United Healthcare®

UnitedHealthcare Individual Exchange

Medical Policy Update Bulletin: November 2022

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2023 UnitedHealthcare Individual Exchange Plan Updates

Effective Jan. 1, 2023, the Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, and Utilization Review Guidelines for UnitedHealthcare Individual Exchange Plans will now apply to the states of Kansas, Mississippi, Missouri, and Ohio. The following policies have been updated to reflect the new state-specific application guidelines, as appropriate. State exclusions apply to the policies noted with an asterisk (*) below; click the policy title for complete details on applicable coverage guidelines.

Refer to the UnitedHealthcare news article titled Updates to Individual Exchange plans for 2023 for additional information.

- 17-Alpha-Hydroxyprogesterone Caproate (Makena® and 17P)
- Ablative Treatment for Spinal Pain
- Abnormal Uterine Bleeding and Uterine Fibroids
- Actemra® (Tocilizumab) Injection for Intravenous Infusion
- Adakveo® (Crizanlizumab-Tmca)
- Aduhelm™ (Aducanumab-Avwa)
- Airway Clearance Devices
- Alpha1-Proteinase Inhibitors
- Ambulance Services
- Amondys 45™ (Casimersen)
- Antiemetics for Oncology
- Antithrombin III (ATryn®, Thrombate III®)
- Anti-Thymocyte Globulin (Lymphocyte Immune Globulin)
- Apheresis
- Apokyn® (Apomorphine)
- Articular Cartilage Defect Repairs, Knee
- Athletic Pubalgia Surgery
- Attended Polysomnography for Evaluation of Sleep Disorders
- Autologous Cellular Therapy
- Balloon Sinus Ostial Dilation
- Bariatric Surgery*
- Beds and Mattresses
- Benlysta® (Belimumab)
- Boniva® (Ibandronate)
- Botulinum Toxins A and B
- Breast Imaging for Screening and Diagnosing Cancer
- Breast Reconstruction
- Breast Reduction Surgery
- Brineura® (Cerliponase Alfa)
- Bronchial Thermoplasty
- Brow Ptosis and Eyelid Repair
- Buprenorphine (Probuphine® & Sublocade®)
- Cardiac Event Monitoring
- Cardiovascular Disease Risk Tests
- Carrier Testing for Genetic Diseases
- Catheter Ablation for Atrial Fibrillation
- Cell-Free Fetal DNA Testing
- Ceprotin® (Protein C Concentrate)
- Chelation Therapy for Non-Overload Conditions
- Chemotherapy Observation or Inpatient Hospitalization
- Chromosome Microarray Testing (Non-Oncology Conditions)
- Cimzia® (Certolizumab Pegol)
- Clinical Trials
- Cochlear Implants
- Cognitive Rehabilitation
- Collagen Crosslinks and Biochemical Markers of Bone Turnover
- Complement Inhibitors (Soliris® & Ultomiris®)
- Computed Tomographic Colonography
- Computer-Assisted Surgical Navigation for Musculoskeletal Procedures
- Computerized Dynamic Posturography
- Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes
- Core Decompression for Avascular Necrosis
- Corneal Hysteresis and Intraocular Pressure Measurement
- Cosmetic and Reconstructive Procedures
- Crysvita® (Burosumab-Twza)
- Cytogam® (Cytomegalovirus Immune Globulin)
- Cytological Examination of Breast Fluids for Cancer Screening or Diagnosis
- Deep Brain and Cortical Stimulation
- Denosumab (Prolia® & Xgeva®)
- Diagnostic Dynamic Spinal Visualization and Vertebral Motion Analysis
- Diagnostic Spinal Ultrasonography
- Discogenic Pain Treatment
- Durable Medical Equipment, Orthotics, Medical Supplies and Repairs/Replacements
- Elective Inpatient Services
- Electric Tumor Treatment Field Therapy
- Electrical and Ultrasound Bone Growth Stimulators
- Electrical Bioimpedance for Cardiac Output Measurement
- Electrical Stimulation and Electromagnetic Therapy for Wounds

Take Note

- Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation
- Embolization of the Ovarian and Iliac Veins for Pelvic Congestion Syndrome
- Enjaymo™ (Sutimlimab-Jome)
- Enteral Nutrition
- Entyvio® (Vedolizumab)
- Environmental Allergen Immunotherapy
- Epidural Steroid Injections for Spinal Pain
- Epiduroscopy, Epidural Lysis of Adhesions and Discography
- Erythropoiesis-Stimulating Agents
- Ethyol® (Amifostine)
- Evenity® (Romosozumab-Aqqg)
- Evkeeza™ (Evinacumab-Dgnb)
- Exondys 51® (Eteplirsen)
- Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions and Soft Tissue Wounds
- Facet Joint and Medial Branch Block Injections for Spinal Pain
- Fecal Calprotectin Testing
- Functional Endoscopic Sinus Surgery (FESS)
- GamaSTAN®, GamaSTAN S/D® (Intramuscular Immune Globulin)
- Gamifant® (Emapalumab-Lzsg)
- Gastrointestinal Motility Disorders, Diagnosis and Treatment
- Gastrointestinal Pathogen Nucleic Acid Detection Panel Testing for Infectious Diarrhea
- Gender Dysphoria Treatment*
- Genetic Testing for Cardiac Disease
- Genetic Testing for Hereditary Cancer
- Genetic Testing for Neuromuscular Disorders
- Genitourinary Pathogen Nucleic Acid Detection Panel Testing
- Givlaari® (Givosiran)
- Glaucoma Surgical Treatments
- Gonadotropin Releasing Hormone Analogs
- Gynecomastia Surgery
- Habilitative Services and Outpatient Rehabilitation Therapy
- Hearing Aids and Devices Including Wearable, Bone Anchored and Semi-Implantable*
- Hepatitis Screening
- Hereditary Angioedema (HAE), Treatment and Prophylaxis
- Home Health Care
- Home Hemodialysis
- Home Traction Therapy
- Hospice Care
- Hospital Services: Observation and Inpatient
- Hyperbaric Oxygen Therapy and Topical Oxygen Therapy
- Hysterectomy
- Ilaris® (Canakinumab)
- Ilumya™ (Tildrakizumab-Asmn)
- Immune Globulin (IVIG and SCIG)
- Implantable Beta-Emitting Microspheres for Treatment of Malignant Tumors
- Implanted Electrical Stimulator for Spinal Cord
- Implanted Spinal Drug Delivery Systems
- Infertility Diagnosis, Treatment and Fertility Preservation
- Infliximab (Avsola®, Inflectra®, Remicade®, & Renflexis®)
- Inhaled Nitric Oxide Therapy
- Injectable Anticoagulants Arixtra® (Fondaparinux), Lovenox® (Enoxaparin), Fragmin® (Dalteparin)
- Intensity-Modulated Radiation Therapy
- Intraoperative Hyperthermic Intraperitoneal Chemotherapy (HIPEC)
- Intrauterine Fetal Surgery
- Intravenous Enzyme Replacement Therapy (ERT) for Gaucher Disease
- Intravenous Iron Replacement Therapy (Feraheme®, Injectafer®, & Monoferric®)
- Intravitreal Corticosteroid Implants
- Kepivance® (Palifermin)
- Ketalar® (Ketamine) and Spravato® (Esketamine)
- Korsuva™ (Difelikefalin)
- Krystexxa® (Pegloticase)
- Laser Interstitial Thermal Therapy
- Leqvio® (Inclisiran)
- Left Atrial Appendage Closure
- Lemtrada (Alemtuzumab)
- Light and Laser Therapy
- Liposuction for Lipedema
- Lithotripsy for Salivary Stones
- Long-Acting Injectable Antiretroviral Agents for HIV
- Lower Extremity Invasive Diagnostic and Endovascular Procedures
- Luxturna® (Voretigene Neparvovec-Rzyl)
- Macular Degeneration Treatment Procedures
- Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Scan – Site of Service*
- Manipulation Under Anesthesia
- Manipulative Therapy
- Manual Wheelchairs
- Maximum Dosage and Frequency
- Mechanical Stretching Devices
- Medical Therapies for Enzyme Deficiencies
- Meniscus Implant and Allograft

Take Note

- Minimally Invasive Procedures for Gastroesophageal Reflux Disease (GERD) and Achalasia
- Molecular Oncology Testing for Cancer Diagnosis, Prognosis, and Treatment Decisions
- Motorized Spinal Traction
- Mozobil® (Plerixafor)
- Negative Pressure Wound Therapy
- Nerve Graft to Restore Erectile Function During Radical Prostatectomy
- Neurophysiologic Testing and Monitoring
- Neuropsychological Testing Under the Medical Benefit
- Noncontact Warming Therapy, Ultrasound Therapy and Fluorescence Imaging for Wounds
- Nplate® (Romiplostim)
- Nulojix® (Belatacept)
- Obstetrical Ultrasound
- Obstructive and Central Sleep Apnea Treatment
- Occipital Nerve Injections and Ablation (Including Occipital Neuralgia and Headache)
- Ocrevus® (Ocrelizumab)
- Office Based Procedures - Site of Service*
- Off-Label/Unproven Specialty Drug Treatment
- Omnibus Codes
- Oncology Medication Clinical Coverage
- Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors
- Orencia® (Abatacept) Injection for Intravenous Infusion
- Orthognathic (Jaw) Surgery
- Outpatient Surgical Procedures – Site of Service*
- Oxlumo™ (Lumasiran)
- Panhematin® (Hemin)
- Panniculectomy and Body Contouring Procedures
- Parsabiv® (Etelcalcetide)
- Patient Lifts
- Pectus Deformity Repair
- Pediatric Gait Trainers and Standing Systems
- Percutaneous Neuroablation for Pancreatic Cancer Pain, Severe Cancer Pain, and Trigeminal Neuralgia
- Percutaneous Patent Foramen Ovale (PFO) Closure
- Percutaneous Vertebroplasty and Kyphoplasty
- Pharmacogenetic Testing
- Plagiocephaly and Craniosynostosis Treatment
- Pneumatic Compression Devices
- Power Mobility Devices*
- Preimplantation Genetic Testing and Related Services
- Preventive Care Services
- Private Duty Nursing Services*
- Prolotherapy and Platelet Rich Plasma Therapies
- Prostate Surgeries and Interventions
- Prosthetic Devices, Wigs, Specialized, Microprocessor or Myoelectric Limbs
- Proton Beam Radiation Therapy
- Pulmonary Arterial Hypertension Agents
- Radiation Therapy: Fractionation, Image-Guidance, and Special Services
- Radicava® (Edaravone)
- Reblozyl® (Luspatercept-Aamt)
- Referral to Out-of-Network Specialists
- Repository Corticotropin Injections
- Respiratory Interleukins (Cinqair®, Fasenra®, & Nucala®)
- Review at Launch for New to Market Medications
- Rhinoplasty and Other Nasal Surgeries
- Rituximab (Riabni™, Rituxan®, Ruxience®, & Truxima®)
- RNA-Targeted Therapies (Amvuttra™ and Onpattro®)
- Ryplazim® (Plasminogen, Human-Tvmh)
- Sacroiliac Joint Interventions
- Saphnelo™ (Anifrolumab-Fnia)
- Scenesse® (Afamelanotide)
- Screening Colonoscopy Procedures – Site of Service*
- Self-Administered Medications
- Sensory Integration Therapy and Auditory Integration Training
- Simponi Aria® (Golimumab) Injection for Intravenous Infusion
- Simulect® (Basiliximab)
- Skilled Care and Custodial Care Services
- Skin and Soft Tissue Substitutes
- Skyrizi® (Risankizumab-Rzaa)
- Sodium Hyaluronate
- Somatostatin Analogs
- Speech Generating Devices
- Spinal Fusion and Bone Healing Enhancement Products
- Spinraza® (Nusinersen)
- Stelara® (Ustekinumab)
- Stereotactic Body Radiation Therapy and Stereotactic Radiosurgery
- Subcutaneous Implantable Naltrexone Pellets
- Surgery of the Ankle
- Surgery of the Elbow

