

Rehabilitation: Medical Rehabilitation (OT, PT and ST, Including Cognitive Rehabilitation)

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Related Medicare Advantage Policy Guidelines
• Diathermy Treatment (NCD 150.5)
• Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) (NCD 20.35)

Coverage Guidelines

Medical rehabilitation (occupational therapy, physical therapy, speech-language pathology , including cognitive rehabilitation) is covered when Medicare coverage criteria are met.

COVID-19 Public Health Emergency Waivers & Flexibilities: In response to the COVID-19 Public Health Emergency, CMS has updated some guidance for certain rehabilitation services. For a comprehensive list of Coronavirus Waivers & Flexibilities, refer to <https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers>. (Accessed April 8, 2021)

Outpatient Rehabilitation Therapy (Physical Therapy, Occupational Therapy and Speech-Language Pathology Services)

Conditions of Coverage

Outpatient therapy services are covered in accordance with certain conditions as outlined in the [Medicare Benefit Policy Manual, Chapter 15, §220.1 – Conditions of Coverage and Payment for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services](#). (Accessed April 8, 2021)

Reasonable and Necessary

To be covered, services must be skilled therapy services and be rendered under the conditions specified. Services provided by professionals or personnel who do not meet the qualification standards, and services by qualified people that are not appropriate to the setting or conditions are unskilled services. A service is not considered a skilled therapy service merely because it is furnished by a therapist or by a therapist/therapy assistant under the direct or general supervision, as applicable, of a therapist. If a service can be self-administered or safely and effectively furnished by an unskilled person, without the direct

or general supervision, as applicable, of a therapist, the service cannot be regarded as a skilled therapy service even though a therapist actually furnishes the service. Similarly, the unavailability of a competent person to provide a non-skilled service, notwithstanding the importance of the service to the patient, does not make it a skilled service when a therapist furnishes the service.

Skilled therapy services may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition. For further information, refer to sections [Rehabilitative Therapy](#) and [Maintenance Programs](#).

Services that do not meet the requirements for covered therapy services in Medicare manuals are not payable using codes and descriptions as therapy services. For example, services related to activities for the general good and welfare of patients, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute therapy services for Medicare purposes. Also, services not provided under a therapy plan of care, or provided by staff who are not qualified or appropriately supervised, are not payable therapy services.

To be considered reasonable and necessary, each of the following conditions must be met.

- The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the member's condition.
Notes:
 - Acceptable practices for therapy services are found in:
 - Medicare manuals (such as Publications 100-2, 100-03 and 100-04),
 - Local Coverage Determinations, and
 - Guidelines and literature of the professions of physical therapy, occupational therapy and speech-language pathology
 - When establishing the plan of care, the services must relate directly and specifically to a written treatment plan as described in §220.1.2 of Medicare Benefit Policy Manual, Chapter 15). The plan, (also known as a plan of care or plan of treatment) must be established before treatment is begun. The plan is established when it is developed (e.g., written or dictated). Refer to the [Medicare Benefit Policy Manual, Chapter 15, §220.1.2 – Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services](#). (Accessed April 8, 2021)
- The services shall be of such a level of complexity and sophistication or the condition of the member shall be such that the services required can be safely and effectively performed only by a therapist, or in the case of physical therapy and occupational therapy by or under the supervision of a therapist. Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional. Medicare coverage does not turn on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care. For additional guidance, refer to the [Maintenance Programs](#) section.
- If the Health Plan determines the services furnished were of a type that could have been safely and effectively performed only by or under the supervision of such a qualified professional, the Health Plan shall presume that such services were properly supervised when required. However, this presumption is rebuttable, and, if in the course of processing a claim, the Health Plan finds that services were not furnished under proper supervision, the claim shall be denied.
- While a member's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a member's diagnosis or prognosis cannot be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by non-skilled personnel.
- The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. The contractor shall consult local professionals or the state or national therapy associations in the development of any utilization guidelines.

