2020

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<thead>
<tr>
<th>ID #</th>
<th>Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>L34370</td>
<td>Category III CPT® Codes</td>
<td>MAC Part A and B</td>
<td>CGS Administrators, LLC</td>
<td>KY, OH</td>
</tr>
<tr>
<td>L33777</td>
<td>Non-covered Services</td>
<td>A and B MAC</td>
<td>First Coast Service Options, Inc.</td>
<td>FL, PR, VI</td>
</tr>
<tr>
<td>L33392</td>
<td>Category III CPT® Codes</td>
<td>MAC Part A and B</td>
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<td>IL, MN, WI, CT, NY, ME, MA, NH, RI, VT</td>
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<td>CT, IL, MA, ME, MN, NH, NY, RI, VT, WI</td>
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<td>Noridian Healthcare Solutions, LLC</td>
<td>CA, AS, GU, HI, MP, NV</td>
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<td>L35008</td>
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<td>Noridian Healthcare Solutions, LLC</td>
<td>AK, AZ, ID, OR, MT, ND, SD, UT, WA, WY</td>
</tr>
<tr>
<td></td>
<td>(Note: States notated with an asterisk should follow the other available state-specific LCD listed on this grid. This WPS LCD only applies to states without asterisk.)</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

**End of Attachment A**