Take Note

- Surgery of the Foot
- Surgery of the Hand or Wrist
- Surgery of the Hip
- Surgery of the Knee
- Surgery of the Shoulder
- Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins
- Surgical Treatment for Spine Pain
- Surgical Treatment of Lymphedema
- Sympathetic Blockade
- Synagis® (Palivizumab)
- Temporomandibular Joint Disorders
- Tepezza® (Teprotumumab-Trbw)
- Testosterone Replacement or Supplementation Therapy
- Tezspire™ (Tezepelumab-Ekko)
- Thermography
- Thyrogen® (Thyrotropin Alfa)
- Total Artificial Disc Replacement for the Spine
- Total Artificial Heart and Ventricular Assist Devices
- Transcatheter Heart Valve Procedures
- Transcranial Magnetic Stimulation
- Transpupillary Thermotherapy
- Trogarzo® (Ibalizumab-Uiyk)
- Tysabri® (Natalizumab)
- Umbilical Cord Blood Harvesting and Storage for Future Use
- Unicondylar Spacer Devices for Treatment of Pain or Disability
- Uplizna™ (Inebilizumab-Cdon)
- Vaccines
- Vagus and External Trigeminal Nerve Stimulation
- Vertebral Body Tethering for Scoliosis
- Vibativ® (Telavancin)
- Video Electroencephalographic (vEEG) Monitoring and Recording
- Viltepso® (Viltolarsen)
- Virtual Upper Gastrointestinal Endoscopy
- Visual Information Processing Evaluation and Orthoptic and Vision Therapy
- Visudyne® (Verteporfin for Injection)
- Vitamin D Testing
- Vivitrol® (Naltrexone for Extended-Release Injectable Suspension)
- Voraxaze® (Glucarpidase)
- Vyepti™ (Eptinezumab-Jjmr)
- Vyondys 53™ (Golodirsen)
- Vyvgart® (Efgartigimod Alfa-Fcab)
- Walkers
- Wheelchair Options and Accessories
- Wheelchair Seating
- White Blood Cell Colony Stimulating Factors
- Whole Exome and Whole Genome Sequencing
- Xiaflex® (Collagenase Clostridium Histolyticum)
- Xolair® (Omalizumab)
- Zilretta® (Triamcinolone Acetonide Extended Release)
- Zinplava™ (Bezlotoxumab)
- Zoledronic Acid
- Zolgensma® (Onasemnogene Abeparvovec-Xioi)
- Zulresso™ (Brexanolone)

New		
Policy Title	**Effective Date**	**Coverage Rationale**
Hyperbaric Oxygen Therapy and Topical Oxygen Therapy	Jan. 1, 2023	Hyperbaric Oxygen Therapy (HBOT) is proven and medically necessary for the following conditions: • Acute traumatic peripheral ischemia/insufficiency (i.e. crush injury, reattachment of severed limbs, compartment syndrome) • Air or gas embolism • Anemia, severe, when transfusion is refused, delayed, or unavailable • Carbon monoxide poisoning • Central retinal artery occlusion • Chronic osteomyelitis, refractory to medical and surgical management • Clostridial myonecrosis (gas gangrene) • Compromised skin grafts/flaps • Cyanide poisoning, associated with carbon monoxide poisoning • Decompression sickness • Delayed radiation injuries (soft tissue and bony necrosis) • Diabetic lower extremity wounds • Idiopathic sudden sensorineural hearing loss (ISSHL) • Intracranial abscess • Necrotizing soft tissue infections • Thermal burns, second, or third degree Hyperbaric Oxygen Therapy is unproven and not medically necessary due to insufficient evidence of efficacy for treating and managing ALL other indications not listed above as proven. Topical Oxygen Therapy (TOT) is unproven and not medically necessary for the treatment of wounds or ulcers due to insufficient evidence of efficacy.

Surgical Treatment of Lymphedema	Jan. 1, 2023	Surgical procedures for the treatment or prevention of lymphedema are unproven and not medically necessary due to insufficient evidence of safety and/or efficacy. These procedures include, but are not limited to:
		• Liposuction/Lipectomy
		• Microsurgical treatment
		  ○ Lymphaticovenous anastomosis
		  ○ Lymphovenous bypass
		• Vascularized Lymph Node Transfer

Updated		
Policy Title	**Effective Date**	**Summary of Changes**

Autologous Cellular Therapy	Jan. 1, 2023	Applicable States
		• Revised language to indicate this Medical Policy applies to Individual Exchange benefit plans in all states except for Colorado, Massachusetts, Nevada, and New York
		Definitions
		• Updated definition of:
		  ○ Autologous Cellular Therapy
		  ○ Autologous Adipose-Derived Regenerative Cellular Therapy
		Supporting Information
		• Updated *Description of Services*, *Clinical Evidence,* and *References* sections to reflect the most current information

Breast Imaging for Screening and Diagnosing Cancer	Jan. 1, 2023	Applicable States • Revised language to indicate this Medical Policy applies to Individual Exchange benefit plans in all states except for Colorado, Massachusetts, Nevada, and New York Definitions • Updated definition of "Automated Breast Ultrasound (ABUS)" Supporting Information • Added *Documentation Requirements* section • Updated *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information
Carrier Testing for Genetic Diseases	Jan. 1, 2023	Applicable States • Revised language to indicate this Medical Policy applies to Individual Exchange benefit plans in all states except for Colorado, Massachusetts, Nevada, and New York Supporting Information • Added *Documentation Requirements* section • Updated *Clinical Evidence* and *References* sections to reflect the most current information
Chromosome Microarray Testing (Non-Oncology Conditions)	Jan. 1, 2023	Applicable States • Revised language to indicate this Medical Policy applies to Individual Exchange benefit plans in all states except for Colorado, Massachusetts, Nevada, and New York Applicable Codes • Updated list of ICD-10 diagnosis codes to reflect annual edits: ○ Added O35.00X0, O35.00X1, O35.00X2, O35.00X3, O35.00X4, O35.00X5, O35.00X9, O35.01X0, O35.01X1, O35.01X2, O35.01X3, O35.01X4, O35.01X5, O35.01X9, O35.02X0, O35.02X1, O35.02X2, O35.02X3, O35.02X4, O35.02X5, O35.02X9, O35.03X0, O35.03X1, O35.03X2, O35.03X3, O35.03X4, O35.03X5, O35.03X9, O35.04X0, O35.04X1, O35.04X2, O35.04X3, O35.04X4, O35.04X5, O35.04X9, O35.05X0, O35.05X1, O35.05X2, O35.05X3,

Medical Policy Updates

Updated		
Policy Title	**Effective Date**	**Summary of Changes**
Chromosome Microarray Testing (Non-Oncology Conditions) (continued)	Jan. 1, 2023	O35.05X4, O35.05X5, O35.05X9, O35.06X0, O35.06X1, O35.06X2, O35.06X3, O35.06X4, O35.06X5, O35.06X9, O35.07X0, O35.07X1, O35.07X2, O35.07X3, O35.07X4, O35.07X5, O35.07X9, O35.08X0, O35.08X1, O35.08X2, O35.08X3, O35.08X4, O35.08X5, O35.08X9, O35.09X0, O35.09X1, O35.09X2, O35.09X3, O35.09X4, O35.09X5, O35.09X9, O35.10X0, O35.10X1, O35.10X2, O35.10X3, O35.10X4, O35.10X5, O35.10X9, O35.11X0, O35.11X1, O35.11X2, O35.11X3, O35.11X4, O35.11X5, O35.11X9, O35.12X0, O35.12X1, O35.12X2, O35.12X3, O35.12X4, O35.12X5, O35.12X9, O35.13X0, O35.13X1, O35.13X2, O35.13X3, O35.13X4, O35.13X5, O35.13X9, O35.14X0, O35.14X1, O35.14X2, O35.14X3, O35.14X4, O35.14X5, O35.14X9, O35.15X0, O35.15X1, O35.15X2, O35.15X3, O35.15X4, O35.15X5, O35.15X9, O35.19X0, O35.19X1, O35.19X2, O35.19X3, O35.19X4, O35.19X5, O35.19X9, O35.AXX0, O35.AXX1, O35.AXX2, O35.AXX3, O35.AXX4, O35.AXX5, O35.AXX9, O35.BXX0, O35.BXX1, O35.BXX2, O35.BXX3, O35.BXX4, O35.BXX5, O35.BXX9, O35.CXX0, O35.CXX1, O35.CXX2, O35.CXX3, O35.CXX4, O35.CXX5, O35.CXX9, O35.DXX0, O35.DXX1, O35.DXX2, O35.DXX3, O35.DXX4, O35.DXX5, O35.DXX9, O35.EXX0, O35.EXX1, O35.EXX2, O35.EXX3, O35.EXX4, O35.EXX5, O35.EXX9, O35.FXX0, O35.FXX1, O35.FXX2, O35.FXX3, O35.FXX4, O35.FXX5, O35.FXX9, O35.GXX0, O35.GXX1, O35.GXX2, O35.GXX3, O35.GXX4, O35.GXX5, O35.GXX9, O35.HXX0, O35.HXX1, O35.HXX2, O35.HXX3, O35.HXX4, O35.HXX5, O35.HXX9, Q21.10, Q21.11, Q21.12, Q21.13, Q21.14, Q21.15, Q21.16, Q21.19, Q21.20, Q21.21, Q21.22, and Q21.23 ○ Removed O35.0XX0, O35.0XX1, O35.0XX2, O35.0XX3, O35.0XX4, O35.0XX5, O35.0XX9, O35.1XX0, O35.1XX1, O35.1XX2, O35.1XX3, O35.1XX4, O35.1XX5, O35.1XX9, Q21.1, and Q21.2 **Supporting Information** • Added *Documentation Requirements* section • Updated *Clinical Evidence* and *References* sections to reflect the most current information
Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes	Nov. 1, 2022	**Coverage Rationale** • Added instruction to refer to the member specific benefit plan document for [information on] Omnipod 5
Genetic Testing for Cardiac Disease	Jan. 1, 2023	**Applicable States** • Revised language to indicate this Medical Policy applies to Individual Exchange benefit plans in all states except for Colorado, Massachusetts, Nevada, and New York **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information
Hepatitis Screening	Jan. 1, 2023	**Applicable States** • Revised language to indicate this Medical Policy applies to Individual Exchange benefit plans in all states except for Colorado, Massachusetts, Nevada, and New York

