

Facet Joint Interventions for Pain Management

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<p>Related Medicare Advantage Policy Guideline</p> <ul style="list-style-type: none"> • Category III CPT Codes
<p>Related Medicare Advantage Reimbursement Policies</p> <ul style="list-style-type: none"> • Assistant-at-Surgery Services Policy, Professional • Multiple Procedure Payment Reduction (MPPR) for Medical and Surgical Services Policy, Professional
<p>Related Medicare Advantage Coverage Summary</p> <ul style="list-style-type: none"> • Pain Management and Pain Rehabilitation

Policy Summary

[↪ See Purpose](#)

Overview

Facet joint interventions may be used in pain management for chronic cervical/thoracic and back pain arising from the paravertebral facet joints. The facet block procedure is an injection of a local anesthetic, with or without a steroid medication, either into the facet joint (intra-articular) or outside the joint space around the nerve supply to the joint (the medial branch nerve) known as medial branch block (MBB). Imaging guidance (fluoroscopy or CT per code descriptor) is used to assure accurate placement of the needle for the injection. Paravertebral facet joint denervation is a therapeutic intervention used to provide both long-term pain relief and reduce the likelihood of recurrence of chronic cervical/thoracic or back pain confirmed as originating in the facet joint’s medial branch nerve.

There are various methods that may be used in performing facet joint denervation. Percutaneous radiofrequency ablation (RFA) is a minimally invasive procedure done with imaging guidance (fluoroscopy or CT per code descriptor) and involves using energy in the radiofrequency range to cause necrosis of specific nerves (medial branches of the dorsal rami), preventing the neural transmission of pain. Conventional radiofrequency ablation (non-pulsed or continuous) applies thermal energy of typically 80 to 85 degrees Celsius. The terms RFA and radiofrequency neurotomy are used interchangeably. Both terms refer to a procedure that destroys the functionality of the nerve using radiofrequency energy. Non-thermal methods of denervation include chemical (chemodenervation), low-grade thermal energy (less than 80 degrees Celsius), pulsed RFA, laser neurolysis, and cryoablation.

Guidelines

Facet Joint Interventions

Facet Joint Interventions are considered medically reasonable and necessary for the diagnosis and treatment of chronic pain in patients who meet ALL the following criteria:

- Moderate to severe chronic neck or low back pain, predominantly axial, that causes functional deficit measured on pain or disability scale*
- Pain present for minimum of 3 months with documented failure to respond to noninvasive conservative management (as tolerated)

- Absence of untreated radiculopathy or neurogenic claudication (except for radiculopathy caused by facet joint synovial cyst)
- There is no non-facet pathology per clinical assessment or radiology studies that could explain the source of the patient's pain, including but not limited to fracture, tumor, infection, or significant deformity.

*Pain assessment must be performed and documented at baseline, after each diagnostic procedure and at each follow-up using the same pain scale for each assessment. A disability scale must also be obtained at baseline to be used for functional assessment (if patient qualifies for treatment).

Diagnostic Facet Joint Procedures (IA or MBB):

The primary indication of a diagnostic facet joint procedure is to diagnose whether the patient has facet syndrome. Intraarticular (IA) facet block(s) are considered reasonable and necessary as a diagnostic test only if medial branch blocks (MMB) cannot be performed due to specific documented anatomic restrictions or there is an indication to proceed with therapeutic intraarticular injections. These restrictions must be clearly documented in the medical record and made available upon request.

Diagnostic procedures should be performed with the intent that if successful, radiofrequency ablation (RFA) procedure would be considered the primary treatment goal at the diagnosed level(s).

A second diagnostic facet procedure is considered medically necessary to confirm validity of the initial diagnostic facet procedure when administered at the same level. The second diagnostic procedure may only be performed a minimum of 2 weeks after the initial diagnostic procedure. Clinical circumstances that necessitate an exception to the two-week duration may be considered on an individual basis and must be clearly documented in the medical record.

For the first diagnostic facet joint procedure:

- For the first diagnostic facet joint procedure to be considered medically reasonable and necessary, the patient must meet the criteria outlined under indications for facet joint interventions.
- A second confirmatory diagnostic facet joint procedure is considered medically reasonable and necessary in patients who meet ALL the following criteria:
 - The patient meets the criteria for the first diagnostic procedure; AND
 - After the first diagnostic facet joint procedure, there must be a consistent positive response of at least 80% relief of primary (index) pain (with the duration of relief being consistent with the agent used).

Frequency limitation: For each covered spinal region, no more than four (4) diagnostic joint sessions will be reimbursed per rolling 12 months, in recognition that the pain generator cannot always be identified with the initial and confirmatory diagnostic procedure.