Refer to the [Medicare Benefit Policy Manual, Chapter 15, §220.2 – Reasonable and Necessary Outpatient Rehabilitation Therapy Services](#). (Accessed April 8, 2021)

Rehabilitative Therapy

Rehabilitative therapy includes services designed to address recovery or improvement in function and, when possible, restoration to a previous level of health and well-being. Therefore, evaluation, re-evaluation and assessment documented in the Progress Report should describe objective measurements which, when compared, show improvements in function, decrease in severity or rationalization for an optimistic outlook to justify continued treatment. Improvement is evidenced by successive

objective measurements whenever possible (see objective measurement and other instruments for evaluation in the §220.3.C of the Medicare Benefit Policy Manual, Chapter 15). If an individual's expected rehabilitation potential is insignificant in relation to the extent and duration of therapy services required to achieve such potential, rehabilitative therapy is not reasonable and necessary.

For more detailed guideline, refer to the [Medicare Benefit Policy Manual, Chapter 15, §220.2C – Rehabilitative Therapy](#). (Accessed April 8, 2021)

Maintenance Program

Maintenance program is a program established by a therapist that consists of activities and/or mechanisms that will assist a beneficiary in maximizing or maintaining the progress he or she has made during therapy or to prevent or slow further deterioration due to a disease or illness.

Skilled therapy services that do not meet the criteria for rehabilitative therapy may be covered in certain circumstances as maintenance therapy under a maintenance program. The goals of a maintenance program would be, for example, to maintain functional status or to prevent or slow further deterioration in function.

For more detailed guidelines, refer to:

- [Medicare Benefit Policy Manual, Chapter 15, §220.2D – Maintenance Programs](#). (Accessed April 8, 2021)
- [Medicare Benefit Policy Manual, Chapter 15, §220 – Coverage of Outpatient Rehabilitation Therapy Services \(Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services\) Under Medical Insurance, A – Definitions](#). (Accessed April 8, 2021)

Documentation Requirements for Therapy Services

To be payable, the medical record and the information on the claim form must consistently and accurately report covered therapy services, as documented in the medical record. Documentation must be legible, relevant and sufficient to justify the services billed. In general, services must be covered therapy services provided according to Medicare requirements. Medicare requires that the services billed be supported by documentation that justifies payment. Documentation must comply with all requirements applicable to Medicare claims.

For more detailed documentation requirements, refer to the [Medicare Benefit Policy Manual, Chapter 15, §220.3 – Documentation Requirements for Therapy Services](#). (Accessed April 8, 2021)

Covered Settings for Outpatient Rehabilitation Services

Outpatient rehabilitation services maybe covered in the following settings:

Comprehensive Outpatient Rehabilitation Facility (CORF)

CORF is defined as a facility that is primarily engaged in providing outpatient rehabilitation to the injured and disabled or to patients recovering from illness.

For more detailed guideline, refer to the [Medicare Benefit Policy Manual, Chapter 12 – Comprehensive Outpatient Rehabilitation Facility \(CORF\) Coverage](#). (Accessed April 8, 2021)

Physician's Office or Therapist's Office

Refer to the:

- [Medicare Benefit Policy Manual, Chapter 15, §220 – Coverage of Outpatient Rehabilitation Therapy Services \(Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services\) Under Medical Insurance](#).
- [Medicare Benefit Policy Manual, Chapter 15, §230 – Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology](#). (Accessed April 8, 2021)

Member's Place of Residence

A member's residence is wherever the member makes his/her home. This may be his/her own dwelling, an apartment, a relative's home, home for the aged, or some other type of institution. Refer to the [Medicare Benefit Policy Manual, Chapter 7, §30.1.2 – Patient's Place of Residence](#). (Accessed April 8, 2021)

Therapy Caps

Although CMS implemented therapy caps effective January 1, 2006, this change does not affect the UnitedHealthcare Medicare Advantage plans.

For Medicare information regarding therapy caps, refer to the [Medicare Claims Processing Manual, Chapter 5, §10.2 – The Financial Limitation Therapy Caps](#). (Accessed April 8, 2021)

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

Inpatient Rehabilitation Services

Inpatient Rehabilitation Facility (IRF)

In order for IRF care to be considered reasonable and necessary, the documentation in the patient's IRF medical record (which must include the preadmission screening the post-admission physician evaluation, the overall plan of care and the admission orders) must demonstrate a reasonable expectation that the following criteria were met at the time of admission to the IRF.