Updated		
Policy Title	**Effective Date**	**Summary of Changes**
Hepatitis Screening (continued)	Jan. 1, 2023	**Coverage Rationale** • Revised list of proven and medically necessary indications for Hepatitis B screening; replaced: ○ "Present sexual *partners of HCB-infected*" with "present sexual *partner is infected with HBV*" ○ "Current and past use of injection drug*; this includes those who injected once or a few times many years ago*" with "current and past *recreational* use of injection drug*(s), including those individuals with a history limited to a single use of injection drug and regardless of the duration since use*" **Definitions** • Updated definition of: ○ Hepatitis A Antibody Test ○ Hepatitis B Core Antibody Test ○ Hepatitis B Surface Antigen Test ○ Hepatitis C Antibody Test ○ Hepatitis E **Applicable Codes** • Updated list of ICD-10 diagnosis codes: ○ Added D68.00*, D68.01*, D68.020*, D68.021*, D68.022*, D68.023*, D68.029*, D68.03*, D68.04*, D68.09*, F11.91*, F13.91*, F14.91*, F15.91*, F16.91*, F18.91*, F19.91*, K76.82*, O35.00X0*, O35.00X1*, O35.00X2*, O35.00X3*, O35.00X4*, O35.00X5*, O35.00X9*, O35.01X0*, O35.01X1*, O35.01X2*, O35.01X3*, O35.01X4*, O35.01X5*, O35.01X9*, O35.02X0*, O35.02X1*, O35.02X2*, O35.02X3*, O35.02X4*, O35.02X5*, O35.02X9*, O35.03X0*, O35.03X1*, O35.03X2*, O35.03X3*, O35.03X4*, O35.03X5*, O35.03X9*, O35.04X0*, O35.04X1*, O35.04X2*, O35.04X3, O35.04X4*, O35.04X5*, O35.04X9*, O35.05X0*, O35.05X1*, O35.05X2*, O35.05X3*, O35.05X4*, O35.05X5*, O35.05X9*, O35.06X0*, O35.06X1*, O35.06X2*, O35.06X3*, O35.06X4*, O35.06X5*, O35.06X9*, O35.07X0*, O35.07X1*, O35.07X2*, O35.07X3*, O35.07X4*, O35.07X5*, O35.07X9*, O35.08X0*, O35.08X1*, O35.08X2*, O35.08X3*, O35.08X4*, O35.08X5*, O35.08X9*, O35.09X0*, O35.09X1*, O35.09X2*, O35.09X3*, O35.09X4*, O35.09X5*, O35.09X9*, O35.10X0*, O35.10X1*, O35.10X2*, O35.10X3*, O35.10X4*, O35.10X5*, O35.10X9*, O35.11X0*, O35.11X1*, O35.11X2*, O35.11X3*, O35.11X4*, O35.11X5*, O35.11X9*, O35.12X0*, O35.12X1*, O35.12X2*, O35.12X3*, O35.12X4*, O35.12X5*, O35.12X9*, O35.13X0*, O35.13X1*, O35.13X2*, O35.13X3*, O35.13X4*, O35.13X5*, O35.13X9*, O35.14X0*, O35.14X1*, O35.14X2*, O35.14X3*, O35.14X4*, O35.14X5*, O35.14X9*, O35.15X0*, O35.15X1*, O35.15X2*, O35.15X3*, O35.15X4*, O35.15X5*, O35.15X9*, O35.19X0*, O35.19X1*, O35.19X2*, O35.19X3*, O35.19X4*, O35.19X5*, O35.19X9*, O35.AXX0*, O35.AXX1*, O35.AXX2*, O35.AXX3*, O35.AXX4*, O35.AXX5*, O35.AXX9*, O35.BXX0*, O35.BXX1*, O35.BXX2*, O35.BXX3*, O35.BXX4*, O35.BXX5*, O35.BXX9*, O35.CXX0*, O35.CXX1*, O35.CXX2*, O35.CXX3*, O35.CXX4*, O35.CXX5*, O35.CXX9*, O35.DXX0*, O35.DXX1*, O35.DXX2*, O35.DXX3*, O35.DXX4*,

Updated		
Policy Title	**Effective Date**	**Summary of Changes**
Hepatitis Screening (continued)	Jan. 1, 2023	O35.DXX5*, O35.DXX9*, O35.EXX0*, O35.EXX1*, O35.EXX2*, O35.EXX3*, O35.EXX4*, O35.EXX5*, O35.EXX9*, O35.FXX0*, O35.FXX1*, O35.FXX2*, O35.FXX3*, O35.FXX4*, O35.FXX5*, O35.FXX9*, O35.GXX0*, O35.GXX1*, O35.GXX2*, O35.GXX3*, O35.GXX4*, O35.GXX5*, O35.GXX9*, O35.HXX0*, O35.HXX1*, O35.HXX2*, O35.HXX3*, O35.HXX4*, O35.HXX5*, O35.HXX9*, Z00.121, and Z00.129 ○ Removed D68.0*, O35.0XX0*, O35.0XX1*, O35.0XX2*, O35.0XX3*, O35.0XX4*, O35.0XX5*, O35.0XX9*, O35.1XX0*, O35.1XX1*, O35.1XX2*, O35.1XX3*, O35.1XX4*, O35.1XX5*, and O35.1XX9* *(*annual edit)* Supporting Information ● Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect the most current information
Neuropsychological Testing Under the Medical Benefit	Jan. 1, 2023	Applicable States ● Revised language to indicate this Medical Policy applies to Individual Exchange benefit plans in all states except for Colorado, Massachusetts, Nevada, and New York Applicable Codes ● Removed CPT codes 96130 and 96131 Supporting Information ● Updated *Clinical Evidence* and *References* sections to reflect the most current information
Sacroiliac Joint Interventions	Jan. 1, 2023	Applicable States ● Revised language to indicate this Medical Policy applies to Individual Exchange benefit plans in all states except for Colorado, Massachusetts, Nevada, and New York Definitions ● Updated definition of: ○ Titanium Triangular Implant ○ Sacroiliac Joint ● Removed definition of: ○ Arthrodesis ○ Axial Skeleton ○ Minimally Invasive Procedure ○ Percutaneous ○ Provocative Tests ○ Sacroiliac Joint Fusion ○ Sacroiliac Joint Pain

Medical Policy Updates

Updated

Policy Title	Effective Date	Summary of Changes
Sacroiliac Joint Interventions (continued)	Jan. 1, 2023	**Supporting Information** ● Added *Documentation Requirements* section ● Updated *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information
Sympathetic Blockade	Jan. 1, 2023	**Supporting Information** ● Added *Documentation Requirements* and *Clinical Evidence* sections ● Updated *References* section to reflect the most current information

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Breast Reduction Surgery	Jan. 1, 2023	**Template Update** ● Changed policy type classification from "Coverage Determination Guideline" to "Medical Policy" **Applicable States** ● Revised language to indicate this Medical Policy applies to Individual Exchange benefit plans in all states except for Colorado, Massachusetts, Nevada, and New York **Coverage Rationale** ● Revised coverage guidelines to indicate breast reduction surgery is considered reconstructive and medically necessary in certain circumstances; for medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures: ○ Reduction Mammoplasty, Female ○ Reduction Mammoplasty, Female, Adolescent ● Removed content addressing:	Most UnitedHealthcare plans have a specific exclusion for breast reduction surgery except as required by the Women's Health and Cancer Rights Act of 1998. Refer to the member's specific plan document for applicable coverage. Breast reduction surgery is considered reconstructive and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures: ● Reduction Mammoplasty, Female ● Reduction Mammoplasty, Female, Adolescent Click here to view the InterQual® criteria.

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Breast Reduction Surgery (continued)	Jan. 1, 2023	○ Coverage limitations and exclusions ○ The *Modified Schnur Nomogram Chart* **Documentation Requirements** ● Added list of applicable CPT codes ● Updated list of *Required Clinical Information* to reflect/include: ○ Diagnosis ○ History of the medical condition(s) requiring treatment or surgical intervention, including: ▪ History of chief complaint and associated symptoms ▪ Estimated risk of breast cancer ○ Physical exam including member's height and weight ○ Reports of recent imaging studies and applicable diagnostic tests (within 1 year), including to rule out: ▪ Tumor or malignant changes of the breast ▪ Orthopedic, neurologic, rheumatologic, endocrine, or metabolic condition ○ Description of physiologic functional impairments and etiology (e.g., back pain, grooving from bras straps, skin breakdown, paresthesias, etc.)	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Breast Reduction Surgery (continued)	Jan. 1, 2023	○ For a diagnosis of macromastia, include high quality color photograph(s): ▪ All photograph(s) must be labeled with the: – Date taken – Applicable case number obtained at time of notification or member's name and ID number on the photograph(s) ▪ Note: Submission of color image(s)are required and can be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted ○ Reduction mammoplasty documentation should include: ▪ The evaluation and management note for the date of service ▪ The note for the day the decision to perform surgery was made ▪ Physicians plan of care, including estimated volume of breast tissue per breast to be removed **Definitions** ● Removed definition of: ○ Congenital Anomaly ○ Cosmetic Procedures	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Breast Reduction Surgery (continued)	Jan. 1, 2023	○ Functional/Physical or Physiological Impairment ○ Macromastia (Breast Hypertrophy) ○ Reconstructive Procedures **Supporting Information** ● Updated *References* section to reflect the most current information	
Environmental Allergen Immunotherapy	Jan. 1, 2023	**Title Change** ● Previously titled *Sublingual Immunotherapy* **Applicable States** ● Revised language to indicate this Medical Policy applies to Individual Exchange benefit plans in all states except for Colorado, Massachusetts, Nevada, and New York **Coverage Rationale** ● Added language to indicate home-administration/self-administration of subcutaneous allergen immunotherapy is unproven and not medically necessary due to insufficient evidence of efficacy and safety **Applicable Codes** ● Added CPT codes 95115 and 95117 ● Added notation to indicate: ○ CPT 95165 or 95199 should be reported with 95115 or 95117 for subcutaneous allergen immunotherapy given in the	Home-administration/self-administration of subcutaneous allergen immunotherapy is unproven and not medically necessary due to insufficient evidence of efficacy and safety. Sublingual liquid immunotherapy or non-Food and Drug Administration (FDA) approved sublingual allergen extract tablets for the treatment of any condition/disease, including but not limited to allergic rhinitis and allergic rhinoconjunctivitis, are unproven and not medically necessary due to insufficient evidence of efficacy and safety. Note: This policy does not apply to FDA approved sublingual allergen extract tablets.

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Environmental Allergen Immunotherapy (continued)	Jan. 1, 2023	office/ambulatory setting and furnished by a physician or other qualified health care practitioner ○ CPT 95165 or 95199 reported without 95115 or 95117 is reported for the supervision of preparation and provision of antigens for allergen immunotherapy and furnished without a physician or other qualified health care practitioner (i.e., home-administration/self-administration) **Supporting Information** ● Updated *Description of Services*, *Benefit Considerations*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	
Epidural Steroid Injections for Spinal Pain	Jan. 1, 2023	**Applicable States** ● Revised language to indicate this Medical Policy applies to Individual Exchange benefit plans in all states except for Colorado, Massachusetts, Nevada, and New York **Coverage Rationale** ● Revised coverage criteria: ○ Added criterion requiring: ▪ Evidence of nerve impingement by imaging or EMG ▪ The injection is performed under fluoroscopic or CT	Epidural Steroid Injections (ESI) are proven and medically necessary when all of the following criteria are met: ● The injection is intended for the management of Radicular Pain as evidenced by history and physical exam; and ● The Radicular Pain is unresponsive to conservative treatment for ≥ 4 weeks: ○ Pharmacotherapy such as NSAIDS or acetaminophen; or ○ Activity modification (including but not limited to heavy lifting, bending, spinal torsion activities); or ○ PT or home exercise ● Evidence of nerve impingement by imaging or EMG ● The injection is performed under fluoroscopic or CT guidance ● There is no evidence of a condition that would contraindicate ESIs. Conditions that would contraindicate ESIs include but are not limited to:

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Epidural Steroid Injections for Spinal Pain (continued)	Jan. 1, 2023	guidance ▪ There is no evidence of a condition that would contraindicate Epidural Steroid Injections (ESIs); conditions that would contraindicate ESIs include but are not limited to: – Spinal neoplasm – Rapidly progressing neurological deficit – Epidural abscess – Infection at the site of injection ○ Replaced criterion requiring: ▪ "The injection is intended for the *short-term* management of *acute or subacute* radicular pain" with "the injection is intended for the management of Radicular Pain *as evidenced by history and physical exam*" ▪ "The radicular pain is unresponsive to pharmacotherapy such as NSAIDS or acetaminophen ≥ *3* weeks" with "the Radicular Pain is unresponsive to pharmacotherapy such as NSAIDS or acetaminophen ≥ *4* weeks"	○ Spinal neoplasm ○ Rapidly progressing neurological deficit ○ Epidural abscess ○ Infection at the site of injection The following are unproven and not medically necessary due to insufficient evidence of efficacy: • The use of ultrasound guidance for ESIs • ESI for all other indications of the spine not included above **Epidural Steroid Injection Limitations** • A maximum of four (4) ESI sessions (per region, regardless of level, location, or side) per year ○ A session is defined as one date of service in which ESI injection(s) are performed ○ A region is defined by either the region of the cervical, thoracic or lumbosacral ○ A year is defined as the 12-month period starting from the date of service of the first approved injection • Subsequent ESIs may be provided only if: ○ Pain has returned or deterioration in function has occurred; and ○ The previous injection resulted in ≥ 50% pain relief or functional improvement for three or more months as measured by validated measurement tools ; or ○ The previous injection resulted in ≤ 50% pain relief or functional improvement for less than three months as measured by validated measurement tools and there has been a reassessment of the individual and the injection site and technique

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Epidural Steroid Injections for Spinal Pain (continued)	Jan. 1, 2023	*Epidural Steroid Injection Limitations* • Changed frequency limitation from "a maximum of *three (3)* ESI sessions (per region, regardless of level, location, or side) per year" to "a maximum of *four (4)* ESI sessions (per region, regardless of level, location, or side) per year" Subsequent ESIs • Replaced reference to "*repeat* ESIs" with "*subsequent* ESIs" • Revised guidelines to indicate subsequent ESIs may be provided only if: ○ The pain has returned or deterioration in function has occurred; and ○ The previous injection resulted in ≥ 50% pain relief or functional improvement for three or more months as measured by validated measurement tools; or ○ The previous injection resulted in ≤ 50% pain relief or functional improvement for less than three months as measured by validated measurement tools and there has been a reassessment of the individual and the injection site and technique	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Epidural Steroid Injections for Spinal Pain (continued)	Jan. 1, 2023	Documentation Requirements ● Updated list of *Required Clinical Information*: *Initial Injection* ○ Removed: ▪ History of epidural injections in the previous 12 months, including location and clinical response to previous injections ○ Replaced: ▪ "Physical exam" with "physical exam *demonstrating presence of radicular pain*" ▪ "Relevant medical history" with "relevant medical history *related to the spine or surrounding tissues*" ▪ "Treatments tried, failed, or contraindicated; include the dates and reason for discontinuation" with "treatments tried *(e.g., pharmacotherapy, exercises)*, failed, or contraindicated; include the dates, *duration of treatment,* and reason for discontinuation" ▪ "Plan for use of ultrasound guidance" with "plan for use	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Epidural Steroid Injections for Spinal Pain (continued)	Jan. 1, 2023	of *fluoroscopic, CT, or* ultrasound guidance" *Subsequent Injection* ○ Replaced: ▪ "Duration of the effect" with "*dates, location, and* duration of the effect *for the prior 12 months*" ▪ "Functional improvement as measured on a validated measurement tool, *such as the Oswestry Disability Index*" with "functional improvement as measured on a validated measurement tool" Definitions ● Added definition of: ○ Functional Impairments ● Removed definition of: ○ Acute Low Back Pain ○ Oswestry Disability Index (also known as the Oswestry Low Back Pain Disability Questionnaire) ○ Radiculopathy ○ Sub-Acute Low Back Pain Applicable Codes ● Updated list of ICD-10 diagnosis codes to reflect annual edits; added M51.A0, M51.A1, M51.A2, M51.A3, M51.A4, and M51.A5	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Epidural Steroid Injections for Spinal Pain (continued)	Jan. 1, 2023	Supporting Information • Updated *References* section to reflect the most current information	
Implanted Electrical Stimulator for Spinal Cord	Jan. 1, 2023	Applicable States • Revised language to indicate this Medical Policy applies to Individual Exchange benefit plans in all states except for Colorado, Massachusetts, Nevada, and New York Coverage Rationale • Added language to indicate implanted electrical spinal cord stimulators are unproven and not medically necessary for treating chronic intractable back pain without prior spine surgery due to insufficient evidence of efficacy Documentation Requirements • Added list of applicable CPT codes • Updated list of *Required Clinical Information* to reflect/include: ○ Indicate if this request is for a trial or permanent placement; if for permanent placement, include: ▪ Percentage of pain reduction with temporary implant ▪ Operative notes from the spinal cord stimulatory trial ○ Condition requiring procedure: ▪ Physical examination	Implanted electrical spinal cord stimulators are proven and medically necessary for treating the following indications in certain circumstances, when performed according to U.S. Food and Drug Administration (FDA) labeled indications, contraindications, warnings and precautions: • Complex regional pain syndrome (CRPS) • Painful lower limb diabetic neuropathy • Failed back surgery syndrome Implanted electrical spinal cord stimulators are unproven and not medically necessary for treating the following conditions due to insufficient evidence of efficacy: • Chronic intractable back pain without prior spine surgery • Refractory angina pectoris Dorsal root ganglion (DRG) stimulation is proven and medically necessary for treating refractory complex regional pain syndrome (CRPS I, CPRS II) in certain circumstances when performed according to U.S. Food and Drug Administration (FDA) labeled indications, contraindications, warnings and precautions. Dorsal root ganglion (DRG) stimulation is unproven and not medically necessary for treating all other indications due to insufficient evidence of efficacy. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Spinal Cord Stimulator (SCS) Insertion. Click here to view the InterQual® criteria. Note: Coverage of a replacement battery/generator for a previously implanted

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Implanted Electrical Stimulator for Spinal Cord (continued)	Jan. 1, 2023	▪ Prior therapies/treatments tried, failed, or contraindicated; include the dates and reason for discontinuation ○ Documentation of psychological evaluation ○ Physician Plan of Care ○ For revision or removal, include documentation of: ▪ Details of complication ▪ Complete treatment plan **Supporting Information** ● Updated *Clinical Evidence, FDA*, and *References* sections to reflect the most current information	electrical stimulator is appropriate when the individual's existing battery/generator is malfunctioning, cannot be repaired, and is no longer under warranty.
Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Scan – Site of Service	Feb. 1, 2023	**Template Update** ● Changed policy type classification from "Utilization Review Guideline" to "Medical Policy" **Coverage Rationale** ● Added language to indicate authorization is not required for procedures performed in an emergency room, observation unit, urgent care center, or during an inpatient stay ***Medically Necessary (Hospital Outpatient Department)*** ● Replaced references to "advanced radiologic imaging procedure(s)" with "magnetic resonance imaging	A magnetic resonance imaging (MRI) or computed tomography (CT) imaging procedure in the hospital outpatient department is considered medically necessary for individuals who meet any of the following criteria: ● Under 18 years of age ● Require obstetrical observation ● Require perinatology services ● Have a known allergy to a contrast agent used for the procedure ● Have a known chronic disease undergoing active treatment, when direct comparison to prior studies requires the same imaging protocol or equipment obtained at the same hospital-based facility where the procedure is requested ● Have a systemic cancer on active treatment, when restaging studies require the same imaging protocol or equipment used for prior studies obtained at the same hospital-based facility where the procedure is requested ● Pre-procedure imaging which is done within 24 hours of the interventional or surgical procedure and is an integral part of the planned procedure

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Scan – Site of Service (continued)	Feb. 1, 2023	(MRI) or computed tomography (CT) imaging procedure(s)" • Revised coverage criteria: ○ Added criterion requiring: ▪ Individuals have a systemic cancer on active treatment when restaging studies require the same imaging protocol or equipment used for prior studies obtained at the same hospital-based facility where the procedure is requested ▪ Individuals are scheduled for the MRI/CT imaging procedure within 24 hours of a hospital specialist appointment at the same hospital-based facility where the procedure is requested ▪ Individuals are participating in a clinical trial that requires a specific imaging protocol or equipment not available in a freestanding facility ○ Replaced criterion requiring: ▪ "Individuals have a known contrast allergy" with "individuals have a known allergy *to a* contrast *agent used for the procedure*" ▪ "Individuals have a known chronic disease undergoing	• Are scheduled for the MRI/CT imaging procedure within 24 hours of a hospital specialist appointment at the same hospital-based facility where the procedure is requested • Are participating in a clinical trial that requires a specific imaging protocol or equipment not available in a freestanding facility An MRI/CT imaging procedure in the hospital outpatient department is also considered medically necessary when there are no geographically accessible appropriate alternative sites for the individual to undergo the procedure, including but not limited to the following: • Moderate or deep sedation or general anesthesia is required for the procedure and freestanding facility providing such sedation is not available; or • The equipment for the size of the individual is not available; or • Open MRI is required because the member has a documented diagnosis of claustrophobia and/or severe anxiety which is not available in a freestanding facility An MRI/CT imaging procedure in the hospital outpatient department is considered medically necessary when imaging in a physician's office or freestanding imaging center would reasonably be expected to delay care and adversely impact health outcome. All other MRI/CT imaging procedures at a hospital-based imaging department or facility are considered not medically necessary. This includes but is not limited to imaging for: • Cancer screening • Initial diagnosis and/or initial staging for suspected or known cancer • Surveillance of cancer in remission with no clinical suspicion for change in disease status • Non-cancerous musculoskeletal conditions Note: Authorization is not required for procedures performed in an emergency room, observation unit, urgent care center or during an inpatient stay.

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Scan – Site of Service (continued)	Feb. 1, 2023	active treatment *or surveillance for which* direct comparison to prior hospital-based *imaging is required for care planning*" with "individuals have a known chronic disease undergoing active treatment *when* direct comparison to prior *studies requires the same imaging protocol or equipment obtained at the same* hospital-based *facility where the procedure is requested*" • Added language to clarify an MRI/CT imaging procedure in the hospital outpatient department is also considered medically necessary when there are no geographically accessible appropriate alternative sites for the individual to undergo the procedure, including: ○ Moderate or deep sedation or general anesthesia is required for the procedure *and freestanding facility providing such sedation is not available* ○ Open MRI is required because the member has a documented diagnosis of claustrophobia and/or severe anxiety *[and an open MRI] is not available in a freestanding facility*	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Scan – Site of Service (continued)	Feb. 1, 2023	*Not Medically Necessary* ● Revised language to indicate all other MRI/CT imaging procedures at a hospital-based imaging department or facility [not listed in the policy as medically necessary] are considered not medically necessary; this includes but is not limited to imaging for: ○ Cancer screening ○ Initial diagnosis and/or initial staging for suspected or known cancer ○ Surveillance of cancer in remission with no clinical suspicion for change in disease status ○ Non-cancerous musculoskeletal conditions Documentation Requirements ● Added list of applicable CPT/HCPCS codes ● Updated list of *Required Clinical Information* to reflect/include: ○ Provider should call the number on the member's ID card when referring for radiology services ○ If location being requested is an outpatient hospital, provide medical notes documenting the following: ▪ Recent history	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Scan – Site of Service (continued)	Feb. 1, 2023	▪ Physical examination including patient weight ▪ Patient condition, allergy, chronic disease, and surgical plan ▪ Other specific criteria (refer to the *Coverage Rationale* section of the policy) that qualifies the individual for the site of service requested ● Removed reference link to the *Exchange Plans Advanced Notification/Prior Authorization Requirements* **Applicable Codes** ● Added list of CPT/HCPCS codes for: *Computed Tomography* ○ 70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 70496, 70498, 71250, 71260, 71270, 71271, 71275, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72191, 72192, 72193, 72194, 73200, 73201, 73202, 73206, 73700, 73701, 73702, 73706, 74150, 74160, 74170, 74174, 74175, 74176, 74177, 74178, 74261, 74262, 74263, 75571, 75572, 75573, 75574, 75635, 76380, and 76497	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Scan – Site of Service (continued)	Feb. 1, 2023	*Magnetic Resonance Imaging* ○ 70336, 70540, 70542, 70543, 70544, 70545, 70546, 70547, 70548, 70549, 70551, 70552, 70553, 70554, 70555, 71550, 71551, 71552, 71555, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72159, 72195, 72196, 72197, 72198, 73218, 73219, 73220, 73221, 73222, 73223, 73225, 73718, 73719, 73720, 73721, 73722, 73723, 73725, 74181, 74182, 74183, 74185, 74712, 74713, 75557, 75559, 75561, 75563, 76390, 76498, 77046, 77047, 77048, 77049, 77084, C8900, C8901, C8902, C8903, C8905, C8906, C8908, C8909, C8910, C8911, C8912, C8913, C8914, C8918, C8919, C8920, C8931, C8932, C8933, C8934, C8935, C8936, S8037, and S8042 Supporting Information • Added *Clinical Evidence* section • Updated *References* section to reflect the most current information	