Therapeutic Facet Joint Procedures (IA):

Therapeutic facet joint procedures is considered medically reasonable and necessary for patients who meet ALL the following criteria:

- The patient has had two (2) medically reasonable and necessary diagnostic facet joint procedures with each one providing a consistent minimum of 80% relief of primary (index) pain (with the duration of relief being consistent with the agent used); AND
- Subsequent therapeutic facet joint procedures at the same anatomic site results in at least consistent 50% pain relief for at least three (3) months from the prior therapeutic procedure or at least 50% consistent improvement in the ability to perform previously painful movements and ADLs as compared to baseline measurement using the same scale; AND
- Documentation of why the patient is not a candidate for radiofrequency ablation (such as established spinal pseudarthrosis, implanted electrical device)

Frequency Limitations: For each covered spinal region no more than four (4) therapeutic facet joint (IA) sessions will be reimbursed per rolling 12 months.

Facet Joint Denervation:

The thermal radiofrequency destruction of cervical, thoracic, or lumbar paravertebral facet joint (medial branch) nerves are considered medically reasonable and necessary for patients who meet ALL the following criteria:

- Initial thermal RFA:

After the patient has had at least two (2) medically reasonable and necessary diagnostic MBBs, with each one providing a consistent minimum of 80% sustained relief of primary (index) pain (with the duration of relief being consistent with the agent used) AND

- Repeat thermal facet joint RFA at the same anatomic site is considered medically reasonable and necessary provided the patient had a minimum of consistent 50% improvement in pain for at least six (6) months or at least 50% consistent improvement in the ability to perform previously painful movements and ADLs as compared to baseline measurement using the same scale;

Frequency Limitation: For each covered spinal region no more than two (2) radiofrequency sessions will be reimbursed per rolling 12 months.

Facet Cyst Aspiration/Rupture:

Intra-articular facet joint injection performed with synovial cyst aspiration is considered medically necessary when both of the following criteria are met:

- Advanced diagnostic imaging study (e.g. MRI/CT/myelogram) confirm compression or displacement of the corresponding nerve root by a facet joint synovial cyst; AND
- Clinical and physical symptoms related to synovial facet cyst are documented

Frequency Limitation: Cyst aspiration/rupture may be repeated once and only if there is 50% or more consistent improvement in pain for at least three (3) months.

Reporting Guidelines for CPT code 64999:

- Report CPT code 64999 when facet cyst aspiration/rupture is performed.
- CPT code 64999 is non covered when used to report non thermal facet joint denervation including chemical, low grade thermal energy (less than 80 degrees Celsius) or any form of pulsed radiofrequency.

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 guideline does not imply that the service described by the code is a covered or non-covered health service. 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
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)
64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure) (Non-Covered)
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)
64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure) (Non-Covered)
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint

CPT Code	Description
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)
64999	Unlisted procedure, nervous system

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Modifier	Description
LT	Left side (used to identify procedures performed on the left side of the body)
RT	Right side (used to identify procedures performed on the right side of the body)
50	Bilateral procedure

References

CMS Local Coverage Determinations (LCDs) and Articles

LCD	Article	Contractor	Medicare Part A	Medicare Part B
L33930 Facet Joint Interventions for Pain Management	A57787 Billing and Coding: Facet Joint Interventions for Pain Management	First Coast	FL, PR, VI	FL, PR, VI
L38773 Facet Joint Interventions for Pain Management	A58364 Billing and Coding: Facet Joint Interventions for Pain Management	CGS	KY, OH	KY, OH
L34832 Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy Retired 05/01/2021; See L38773	A56463 Billing and Coding: Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy			
L34892 Facet Joint Interventions for Pain Management	A56670 Billing and Coding: Facet Joint Interventions for Pain Management	Novitas	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
L38801 Facet Joint Interventions for Pain Management	A58403 Billing and Coding: Facet Joint Interventions for Pain Management	Noridian	AS, CA, GU, HI, MP, NV	AS, CA, GU, HI, MP, NV
L34993 Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy Retired 04/24/2021; See L38801	A57727 Billing and Coding: Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy Retired 04/24/2021; See A58403			
L38803 Facet Joint Interventions for Pain Management	A58405 Billing and Coding: Facet Joint Interventions for Pain Management	Noridian	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY

LCD	Article	Contractor	Medicare Part A	Medicare Part B
L34995 Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy Retired 04/24/2021; See L38803	A57728 Billing and Coding: Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy Retired 04/24/2021; See A58405			
L35936 Facet Joint Interventions for Pain Management	A57826 Billing and Coding: Facet Joint Interventions for Pain Management	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI
L38841 Facet Joint Interventions for Pain Management	A58477 Billing and Coding: Facet Joint Interventions for Pain Management	WPS	AK, AL, AR, AZ, CA, CO, CT, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, VT, WA, WI, WV, WY	IA, IN, KS, MI, MO, NE
L35996 Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy Retired 04/24/2021; See L38841	A57553 Billing and Coding: Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy Retired 04/24/2021; See A58477			
L38765 Facet Joint Interventions for Pain Management	A58350 Billing and Coding: Facet Joint Interventions for Pain Management	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
L36471 Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy Retired 04/24/2021; See L38765	A56687 Billing and Coding: Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy Retired 04/24/2021; See A58350			

CMS Benefit Policy Manual

[Chapter 15: § 50 Drugs and Biologicals](#)

CMS Claims Processing Manual

[Chapter 14: § 20 List of Covered Ambulatory Surgical Center Procedures](#)

MLN Matters

[Article SE1102, Inappropriate Medicare Payments for Transforaminal Epidural Injection Services](#)

[Article MM6518, Revised, Appropriate Use of Modifier 50 and Add-On Current Procedural Terminology Codes \(CPT\) for Facet Joint Injection Services](#)

UnitedHealthcare Commercial Policies

[Ablative Treatment for Spinal Pain](#)

[Facet Joint Injections for Spinal Pain](#)

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
06/09/2021	<p>Title Change</p> <ul style="list-style-type: none"> Previously titled <i>Paravertebral Facet Joint Injections</i> <p>Policy Summary</p> <p>Overview</p> <ul style="list-style-type: none"> Revised language to indicate: <ul style="list-style-type: none"> Facet joint interventions may be used in pain management for chronic cervical/thoracic and back pain arising from the paravertebral facet joints <ul style="list-style-type: none"> The facet block procedure is an injection of a local anesthetic, with or without a steroid medication, either into the facet joint (intra-articular) or outside the joint space around the nerve supply to the joint (the medial branch nerve) known as medial branch block (MBB) Imaging guidance (fluoroscopy or CT per code descriptor) is used to assure accurate placement of the needle for the injection Paravertebral facet joint denervation is a therapeutic intervention used to provide both long-term pain relief and reduce the likelihood of recurrence of chronic cervical/thoracic or back pain confirmed as originating in the facet joint's medial branch nerve There are various methods that may be used in performing facet joint denervation <ul style="list-style-type: none"> Percutaneous radiofrequency ablation (RFA) is a minimally invasive procedure done with imaging guidance (fluoroscopy or CT per code descriptor) and involves using energy in the radiofrequency range to cause necrosis of specific nerves (medial branches of the dorsal rami), preventing the neural transmission of pain Conventional radiofrequency ablation (non-pulsed or continuous) applies thermal energy of typically 80 to 85 degrees Celsius The terms RFA and radiofrequency neurotomy are used interchangeably; both terms refer to a procedure that destroys the functionality of the nerve using radiofrequency energy Non-thermal methods of denervation include chemical (chemodenervation), low-grade thermal energy (less than 80 degrees Celsius), pulsed RFA, laser neurolysis, and cryoablation <p>Guidelines</p> <ul style="list-style-type: none"> Revised language to indicate: <p>Facet Joint Interventions</p> <ul style="list-style-type: none"> Facet Joint Interventions are considered medically reasonable and necessary for the diagnosis and treatment of chronic pain in patients who meet all the following criteria: <ul style="list-style-type: none"> Moderate to severe chronic neck or low back pain, predominantly axial, that causes functional deficit measured on pain or disability scale <ul style="list-style-type: none"> Pain assessment must be performed and documented at baseline, after each diagnostic procedure and at each follow-up using the same pain scale for each assessment A disability scale must also be obtained at baseline to be used for functional assessment (if patient qualifies for treatment) Pain present for minimum of 3 months with documented failure to respond to noninvasive conservative management (as tolerated) Absence of untreated radiculopathy or neurogenic claudication (except for radiculopathy caused by facet joint synovial cyst) There is no non-facet pathology per clinical assessment or radiology studies that could explain the source of the patient's pain, including but not limited to fracture, tumor, infection, or significant deformity <p>Diagnostic Facet Joint Procedures (IA or MBB)</p>