- The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), one of which must be physical or occupational therapy.
- The patient must generally require an intensive rehabilitation therapy program. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy per day at least 5 days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period, beginning with the date of admission to the IRF.
- The patient must reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program at the time of admission to the IRF. The patient can only be expected to benefit significantly from the intensive rehabilitation therapy program if the patient's condition and functional status are such that the patient can reasonably be expected to make measurable improvement (that will be of practical value to improve the patient's functional capacity or adaptation to impairments) as a result of the rehabilitation treatment, and if such improvement can be expected to be made within a prescribed period of time.

The patient need not be expected to achieve complete independence in the domain of self-care nor be expected to return to his or her prior level of functioning in order to meet this standard. The patient must require physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.

- The patient must require an intensive and coordinated interdisciplinary approach to providing rehabilitation.

For detailed guideline, refer to the [Medicare Benefit Policy Manual, Chapter 1, §110 – Inpatient Rehabilitation Facility \(IRF\) Services](#). (Accessed April 8, 2021)

For the list of medical conditions and facility requirements for intensive rehabilitative services, refer to the [CMS Fact Sheet #1 Inpatient Rehabilitation Facility Classification Requirements](#). (Accessed April 8, 2021)

Skilled Nursing Facility

Refer to the Coverage Summary titled [Skilled Nursing Facility \(SNF\) Care and Exhaustion of SNF Benefits](#)

Local Coverage Determinations (LCDs)/ Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

Cognitive Therapy

In addition to the three required core CORF services, the CORF may furnish any of the other covered and medically necessary items and services listed in §20.2 of the Medicare Benefit Policy Manual, Chapter 12. These optional services must directly relate to, and be consistent with, the rehabilitation plan of treatment, and must be necessary to achieve the patient's rehabilitation goals. When a CORF provides occupational therapy, speech-language pathology and/or respiratory therapy services in addition to the required physical therapy services, the physical therapy services shall represent the predominate rehabilitation service provided

For occupational therapy, services include assessment of an individual's level of independent functioning, selection and teaching of task-oriented therapeutic activities to restore sensory-integrative functions, teaching of compensatory techniques to permit an individual with a physical or cognitive impairment or limitation to engage in daily activities. See the Medicare Benefit Policy Manual, Chapter 12 §20.2 – Optional CORF Services.

For discussion of payment rules, refer to the [Medicare Benefit Policy Manual, Chapter 12 §30.1 Rules of Payment of CORF Services](#).

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) which address the development of cognitive skills exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. (Accessed April 8, 2021)

Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) (CPT code 93668)

Supervised exercise therapy (SET) for members with intermittent claudication (IC) for the treatment of symptomatic peripheral artery disease (PAD) is covered when criteria are met. Refer to the [National Coverage Determination \(NCD\) for Supervised Exercise Therapy \(SET\) for Symptomatic Peripheral Artery Disease \(PAD\) \(20.35\)](#). (Accessed April 8, 2021)

Rehabilitation Services for Members with Vision Impairment

Rehabilitation services are covered for members with a primary vision impairment diagnosis pursuant to a written treatment plan by the member's physician and provided by a qualified occupational or physical therapist (or a person supervised by a qualified therapist) or incident to physician services.

- Vision impairment ranging from low vision to total blindness may result from a primary eye diagnosis, such as macular degeneration, retinitis pigmentosa or glaucoma, or as a condition secondary to another primary diagnosis, such as diabetes mellitus or acquired immune deficiency syndrome (AIDS).
- The member must have the potential for restoration or improvement of lost functions in a reasonable amount of time.
- Most rehabilitation is short-term and intensive, and maintenance therapy – services required to maintain a level of functioning are not covered.
- A person with profound impairment in both eyes (i.e., best corrected visual acuity is less than 20/400 or visual field is 10 degrees or less) would generally be eligible for, and may be provided, rehabilitation services under HCPCS code 97535, (self-care/home management training, i.e., activities of daily living, compensatory training, meal preparation, safety procedures, and instruction in the use of adaptive equipment).