Medical Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Percutaneous Neuroablation for Pancreatic Cancer Pain, Severe Cancer Pain, and Trigeminal Neuralgia	Jan. 1, 2023	**Title Change** • Previously titled *Percutaneous Neuroablation for Severe Cancer Pain and Trigeminal Neuralgia* **Applicable States** • Revised language to indicate this Medical Benefit Drug Policy applies to Individual Exchange benefit plans in all states except for Massachusetts, Nevada, New York, and Texas **Coverage Rationale** • Added language to indicate Percutaneous Neuroablation is proven and medically necessary for the treatment of pancreatic cancer pain **Applicable Codes** • Added CPT code 64600 **Supporting Information** • Added *Documentation Requirements* section • Updated *References* section to reflect the most current information	Percutaneous Neuroablation is proven and medically necessary for the treatment of pancreatic cancer pain, severe cancer pain, and Trigeminal Neuralgia. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Neuroablation, Percutaneous. Click here to view the InterQual® criteria.
Prostate Surgeries and Interventions	Jan. 1, 2023	**Applicable States** • Revised language to indicate this Medical Policy applies to Individual Exchange benefit plans in all states except for Colorado, Massachusetts, Nevada, and New York **Coverage Rationale** • Added language to indicate:	Transurethral ablation of the prostate is proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Prostatectomy, Transurethral Ablation. Click here to view the InterQual® criteria. Transurethral ablation of the prostate is unproven and not medically necessary for all other indications due to insufficient evidence of safety

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Prostate Surgeries and Interventions (continued)	Jan. 1, 2023	○ High-energy water vapor thermotherapy for the treatment of benign prostatic hyperplasia (BPH) is proven and medically necessary when performed according to the following U.S. FDA labeled indications, contraindications, warnings, and precautions: ▪ To relieve symptoms, obstructions and reduce prostate tissue in men 50 years of age or older with a prostate volume ≥ 30 cm and ≤ 80 cm; or ▪ Treatment of the prostate with hyperplasia of the central zone and/or a median lobe ○ Transperineal laser ablation (TPLA) is unproven and not medically necessary ○ The following procedures are unproven and not medically necessary for all other indications [not listed in the policy as proven and medically necessary] due to insufficient evidence of safety and/or efficacy: ▪ Prostatic urethral lift (PUL) ▪ Surgical prostatectomy	and/or efficacy. Cryoablation of the prostate is proven and medically necessary for recurrent prostate cancer diagnosed by biopsy. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Cryoablation, Prostate. Click here to view the InterQual® criteria. Cryoablation of the prostate is unproven and not medically necessary for initial treatment of prostate cancer and for all other indications due to insufficient evidence of safety and/or efficacy. Surgical prostatectomy is proven and medically necessary in certain circumstances, including for some individuals with very high risk or recurrent prostate cancer. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Prostatectomy, Radical. Click here to view the InterQual® criteria. Surgical prostatectomy is unproven and not medically necessary for all other indications due to insufficient evidence of safety and/or efficacy. Prostatic urethral lift (PUL) is proven and medically necessary when performed according to the following U.S. Food and Drug Administration (FDA) labeled indications, contraindications, warning and precautions: ● Treating symptoms due to urinary outflow obstruction secondary to benign prostatic hyperplasia (BPH), including lateral and median lobe hyperplasia; in men 45 years of age or older, and ● The following are not present: ○ Prostate volume of > 100 cc ○ A urinary tract infection

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Prostate Surgeries and Interventions (continued)	Jan. 1, 2023	▪ Transurethral ablation of the prostate • Removed language indicating surgical prostatectomy is proven and medically necessary in certain circumstances • Removed instruction to refer to the InterQual® CP: Procedures, Prostatectomy, Radical for medical necessity clinical coverage criteria for surgical prostatectomy • Replaced language indicating: ○ "Cryoablation of the prostate is proven and medically necessary *in certain circumstances*" with "cryoablation of the prostate is proven and medically necessary for *recurrent prostate cancer diagnosed by biopsy*" ○ "Prostatic urethral lift (PUL) is proven and medically necessary when performed according to the following U.S. FDA labeled indication" with "prostatic urethral lift (PUL) is proven and medically necessary when performed according to the following U.S. FDA labeled indications, *contraindications, warnings, and precautions*" ○ "High-energy water vapor thermotherapy for the treatment of malignant prostate tissue is	○ Urethra conditions that may prevent insertion of delivery system into bladder ○ Urinary incontinence due to incompetent sphincter ○ Current gross hematuria Prostatic urethral lift (PUL) is unproven and not medically necessary for all other indications due to insufficient evidence of safety and/or efficacy. High-energy water vapor thermotherapy for the treatment of benign prostatic hyperplasia (BPH) is proven and medically necessary when performed according to the following U.S. Food and Drug Administration (FDA) labeled indications, contraindications, warning and precautions: • To relieve symptoms, obstructions and reduce prostate tissue in men 50 years of age or older with a prostate volume ≥ 30 cm and ≤ 80 cm, or • Treatment of the prostate with hyperplasia of the central zone and/or a median lobe High-energy water vapor thermotherapy for the treatment of BPH in circumstances not listed above or for the treatment of malignant prostate tissue is unproven and not medically necessary due to insufficient evidence of safety and/or efficacy. The transperineal placement of biodegradable material, peri-prostatic (via needle) is proven and medically necessary for use with radiotherapy for treating prostate cancer. The transperineal placement of biodegradable material, peri-prostatic (via needle) is unproven and not medically necessary for all other indications due to insufficient evidence of safety and/or efficacy. The following procedures are unproven and not medically necessary due to insufficient evidence of safety and/or efficacy: • Transperineal focal laser ablation

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Prostate Surgeries and Interventions (continued)	Jan. 1, 2023	unproven and not medically necessary" with "high-energy water vapor thermotherapy for the treatment *of BPH in circumstances not listed above or for the treatment* of malignant prostate tissue is unproven and not medically necessary" ○ "Focal laser ablation is unproven and not medically necessary" with "*transperineal* focal laser ablation is unproven and not medically necessary" **Applicable Codes** • Added CPT code 0714T **Supporting Information** • Added *Documentation Requirements* section • Updated *Description of* Services, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	• Insertion of a temporary prostatic urethral stent • Transperineal laser ablation (TPLA) • Transurethral waterjet ablation of the prostate (aquablation) • Vascular embolization
Spinal Fusion and Bone Healing Enhancement Products	Jan. 1, 2023	**Title Change** • Previously titled *Spinal Fusion Enhancement Products* **Applicable States** • Revised language to indicate this Medical Policy applies to Individual Exchange benefit plans in all states except for Colorado, Massachusetts, Nevada, and New York	The following are proven and medically necessary for the enhancement of spinal fusion: • Autografts (including bone marrow aspirate used for bone grafting) • Demineralized Bone Matrix (DBM) without added products listed below as unproven and not medically necessary • Allograft-based products not listed below as unproven and not medically necessary • InFUSE® Bone Graft (Recombinant human bone morphogenetic protein-2 (rhBMP-2) of the lumbar spine when the following criteria are met: ○ The approach is anterior or oblique and used in conjunction with an FDA-approved interbody fusion device

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Spinal Fusion and Bone Healing Enhancement Products (continued)	Jan. 1, 2023	Coverage Rationale • Revised list of products that are proven and medically necessary for the enhancement of spinal fusion; replaced "the InFUSE/MASTERGRAFT™ Posterolateral Revision Device System (or InFUSE BMP used with MASTERGRAFT) when used according to U.S. FDA indications in individuals who meet all of the [listed] criteria" with "the InFUSE/MASTERGRAFT™ Posterolateral Revision Device System (or InFUSE BMP used with MASTERGRAFT) when used according to U.S. FDA indications, *contraindications, warnings, and precautions* in individuals who meet all of the [listed] criteria" • Replaced language indicating "the [listed products] are unproven and not medically necessary for the enhancement of spinal fusion due to insufficient evidence of efficacy" with "the [listed products] are unproven and not medically necessary for the enhancement of spinal fusion *and bone healing* due to insufficient evidence of efficacy *and/or safety*" • Revised list of products that are unproven and not medically necessary; replaced:	○ Skeletally mature individual (18 years of age or older or radiographic evidence of epiphyseal closure) with degenerative disc disease (DDD) ○ The fusion involves vertebral bodies L2-S1, without or with spondylolisthesis of no more than grade 1 (25% displacement) at the involved level ○ The fusion is single level • The InFUSE/MASTERGRAFT™ Posterolateral Revision Device System (or InFUSE BMP used with MASTERGRAFT) when used according to U.S. Food and Drug Administration (FDA) indications, contraindications, warnings and precautions in individuals who meet all of the following criteria: ○ Implanted via a posterolateral approach ○ Presence of symptomatic posterolateral lumbar spine pseudoarthrosis ○ Skeletally mature patient (older than 21 years of age or radiographic evidence of epiphyseal closure) ○ Autologous bone and/or bone marrow harvest is not feasible or is not expected to promote fusion The following are unproven and not medically necessary for the enhancement of spinal fusion and bone healing due to insufficient evidence of efficacy and/or safety: • Allograft based products ○ Cell-based (e.g., mesenchymal stem cells (MSC) ○ Human amniotic tissue materials, including amniotic fluid stem cell substitutes for ○ Recombinant human bone morphogenetic protein-2 (e.g., rhBMP-2, InFUSE) and InFUSE/MASTERGRAFT™ (or InFUSE BMP used with Mastergraft or Mastergraft alone) Posterolateral Revision Device for all other indications not included above ○ Ceramic-Based products (e.g., beta tricalcium phosphate (b-TCP), calcium phosphate, calcium sulfate) used alone or in combination with other grafts including bone marrow aspirate ○ Bioactive Glass used alone or in combination with other grafts

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Spinal Fusion and Bone Healing Enhancement Products (continued)	Jan. 1, 2023	○ "Human amniotic tissue materials, including amniotic fluid stem cell substitutes *for the treatment of spine disease or in spine surgery*" with "human amniotic tissue materials, including amniotic fluid stem cell substitutes" ○ "*OptiMesh*® Expandable Interbody Fusion System" with "Expandable Interbody Fusion System" **Definitions** ● Added definition of: ○ Bioactive Glass ○ Duo™ Ti Expandable Interbody Fusion System ● Removed definition of: ○ Anorganic Bone Graft Materials ○ Carrier Systems ○ Cell-Based Products ○ Combination Bone Graft Substitutes ○ Orthobiologics ● Updated definition of: ○ Allograft ○ Autograft ○ Bone Marrow Aspirate ○ Bone Morphogenetic Proteins (BMP) and Recombinant Human Bone Morphogenetic Proteins (rhBMP) ○ Ceramic-Based Products	including bone marrow aspirate ○ Expandable Interbody Fusion System

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Spinal Fusion and Bone Healing Enhancement Products (continued)	Jan. 1, 2023	○ Demineralized Bone Matrix (DBM) ○ Human Amniotic Tissue Membrane ○ InFUSE™ Bone Graft ○ OptiMesh® Expandable Interbody Fusion System® **Supporting Information** ● Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	