Date	Summary of Changes
	<ul style="list-style-type: none"> • The primary indication of a diagnostic facet joint procedure is to diagnose whether the patient has facet syndrome • Intraarticular (IA) facet block(s) are considered reasonable and necessary as a diagnostic test only if medial branch blocks (MMB) cannot be performed due to specific documented anatomic restrictions or there is an indication to proceed with therapeutic intraarticular injections; these restrictions must be clearly documented in the medical record and made available upon request • Diagnostic procedures should be performed with the intent that if successful, radiofrequency ablation (RFA) procedure would be considered the primary treatment goal at the diagnosed level(s) • A second diagnostic facet procedure is considered medically necessary to confirm validity of the initial diagnostic facet procedure when administered at the same level • The second diagnostic procedure may only be performed a minimum of 2 weeks after the initial diagnostic procedure • Clinical circumstances that necessitate an exception to the two-week duration may be considered on an individual basis and must be clearly documented in the medical record • For the first diagnostic facet joint procedure to be considered medically reasonable and necessary, the patient must meet the criteria outlined under indications for facet joint interventions • A second confirmatory diagnostic facet joint procedure is considered medically reasonable and necessary in patients who meet all the following criteria: <ul style="list-style-type: none"> ○ The patient meets the criteria for the first diagnostic procedure; and ○ After the first diagnostic facet joint procedure, there must be a consistent positive response of at least 80% relief of primary (index) pain (with the duration of relief being consistent with the agent used) • Frequency Limitation: For each covered spinal region, no more than four (4) diagnostic joint sessions will be reimbursed per rolling 12 months, in recognition that the pain generator cannot always be identified with the initial and confirmatory diagnostic procedure <p>Therapeutic Facet Joint Procedures (IA)</p> <ul style="list-style-type: none"> • Therapeutic facet joint procedures are considered medically reasonable and necessary for patients who meet all the following criteria: <ul style="list-style-type: none"> ○ The patient has had two (2) medically reasonable and necessary diagnostic facet joint procedures with each one providing a consistent minimum of 80% relief of primary (index) pain (with the duration of relief being consistent with the agent used); and ○ Subsequent therapeutic facet joint procedures at the same anatomic site results in at least consistent 50% pain relief for at least three (3) months from the prior therapeutic procedure or at least 50% consistent improvement in the ability to perform previously painful movements and ADLs as compared to baseline measurement using the same scale; and ○ Documentation of why the patient is not a candidate for radiofrequency ablation (such as established spinal pseudarthrosis, implanted electrical device) • Frequency Limitation: For each covered spinal region, no more than four (4) therapeutic facet joint (IA) sessions will be reimbursed per rolling 12 months <p>Facet Joint Denervation</p> <ul style="list-style-type: none"> • The thermal radiofrequency destruction of cervical, thoracic, or lumbar paravertebral facet joint (medial branch) nerves are considered medically reasonable and necessary for patients who meet all the following criteria: <ul style="list-style-type: none"> Initial thermal RFA: After the patient has had at least two (2) medically reasonable and necessary diagnostic MBBs, with each one providing a consistent minimum of 80% sustained relief of primary (index) pain (with the duration of relief being consistent with the agent used); and ○ Repeat thermal facet joint RFA at the same anatomic site is considered medically reasonable and necessary provided the patient had a minimum of consistent 50% improvement in pain for at least six (6) months or at least 50% consistent improvement in the ability to perform previously painful movements and ADLs as compared to baseline measurement using the same scale

Date	Summary of Changes
	<ul style="list-style-type: none"> Frequency Limitation: For each covered spinal region, no more than two (2) radiofrequency sessions will be reimbursed per rolling 12 months <p>Facet Cyst Aspiration/Rupture</p> <ul style="list-style-type: none"> Intra-articular facet joint injection performed with synovial cyst aspiration is considered medically necessary when both of the following criteria are met: <ul style="list-style-type: none"> Advanced diagnostic imaging study (e.g. MRI/CT/myelogram) confirm compression or displacement of the corresponding nerve root by a facet joint synovial cyst; and Clinical and physical symptoms related to synovial facet cyst are documented Frequency Limitation: Cyst aspiration/rupture may be repeated once and only if there is 50% or more consistent improvement in pain for at least three (3) months <p>Reporting Guidelines for CPT code 64999</p> <ul style="list-style-type: none"> Report CPT code 64999 when facet cyst aspiration/rupture is performed CPT code 64999 is non-covered when used to report non-thermal facet joint denervation including chemical, low grade thermal energy (less than 80 degrees Celsius) or any form of pulsed radiofrequency <p>Applicable Codes</p> <ul style="list-style-type: none"> Added CPT codes 64633, 64634, 64635, 64636, and 64999 Revised notation pertaining to CPT codes 64492 and 64495 to indicate these codes are “non-covered” <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>References</i> section to reflect the most current information Archived previous policy version MPG335.06

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers’ submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

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

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the [References](#) section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. 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 the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines 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 Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines 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.

Medicare Advantage Policy Guidelines are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

*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](#).