Refer to the [Medicare Program Memorandum AB-02-078, Provider Education Article: Medicare Coverage of Rehabilitation Services for Beneficiaries With Vision Impairment, Change Request 2083, May 29, 2002](#). (Accessed April 8, 2021)

Local Coverage Determinations (LCDs)/ Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search.asp&>.

Other Rehabilitation Therapy Services

Other examples of rehabilitation therapy services include, but are not limited to:

- Aqua/pool therapy/hydrotherapy only as part of an authorized physical therapy treatment plan conducted by a licensed physical therapist with the therapist in attendance.

For descriptions of aquatic therapy in a community center pool; refer to the [Medicare Benefit Policy Manual, Chapter 15, §220C – General](#). (Accessed April 8, 2021)

- Local Coverage Determinations (LCDs/ Local Coverage Articles (LCAs) exist and compliance with these policies are required where applicable. These LCDs/LCAs are available at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search.asp&>.
- Fluidized therapy (fluidotherapy) as a part of an authorized physical therapy treatment plan for the treatment of acute or subacute, traumatic or nontraumatic, musculoskeletal disorders of the extremities. Refer to the [National Coverage Determination \(NCD\) for Fluidized Therapy Dry Heat for Certain Musculoskeletal Disorders\(150.8\)](#) (Accessed April 8, 2021)
 - Local Coverage Determinations (LCDs/ Local Coverage Articles (LCAs) exist and compliance with these policies are required where applicable. These LCDs/LCAs are available at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search.asp&>.
- Treatment of Dysphagia: Speech-language pathology services are covered under Medicare for the treatment of dysphagia, regardless of the presence of a communication disability. Refer to the [National Coverage Determination \(NCD\) for Speech Language Pathology Services for the Treatment of Dysphagia \(170.3\)](#). (Accessed April 8, 2021)
 - Local Coverage Determinations (LCDs/ Local Coverage Articles (LCAs) exist and compliance with these policies are required where applicable. These LCDs/LCAs are available at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search.asp&>.
 - For electrical stimulation for the treatment of dysphagia, refer to the Coverage Summary titled [Electrical and Spinal Cord Stimulators](#).
- Diathermy Treatment (CPT code 97024 and 97035)
 - High energy pulsed wave diathermy machines have been found to produce some degree of therapeutic benefit for essentially the same conditions and to the same extent as standard diathermy. Accordingly, where the contractor's medical staff has determined that the pulsed wave diathermy apparatus used is one which is considered therapeutically effective, the treatments are considered a covered service, but only for those conditions for which standard diathermy is medically indicated and only when rendered by a physician or incident to a physician's professional services. Refer to the [NCD for Diathermy Treatment \(150.5\)](#). (Accessed April 8, 2021)
 - Heat treatment, including the use of diathermy and ultrasound for pulmonary conditions are not covered. There is no physiological rationale or valid scientific documentation of effectiveness of diathermy or ultrasound heat treatments for asthma, bronchitis, or any other pulmonary condition and for such purpose this treatment cannot be considered reasonable and necessary. Refer to the [NCD for Heat Treatment, Including the Use of Diathermy and Ultra-Sound for Pulmonary Conditions \(240.3\)](#). (Accessed April 8, 2021)
 - Local Coverage Determinations (LCDs/ Local Coverage Articles (LCAs) exist and compliance with these policies are required where applicable. These LCDs/LCAs are available at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search.asp&>.
- Massage therapy, unless it is part of a multi-modality authorized treatment plan appropriate to the patient's diagnosis plan with a licensed therapist in attendance. Refer to the [Medicare Benefit Policy Manual, Chapter 15, §230.5 – Physical Therapy, Occupational Therapy and Speech-Language Pathology Services Provided Incident to the Services of Physicians and Non-Physician Practitioners \(NPP\)](#). (Accessed April 8, 2021)
- Vocational and prevocational assessment and training related solely to specific employment opportunities, work skills or work settings. Refer to the [Medicare Benefit Policy Manual, Chapter 15, §230.2 – Practice of Occupational Therapy, D- Application of Medicare Guidelines to Occupational Therapy Services](#). (Accessed April 8, 2021)
- General exercises that promote overall fitness. Refer to the [Medicare Benefit Policy Manual, Chapter 15, §220.2 – Reasonable and Necessary Outpatient Rehabilitation Therapy Services, A-General](#). (Accessed April 8, 2021)
- Activities that provide a diversion or general motivation. Refer to the [Medicare Benefit Policy Manual, Chapter 15, §220.2 – Reasonable and Necessary Outpatient Rehabilitation Therapy Services, A-General](#). (Accessed April 8, 2021)
- Recreational therapy. Refer to the [Medicare Benefit Policy Manual, Chapter 15, §230.5 – Physical Therapy, Occupational Therapy and Speech-Language Pathology Services Provided Incident to the Services of Physicians and Non-Physician Practitioners \(NPP\)](#). (Accessed April 8, 2021)
- Melodic Intonation Therapy
Melodic intonation therapy is covered service only for nonfluent aphasic patients unresponsive to conventional therapy, and the conditions for coverage of speech pathology services are met. Refer to the [National Coverage Determination \(NCD\) for Melodic Intonation Therapy \(170.2\)](#) (Accessed April 8, 2021)