Medical Benefit Drug Policy Updates

Updated		
Policy Title	**Effective Date**	**Summary of Changes**
Antithrombin III (ATryn®, Thrombate III®)	Jan. 1, 2023	Applicable States • Revised language to indicate this Medical Benefit Drug Policy applies to Individual Exchange benefit plans in all states except for Massachusetts, Nevada, and New York Coverage Rationale • Removed specific dosage requirements for the use of antithrombin III; refer to the applicable U.S. FDA approved labeling Supporting Information • Updated *References* section to reflect the most current information
Boniva® (Ibandronate)	Jan. 1, 2023	Applicable States • Revised language to indicate this Medical Benefit Drug Policy applies to Individual Exchange benefit plans in all states except for Massachusetts, Nevada, and New York Coverage Rationale • Removed specific dosage requirements for the use of ibandronate; refer to the applicable U.S. FDA approved labeling
Ethyol® (Amifostine)	Jan. 1, 2023	Applicable States • Revised language to indicate this Medical Benefit Drug Policy applies to Individual Exchange benefit plans in all states except for Massachusetts, Nevada, and New York Coverage Rationale • Removed specific dosage requirements for the use of Ethyol; refer to the applicable U.S. FDA approved labeling Supporting Information • Updated *References* section to reflect the most current information
GamaSTAN®, GamaSTAN S/D® (Intramuscular Immune Globulin)	Jan. 1, 2023	Applicable States • Revised language to indicate this Medical Benefit Drug Policy applies to Individual Exchange benefit plans in all states except for Massachusetts, Nevada, and New York Coverage Rationale • Removed specific dosage requirements for the use of GamaSTAN and GamaSTAN S/D (intramuscular immune globulin); refer to the applicable U.S. FDA approved labeling Supporting Information • Updated *Background* and *References* sections to reflect the most current information

Medical Benefit Drug Policy Updates

Updated

Policy Title	Effective Date	Summary of Changes
Injectable Anticoagulants Arixtra® (Fondaparinux), Lovenox® (Enoxaparin), Fragmin® (Dalteparin)	Jan. 1, 2023	**Applicable States** • Revised language to indicate this Medical Benefit Drug Policy applies to Individual Exchange benefit plans in all states except for Massachusetts, Nevada, and New York **Coverage Rationale** • Removed specific dosage requirements for the use of Arixtra (fondaparinux); refer to the applicable U.S. FDA approved labeling **Supporting Information** • Updated *References* section to reflect the most current information
Visudyne® (Verteporfin for Injection)	Jan. 1, 2023	**Applicable States** • Revised language to indicate this Medical Benefit Drug Policy applies to Individual Exchange benefit plans in all states except for Massachusetts, Nevada, and New York **Coverage Rationale** • Removed specific dosage requirements for the use of Visudyne; refer to the applicable U.S. FDA approved labeling

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Medical Therapies for Enzyme Deficiencies	Jan. 1, 2023	**Applicable States** • Revised language to indicate this Medical Benefit Drug Policy applies to Individual Exchange benefit plans in all states except for Massachusetts, Nevada, and New York **Coverage Rationale** • Revised list of applicable medical therapies for enzyme deficiency products; added Xenpozyme™ (olipudase alfa-rpcp) • Added language to indicate: ○ Xenpozyme (olipudase alfa-rpcp) is proven for the treatment of acid sphingomyelinase deficiency (ASMD)	Refer to the policy for complete details.

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Medical Therapies for Enzyme Deficiencies (continued)	Jan. 1, 2023	○ Xenpozyme is medically necessary when all of the following additional criteria are met: *Initial Therapy* ▪ Diagnosis of acid sphingomyelinase deficiency (ASMD) type A/B or B confirmed by one of the following: – Absence or deficiency of acid sphingomyelinase (ASM) enzyme activity – Molecular genetic testing for mutations in the SMPD1 gene ▪ Presence of clinical signs and symptoms of the disease (e.g., hepatosplenomegaly, elevated transaminases, mixed dyslipidemia, abnormal pulmonary function) ▪ Xenpozyme is not being used to treat central nervous system (CNS) manifestations of ASMD ▪ Dosing is in accordance with the U.S. FDA approved labeling	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Medical Therapies for Enzyme Deficiencies (continued)	Jan. 1, 2023	▪ Initial authorization will be for no more than 12 months *Continuation of Therapy* ▪ Patient has previously received treatment with olipudase alfa therapy ▪ Patient has experienced a positive clinical response to olipudase alfa therapy (e.g., reduced spleen volume, reduced liver volume, improved liver transaminase levels, improved lipid profile, improved pulmonary function) ▪ Dosing is in accordance with the U.S. FDA approved labeling ▪ Reauthorization will be for no more than 12 months Applicable Codes *Xenpozyme* (new to policy) ● Added HCPCS codes J3490 and J3590 ● Added ICD-10 diagnosis codes E75.241 and E75.244 Supporting Information ● Updated *Background*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors	Jan. 1, 2023	**Applicable States** • Revised language to indicate this Medical Benefit Drug Policy applies to Individual Exchange benefit plans in all states except for Massachusetts, Nevada, and New York **Coverage Rationale** • Revised list of applicable vascular endothelial growth factor (VEGF) inhibitors and dual VEGF/angiopoietin-2 (Ang-2) inhibitors; added Cimerli™ (ranibizumab-eqrn) • Added language to indicate: ○ Cimerli™ (ranibizumab-eqrn) has been added to the Review at Launch program and some members may not be eligible for coverage of this medication at this time; refer to the Medical Benefit Drug Policy titled *Review at Launch for New to Market Medications* for additional details ○ Cimerli™ (ranibizumab-eqrn) is proven and medically necessary for the treatment of: ▪ Myopic choroidal neovascularization (mCNV) ▪ Diabetic macular edema (DME) ▪ Diabetic retinopathy (DR)	Vabysmo™ (faricimab-svoa), Byooviz™ (ranibizumab-nuna) and Cimerli™ (ranibizumab-eqrn) have been added to the Review at Launch program. Some members may not be eligible for coverage of these medications at this time. Please reference the policy titled Review at Launch for New to Market Medications for additional details. This policy provides information about the use of certain specialty pharmacy medications administered by the intravitreal route for ophthalmologic conditions. This policy refers to the following vascular endothelial growth factor (VEGF) inhibitors and dual VEGF/angiopoietin-2 (Ang-2) inhibitors: • Avastin® (bevacizumab) • Beovu® (brolucizumab-dbll) • Byooviz™ (ranibizumab-nuna) • Cimerli™ (ranibizumab-eqrn) • Eylea® (aflibercept) • Lucentis® (ranibizumab) • Macugen® (pegaptanib) • Vabysmo™ (faricimab-svoa) The following information pertains to medical necessity review: **General Requirements (applicable to all medical necessity requests)** • For initial therapy, both of the following: ○ Diagnosis; and ○ Intravitreal VEGF or dual VEGF/Ang-2 inhibitor administration is no more than 12 doses per year per eye, regardless of diagnosis. • For continuation of therapy, both of the following: ○ Documentation of positive clinical response to anti-VEGF therapy; and ○ Intravitreal VEGF or dual VEGF/Ang-2 inhibitor administration is no more than 12 doses per year per eye, regardless of diagnosis.

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors (continued)	Jan. 1, 2023	▪ Macular edema following retinal vein occlusion (RVO) ▪ Neovascular age-related macular degeneration (AMD) **Applicable Codes** ● Added HCPCS codes C9399, J3490, and J3590 ● Identified the ICD-10 diagnosis codes that apply to Cimerli (HCPCS codes C9399, J3490, and J3590) ● Added *Maximum Allowed Frequencies* for Cimerli (ranibizumab-eqrn): ○ Myopic choroidal neovascularization (mCNV): The recommended dose is 0.5 mg to affected eye(s) once a month (approximately every 28 days) for up to 3 months and may be retreated if necessary; maximum of 12 doses per year per eye ○ Diabetic macular edema (DME) and diabetic retinopathy (DR): The recommended dose is 0.3 mg to affected eye(s) once a month (approximately every 28 days); maximum of 12 doses per year per eye ○ Macular edema following retinal vein occlusion (RVO): The recommended dose is 0.5	**Diagnosis-Specific Requirements** The information below indicates the list of proven and medically necessary indications. Avastin (bevacizumab) is proven and medically necessary for the treatment of: ● Choroidal neovascularization secondary to pathologic myopia, angioid streaks/pseudoxanthoma elasticum, or ocular histoplasmosis syndrome (OHS) ● Diabetic macular edema (DME) ● Macular edema secondary to branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO) ● Neovascular age-related macular degeneration (AMD) ● Neovascular glaucoma ● Neovascularization of the iris (NVI) (rubeosis iridis) ● Proliferative diabetic retinopathy ● Type I retinopathy of prematurity Beovu (brolucizumab) is proven and medically necessary for the treatment of: ● Neovascular age-related macular degeneration (AMD) ● Diabetic Macular Edema (DME) Byooviz (ranibizumab-nuna) is proven and medically necessary for the treatment of: ● Neovascular age - related macular degeneration (AMD) ● Macular Edema Following Retinal Vein Occlusion (RVO) ● Myopic Choroidal Neovascularization (mCNV) Cimerli™ (ranibizumab-eqrn) is proven and medically necessary for the treatment of: ● Myopic choroidal neovascularization (mCNV)

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors (continued)	Jan. 1, 2023	mg to affected eye(s) once a month (approximately every 28 days); maximum of 12 doses per year per eye ○ Neovascular (wet) age-related macular degeneration (AMD): The recommended dose is 0.5 mg to affected eye(s) once a month (approximately every 28 days) and treatment may be reduced to 3 once monthly doses, followed by an average of 4 to 5 injections over the subsequent 9 months; maximum of 12 doses per year per eye **Supporting Information** ● Updated *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	● Diabetic macular edema (DME) ● Diabetic retinopathy (DR) ● Macular edema following Retinal Vein Occlusion (RVO) ● Neovascular age-related macular degeneration (AMD) Eylea (aflibercept) is proven and medically necessary for the treatment of: ● Diabetic macular edema (DME) ● Diabetic retinopathy ● Macular edema secondary to branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO) ● Neovascular age-related macular degeneration (AMD) Lucentis (ranibizumab) is proven and medically necessary for the treatment of: ● Choroidal neovascularization secondary to pathologic myopia, angioid streaks/pseudoxanthoma elasticum, or ocular histoplasmosis syndrome (OHS) ● Diabetic macular edema (DME) ● Diabetic retinopathy ● Macular edema secondary to branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO) ● Neovascular age-related macular degeneration (AMD) Macugen (pegaptanib) is proven and medically necessary for the treatment of: ● Diabetic macular edema ● Neovascular age-related macular degeneration (AMD) Vabysmo (faricimab-svoa) is proven and medically necessary for the treatment of: ● Neovascular age-related macular degeneration (AMD) ● Diabetic macular edema (DME)

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors (continued)	Jan. 1, 2023		**Additional Information** Avastin (bevacizumab) is supplied in sterile vials containing a solution of 25 mg/mL. Doses utilized in ophthalmic conditions generally range from 6.2 mcg to 2.5 mg. Therefore, bevacizumab in vials is often divided into single-dose, prefilled syringes for intravitreal use by compounding pharmacies. Compounding pharmacies must comply with United States Pharmacopeia (USP) Chapter 797, which sets standards for the compounding, transportation, and storage of compounded sterile products (CSP). The Pharmacy Compounding Accreditation Board can verify that the pharmacy is adhering to these standards. The American Society of Retinal Specialists (ASRS) is committed to ensuring that retina specialists have access to compounded drugs (such as Avastin) that are prepared with high-quality material following good quality controls and sound engineering design by appropriately trained personnel. Refer to their information page at https://www.asrs.org/advocacy-practice/access-to-safe-compounded-agents for resources pertaining to access of safe compounded agents. Refer to the *US Food and Drug Administration (FDA)* section of the policy for information related to contamination of compounded bevacizumab. In an effort to guard against contamination during the compounding process, the United States Veterans Health Administration (USVHA) requires that only USVHA pharmacies may dispense bevacizumab for intravitreal administration to Veterans Administration beneficiaries. The medication must be dispensed directly to the VA ophthalmologist, who will then be responsible for preparing and administering the bevacizumab dose for each patient. In addition to strict labeling and storage requirements, the ophthalmologist is required to prepare only one dose of medication from each vial; if both eyes are to be treated, a separate vial and syringe must be utilized.

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**

White Blood Cell Colony Stimulating Factors	Jan. 1, 2023	**Applicable States**
		• Revised language to indicate this Medical Benefit Drug Policy applies to Individual Exchange benefit plans in all states except for Massachusetts, Nevada, and New York
		Coverage Rationale
		• Revised list of applicable white blood cell colony stimulating factors (CSFs); added Rolvedon™ (eflapegrastim-xnst) and Stimufend® (pegfilgrastim-fpgk)
		• Added language to indicate:
		  ○ Coverage for Rolvedon™ (eflapegrastim-xnst) or Stimufend® (pegfilgrastim-fpgk) will be provided contingent on the criteria in the *Preferred Product Criteria* and *Diagnosis-Specific Criteria* sections of the policy
		  ○ In order to continue coverage, members already on Rolvedon or Stimufend will be required to change therapy to Neulasta or Ziextenzo unless they meet the criteria in the *Preferred Product Criteria* section of the policy
		  ○ Treatment with Rolvedon or Stimufend is medically necessary for the indications specified in the policy when one
			Refer to the policy for complete details.

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
White Blood Cell Colony Stimulating Factors (continued)	Jan. 1, 2023	of the following is met: ▪ Both of the following: – History of a trial of adequate dose and duration of Neulasta or Ziextenzo, resulting in minimal clinical response; and – Physician attests that, in their clinical opinion, the clinical response would be expected to be superior Rolvedon or Stimufend than experienced with Neulasta or Ziextenzo ▪ Both of the following: – History of intolerance, contraindication, or adverse event to Neulasta or Ziextenzo; and – Physician attests that, in their clinical opinion, the same intolerance, contraindication, or adverse event would not be expected to occur with Rolvedon or Stimufend ○ Rolvedon and Stimufend are proven and medically necessary for the following indications when the criteria listed in the	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
White Blood Cell Colony Stimulating Factors (continued)	Jan. 1, 2023	policy are met: ▪ Primary Prophylaxis of Chemotherapy-Induced Febrile Neutropenia (FN) ▪ Secondary Prophylaxis of Febrile Neutropenia (FN) ▪ Treatment of Febrile Neutropenia ▪ Hematopoietic Syndrome of Acute Radiation Syndrome ● Removed content addressing non-medical necessity plans ● Revised coverage criteria for: *Acute Myeloid Leukemia (AML) Induction or Consolidation Therapy* ○ Added criterion requiring one of the following: ▪ Patient achieved complete remission after induction therapy; or ▪ Patient is receiving consolidation chemotherapy; or ▪ Patient is receiving fludarabine, cytarabine with or without idarubicin for relapsed or refractory disease; or ▪ Patient is receiving cladribine, cytarabine with or without mitoxantrone or idarubicin for relapsed or	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
White Blood Cell Colony Stimulating Factors (continued)	Jan. 1, 2023	refractory disease ○ Removed criterion requiring the patient has completed either induction or consolidation chemotherapy *Primary Prophylaxis of Chemotherapy-Induced FN* ○ Removed criterion requiring one of the following: ▪ Patient is receiving myelosuppressive anticancer drug(s) given with a curative intent (curative chemotherapy, chemotherapy in curative adjuvant/neoadjuvant setting); or ▪ Patient is receiving myelosuppressive anticancer drug(s) for definitive therapy (bridge to stem cell transplant, organ transplant, definitive surgery for oligometastatic disease) *Secondary Prophylaxis of FN* ○ Added criterion requiring one of the following: ▪ Both of the following: – Patient is receiving myelosuppressive anticancer drug(s) given with non-curative intent; and	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
White Blood Cell Colony Stimulating Factors (continued)	Jan. 1, 2023	– Patient has a documented history of neutropenic event (febrile neutropenia or low neutrophil count leading to delay of subsequent cycle) during a previous cycle of the same chemotherapy regimen after a trial of dose reduction ▪ Patient is receiving myelosuppressive anticancer drug(s) where primary prophylaxis is indicated **Supporting Information** • Updated *FDA* and *References* sections to reflect the most current information	

Coverage Determination Guideline Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Private Duty Nursing Services	Jan. 1, 2023	Applicable States • Revised language to indicate this Medical Policy applies to Individual Exchange benefit plans in all states except for Alabama, Arizona, Colorado, Florida, Georgia, Massachusetts, Mississippi, Nevada, New York, Texas, Tennessee, and Washington Coverage Rationale *Requirements for Coverage* • Replaced language indicating "Private Duty Nursing services are covered and considered Medically Necessary [when criteria are met]" with "*when benefits are available*, Private Duty Nursing services are covered and considered Medically Necessary [when criteria are met]" • Revised coverage criteria; added criterion requiring: ○ Face-to-face visit with the patient within 90 days prior to the start of care, or within 30 days after the start of care ○ Home care agency can safely deliver the required care at home ○ Home environment is safe, accessible, and can be modified to accommodate the home care plan	Refer to the policy for complete details.

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Private Duty Nursing Services (continued)	Jan. 1, 2023	*Documentation Requirements* ● Updated list of required clinical documentation for: Initial Request for Authorization ○ Added: ▪ Comprehensive documentation of the member's medical diagnoses and health status including but not limited to documentation of the Skilled Care needs and medication administration record that support the need for skilled home care nursing services ▪ Discharge summary or recent progress note if member is being discharged from an inpatient setting (note: If member is requesting Private Duty Nursing services for discharge from inpatient setting, subspecialist visit notes are not required) ▪ Delineated scope and duration of Private Duty Nursing hours being requested	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Private Duty Nursing Services (continued)	Jan. 1, 2023	▪ An assessment of the available support system must include but not limited to the following: – Availability of the member's primary caregiver; and – Ability of the member's primary caregiver to provide care; and – School attendance and availability of coverage for services by school district, if applicable; and – Primary caregiver's work schedules, as applicable ▪ Home care agency can safely deliver the required care at home ▪ Home environment is safe, accessible, and can be modified to accommodate the home care plan ▪ Verification of primary caregiver's employment schedule annually, as applicable ○ Removed: ▪ An assessment of the scope and duration of	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Private Duty Nursing Services (continued)	Jan. 1, 2023	Private Duty Nursing services to be provided ○ Replaced: ▪ "Home Health Certification (CMS-485) which includes the Plan of Care signed by a physician (M.D. or D.O.)" with "Home Health Certification (CMS-485) which includes the Plan of Care signed by a physician (M.D. or D.O.) *or signed by an advanced practitioner (NP, CNS, or PA) in accordance with state law*" Renewal of Services *and* Transition of Services ○ Added "verification of primary caregiver's employment schedule annually, as applicable" ○ Replaced "Home Health Certification (CMS-485) which includes the Plan of Care signed by a physician (M.D. or D.O.)" with "Home Health Certification (CMS-485) which includes the Plan of Care signed by a physician (M.D. or D.O.) *or signed by an advanced practitioner (NP, CNS, or PA) in accordance with state law*"	

Coverage Determination Guideline Updates

Replaced		
Policy Title	**Effective Date**	**Summary of Changes**
Fertility Preservation for Iatrogenic Infertility	Nov. 1, 2022	• Policy replaced; refer to the Medical Policy titled Infertility Diagnosis, Treatment and Fertility Preservation
Infertility Services	Nov. 1, 2022	• Policy replaced; refer to the Medical Policy titled Infertility Diagnosis, Treatment and Fertility Preservation
Transcutaneous Electrical Nerve/Joint Stimulators	Nov. 1, 2022	• Policy replaced; refer to the Medical Policy titled Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation

Utilization Review Guideline Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Office Based Procedures – Site of Service	Jan. 1, 2023	**Applicable States** • Revised language to indicate this Medical Policy applies to Individual Exchange benefit plans in all states except for Colorado, Massachusetts, Nevada, New York, and Texas **Coverage Rationale** • Revised medical necessity criteria for an elective surgical procedure performed in an ambulatory surgical center if there is an inability to access an office setting for the procedure; replaced criterion requiring "there is no geographically accessible office that has the necessary equipment for the procedure" with "there is no geographically accessible office that has the necessary equipment for the procedure *[examples include but are not limited to fluoroscopy, laser, ocular equipment, operating microscope, and nonstandard scopes required to perform specialized procedures (i.e., duodenoscope, ureteroscope)]; this specifically excludes surgeon preferred or proprietary instruments, instrument sets, or hardware sets*"	UnitedHealthcare members may choose to receive surgical procedures in an office setting or other locations. We are conducting site of service medical necessity reviews, however, to determine whether the ambulatory surgical center (ASC) is medically necessary, in accordance with the terms of the member's benefit plan. If the ambulatory surgical center is not considered medically necessary, this location will not be covered under the member's plan. Certain elective procedures performed in an ambulatory surgical center are considered medically necessary for an individual who meets any of the following criteria: • Allergy to local anesthetic • Bleeding disorder that would cause a significant risk of morbidity • Developmental stage or cognitive status warranting use of an ambulatory surgical center • Failed office-based procedure attempts due to body habitus, abnormal anatomy, or technical difficulties • Presence of complications and comorbid disease that would cause office based procedure to be unsafe or unsuitable An elective surgical procedure performed in an ambulatory surgical center is considered medically necessary if there is an inability to access an office setting for the procedure due to the following: • There is no geographically accessible office that has the necessary equipment for the procedure; (Examples include but are not limited to fluoroscopy, laser, ocular equipment, operating microscope, nonstandard scopes required to perform specialized procedures (i.e., duodenoscope, ureteroscope)*; or • There is no geographically accessible in-network provider *Note: This specifically excludes surgeon preferred or proprietary instruments, instrument sets, or hardware sets.

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Office Based Procedures – Site of Service (continued)	Jan. 1, 2023	*Elective Procedures List* • Replaced language indicating "prior authorization is required for procedures if not performed in an office setting" with "prior authorization is required for procedures *listed in the Applicable Codes section [of the policy]* if not performed in an office setting" • Removed reference link to the *Exchange Plans Advanced Notification/Prior Authorization Requirements* Documentation Requirements • Added list of applicable CPT codes • Updated list of *Required Clinical Information* to reflect/include: ○ History ○ Physical examination including patient weight and co-morbidities ○ Surgical plan ○ Specific criteria (refer to the *Coverage Rationale* section of the policy) that qualifies the individual for the site of service requested ○ Additional documentation requirements may apply for the following codes; review the below listed policies in conjunction with the guidelines in this document:	**Elective Procedures List** Prior authorization is required for procedures listed in the *Applicable Codes* section of the policy if not performed in an office setting.