- **Passive Rehabilitation Therapy for Mandibular Hypomobility**
Medicare does not have a National Coverage Determination (NCD) for passive rehabilitation therapy for mandibular hypomobility. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time. For coverage guideline, refer to the UnitedHealthcare Commercial Medical Policy titled [Temporomandibular Joint Disorders](#). Note: After searching the [Medicare Coverage Database](#), if no state LCD or LCA is found, then use the above referenced policy.

Definitions

Occupational Therapy: Services provided within the scope of practice of occupational therapists and necessary for the diagnosis and treatment of impairments, functional disabilities or changes in physical function and health status. [Medicare Benefit Policy Manual, Chapter 15, §230.2 – Practice of Occupational Therapy](#). (Accessed April 8, 2021)

Physical Therapy: Services provided within the scope of practice of physical therapists and necessary for the diagnosis and treatment of impairments, functional limitations, disabilities or changes in physical function and health status. [Medicare Benefit Policy Manual, Chapter 15, §230.1 – Practice of Physical Therapy](#). (Accessed April 8, 2021)

Qualified Professional: A physical therapist, occupational therapist, speech-language pathologist, physician, nurse practitioner, clinical nurse specialist, or physician’s assistant, who is licensed or certified by the state to furnish therapy services, and who also may appropriately furnish therapy services under Medicare policies. Qualified professional may also include a physical therapist assistant (PTA) or an occupational therapy assistant (OTA) when furnishing services under the supervision of a qualified therapist, who is working within the state scope of practice in the state in which the services are furnished. Assistants are limited in the services they may furnish (see section 230.1 and 230.2) and may not supervise other therapy caregivers. [Medicare Benefit Policy Manual, Chapter 15, §230 – Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology](#). (Accessed April 8, 2021)

Speech-Language Pathology Services: The services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia) regardless of the presence of a communications disability. [Medicare Benefit Policy Manual, Chapter 15, §230 – Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology](#). (Accessed April 8, 2021)

Therapy Services: Skilled services furnished according to the standards and conditions in CMS manuals, (e.g., Medicare Benefit Policy Manual, Chapter 15 and in Medicare Claims Processing Manual, Chapter 5), within their scope of practice by qualified professionals or qualified personnel, as defined in §230 of the Medicare Benefit Policy Manual, Chapter 15. [Medicare Benefit Policy Manual, Chapter 15, §230 – Practice of Physical Therapy, Occupational Therapy, and Speech-Language Pathology](#). (Accessed April 8, 2021)

Policy History/Revision Information

Date	Summary of Changes
04/20/2021	Template Update <ul style="list-style-type: none"> • Reformatted policy; transferred content to new template • Routine review; no change to coverage guidelines

Instructions for Use

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource 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. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member’s Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy

and the member's EOC/SB, the member's EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

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 are 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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