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Office Based Procedures – Site of Service (continued)	Jan. 1, 2023	▪ For CPT codes 20552 and 20553, refer to the Medical Policy titled *Temporomandibular Joint Disorders* ▪ For CPT code 64633, refer to the Medical Policies titled *Ablative Treatment for Spinal Pain* and *Occipital Nerve Injections and Ablation (Including Occipital Neuralgia and Headache)* ▪ For CPT code 64635, refer to the Medical Policy titled *Ablative Treatment for Spinal Pain*	
Outpatient Surgical Procedures – Site of Service	Jan. 1, 2023	Applicable States ● Revised language to indicate this Medical Policy applies to Individual Exchange benefit plans in all states except for Colorado, Massachusetts, Nevada, New York, and Texas Coverage Rationale ● Revised medical necessity criteria for a planned surgical procedure performed in a hospital outpatient department if there is an inability to access an ambulatory surgical center for the procedure; replaced criterion requiring "there is no geographically accessible	UnitedHealthcare members may choose to receive surgical procedures in an ambulatory surgical center (ASC) or other locations. We are conducting site of service medical necessity reviews; however, to determine whether the outpatient hospital department is medically necessary, in accordance with the terms of the member's benefit plan. If the outpatient hospital department is not considered medically necessary, this location will not be covered under the member's plan. Certain planned surgical procedures performed in a hospital outpatient department are considered medically necessary for an individual who meets any of the following criteria: ● Advanced liver disease (MELD Score > 8) ● Advance surgical planning determines an individual requires overnight recovery and care following a surgical procedure ● Anticipated need for transfusion ● Bleeding disorder requiring replacement factor or blood products or special infusion products to correct a coagulation defect

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Outpatient Surgical Procedures – Site of Service (continued)	Jan. 1, 2023	ambulatory surgical center that has the necessary equipment for the procedure" with "there is no geographically accessible ambulatory surgical center that has the necessary equipment for the procedure *[examples include but are not limited to fluoroscopy, laser, ocular equipment, operating microscope, and nonstandard scopes required to perform specialized procedures (i.e., duodenoscope, ureteroscope)]; this specifically excludes surgeon preferred or proprietary instruments, instrument sets, or hardware sets*" **Documentation Requirements** • Updated list of *Required Clinical Information* to reflect/include: ○ History ○ Physical examination including patient weight and co-morbidities ○ Surgical plan ○ Physician privileging information related to the need for the use of the hospital outpatient department ○ American Society of Anesthesiologists (ASA) score, as applicable	• Cardiac arrhythmia (symptomatic arrhythmia despite medication) • Chronic obstructive pulmonary disease (COPD) (FEV1 < 50%) • Coronary artery disease ([CAD]/peripheral vascular disease [PVD]) (ongoing cardiac ischemia requiring medical management or recently placed [within 1 year] drug eluting stent) • Developmental stage or cognitive status warranting use of a hospital outpatient department • End stage renal disease ([hyperkalemia above reference range] receiving peritoneal or hemodialysis) • History of cerebrovascular accident (CVA) or transient ischemic attack (TIA) (recent event [< 3 months]) • History of myocardial infarction (MI) (recent event [< 3 months]) • Individuals with drug eluting stents (DES) placed within one year or bare metal stents (BMS) or plain angioplasty within 90 days unless acetylsalicylic acid and antiplatelet drugs will be continued by agreement of surgeon, cardiologist and anesthesia • Ongoing evidence of myocardial ischemia • Poorly Controlled asthma (FEV1 < 80% despite medical management) • Pregnancy • Prolonged surgery (> 3 hours) • Resistant hypertension (Poorly Controlled) • Severe valvular heart disease • Sleep apnea (moderate to severe Obstructive Sleep Apnea (OSA) • Uncompensated chronic heart failure (CHF) (NYHA class III or IV) • Uncontrolled diabetes with recurrent diabetic ketoacidosis (DKA) or severe hypoglycemia • Under 18 years of age A planned surgical procedure performed in a hospital outpatient department is considered medically necessary if there is an inability to access an ambulatory surgical center for the procedure due to any one of the following: • There is no geographically accessible ambulatory surgical center that has the necessary equipment for the procedure; (Examples include but are not

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Outpatient Surgical Procedures – Site of Service (continued)	Jan. 1, 2023	○ Specific criteria (refer to the Coverage Rationale) that qualifies the individual for the site of service requested ○ Additional documentation requirements may apply for the following codes; review the below listed policies in conjunction with the guidelines in this document: ▪ For CPT codes 15576, refer to the Medical Policy titled *Cosmetic and Reconstructive Procedures* ▪ For CPT codes 17106, 17107, and 17108, refer to the Medical Policy titled *Light and Laser Therapy* ▪ For CPT codes 20551, 29800, and 29804, refer to the Medical Policy titled *Temporomandibular Joint Disorders* ▪ For CPT codes 20605, 20606, 20610, and 201611, refer to the Medical Benefit Drug Policy titled *Sodium Hyaluronate* ▪ For CPT codes 22513 and 22514, refer to the Medical Policy titled *Percutaneous*	limited to fluoroscopy, laser, ocular equipment, operating microscope, nonstandard scopes required to perform specialized procedures (i.e., duodenoscope, ureteroscope)*; or • There is no geographically accessible ambulatory surgical center available at which the individual's physician has privileges; or • An ASC's specific guideline regarding the individual's weight or health conditions that prevents the use of an ASC *Note: This specifically excludes surgeon preferred or proprietary instruments, instrument sets, or hardware sets. **Planned Surgical Procedures List** Site of service medical necessity reviews will be conducted for surgical procedures only when performed in an outpatient hospital setting. For the complete list of surgical procedures codes requiring prior authorization, refer to UHCProvider.com > Exchange Plans Advanced Notification/Prior Authorization Requirements.

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Outpatient Surgical Procedures – Site of Service (continued)	Jan. 1, 2023	*Vertebroplasty and Kyphoplasty* ▪ For CPT codes 23700 and 27570, refer to the Medical Policy titled *Manipulation Under Anesthesia* ▪ For CPT codes 29914, 29915, and 29916, refer to the Medical Policy titled *Surgery of the Hip* ▪ For CPT codes 42145, refer to the Medical Policy titled *Obstructive and Central Sleep Apnea Treatment* ▪ For CPT codes 58263, refer to the Medical Policy titled *Hysterectomy* ▪ For CPT codes 62281, refer to the Medical Policy titled *Occipital Nerve Injections and Ablation (Including Occipital Neuralgia and Headache)* Supporting Information ● Updated *References* section to reflect the most current information	
Screening Colonoscopy Procedures – Site of Service	Jan. 1, 2023	Applicable States ● Revised language to indicate this Medical Policy applies to Individual Exchange benefit plans in all states except for Colorado, Massachusetts, Nevada, New York,	UnitedHealthcare members may choose to receive a screening colonoscopy in an ambulatory surgical center (ASC) or other locations. We are conducting site of service medical necessity reviews, however, to determine whether the outpatient hospital department is medically necessary, in accordance with the terms of the member's benefit plan. If the outpatient hospital department is not considered medically necessary, this location will not be covered under the

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Screening Colonoscopy Procedures – Site of Service (continued)	Jan. 1, 2023	and Texas Coverage Rationale • Revised medical necessity criteria for a planned preventive screening colonoscopy performed in a hospital outpatient department if there is an inability to access an ambulatory surgical center for the procedure; replaced criterion requiring "there is no geographically accessible ambulatory surgical center that has the necessary equipment for the procedure" with "there is no geographically accessible ambulatory surgical center that has the necessary equipment for the procedure *[examples include but are not limited to fluoroscopy, laser, ocular equipment, operating microscope, and nonstandard scopes required to perform specialized procedures (i.e., duodenoscope, ureteroscope)]; this specifically excludes surgeon preferred or proprietary instruments, instrument sets, or hardware sets*" • Replaced language indicating "site of service medical necessity reviews will be conducted for surgical procedures only when performed in an outpatient hospital	member's plan. Note: When a planned colonoscopy is done for diagnostic purposes it will be considered under the applicable non-preventive medical benefit. Refer to the Utilization Review Guideline titled Outpatient Surgical Procedures – Site of Service. Planned preventive screening colonoscopies performed in a hospital outpatient department are considered medically necessary for an individual who meets any of the following criteria: • Advanced liver disease (MELD Score > 8) • Anticipated need for transfusion • Bleeding disorder requiring replacement factor or blood products or special infusion products to correct a coagulation defect • Cardiac arrhythmia (symptomatic arrhythmia despite medication) • Chronic obstructive pulmonary disease (COPD) (FEV1 < 50%) • Coronary artery disease ([CAD]/peripheral vascular disease [PVD]) (ongoing cardiac ischemia requiring medical management or recently placed [within 1 year] drug eluting stent) • Developmental stage or cognitive status warranting use of a hospital outpatient department • End stage renal disease ([hyperkalemia above reference range] receiving peritoneal or hemodialysis) • History of cerebrovascular accident (CVA) or transient ischemic attack (TIA) (recent event [< 3 months]) • History of myocardial infarction (MI) (recent event [< 3 months]) • Individuals with drug eluting stents (DES) placed within one year or bare metal stents (BMS) or plain angioplasty within 90 days unless acetylsalicylic acid and antiplatelet drugs will be continued by agreement of surgeon, cardiologist and anesthesia • Ongoing evidence of myocardial ischemia • Poorly Controlled asthma (FEV1 < 80% despite medical management)Resistant hypertension (Poorly Controlled)

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Screening Colonoscopy Procedures – Site of Service (continued)	Jan. 1, 2023	setting" with "site of service medical necessity reviews will be conducted for surgical procedures *[in the* Applicable Codes *section of the policy]* only when performed in an outpatient hospital setting" • Removed reference link to the *Exchange Plans Advanced Notification/Prior Authorization Requirements* **Applicable Codes** • Added CPT/HCPCS codes 45378, 45380, 45381, 45384, 45385, G0105, and G0121 • Added ICD-10 diagnosis codes Z00.00, Z00.01, Z12.10, Z12.11, Z12.12, Z80.0, Z83.71, and Z83.79 **Supporting Information** • Updated *References* section to reflect the most current information	• Severe valvular heart disease • Sleep apnea (moderate to severe Obstructive Sleep Apnea (OSA) • Uncompensated chronic heart failure (CHF) (NYHA class III or IV) • Uncontrolled diabetes with recurrent diabetic ketoacidosis (DKA) or severe hypoglycemia A planned preventive screening colonoscopy performed in a hospital outpatient department is considered medically necessary if there is an inability to access an ambulatory surgical center for the procedure due to any one of the following: • There is no geographically accessible ambulatory surgical center that has the necessary equipment for the procedure; (examples include but are not limited to: fluoroscopy, laser, ocular equipment, operating microscope, nonstandard scopes required to perform specialized procedures (i.e., duodenoscope, ureteroscope)*; or • An ASC's specific guideline regarding the individual's weight or health conditions that prevents the use of an ASC *Note: This specifically excludes surgeon preferred or proprietary instruments, instrument sets, or hardware sets. Site of service medical necessity reviews will be conducted for planned preventive screening colonoscopies on the Applicable Codes List only when performed in an outpatient hospital setting

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.

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 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.

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 Medical Policy Update Bulletin was developed to share important information regarding UnitedHealthcare Individual Exchange Medical Policy, Medical Benefit Drug Policy, Coverage Determination Guideline, and Utilization Review Guideline updates. When information in this bulletin conflicts with applicable state and/or federal law, UnitedHealthcare follows such applicable federal and/or state law.

Policy Update Classifications

New

New clinical coverage criteria 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 clinical coverage criteria; however, items such as the clinical evidence, FDA information, and/or list(s) of applicable codes may have been updated

Revised

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

Replaced

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

Retired

The health service(s) addressed in the policy are no longer being managed or are considered to be proven/medically necessary and are therefore not excluded as unproven/not medically necessary services, unless coverage guidelines or criteria are otherwise documented in another policy

The complete library of UnitedHealthcare Individual Exchange Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, and Utilization Review Guidelines is available at UHCprovider.com > Policies and Protocols > Exchange Plans Policies > Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare® Individual Exchange Plans.