United Healthcare Medicare Advantage

UnitedHealthcare Medicare Advantage

Coverage Summary Update Bulletin: April 2024

In This Issue

Coverage Summary Updates

Page

Updated

Approved for Immediate Implementation

Revised

Approved for Immediate Implementation

Approved for Future Implementation

Coverage Summary Updates

Updated

Approved for Immediate Implementation

Policy Title	Summary of Changes
Hearing Services and Devices	**Coverage Guidelines** ***Surgically Implanted Auditory Devices*** Osseointegrated Implants (CPT Codes 69710, 69714, 69716, and 69729 and HCPCS Codes L8690, L8691, and L8692) • Updated list of applicable CPT/HCPCS codes; added 69729
Obesity: Treatment of Obesity, Non-Surgical and Surgical (Bariatric Surgery)	**Supporting Information** • Updated list of applicable Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) to reflect the most current information; modified reference information for *Bariatric Surgical Management of Morbid Obesity*
Sleep Apnea Diagnosis and Treatment	**Supporting Information** • Updated lists of applicable Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) to reflect the most current information; modified reference information for: ○ *Home Sleep Studies or Polysomnography* ○ *Implantable Hypoglossal Nerve Stimulation (HGNS)*
Wound Treatments	**Coverage Guideline** ***Ablative Laser Treatment for Wounds (CPT Code 17999)*** • Replaced instruction to "refer to the UnitedHealthcare Medical Policy titled *Omnibus Codes* for coverage guidelines *for states/territories with no Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs)*" with "refer to the UnitedHealthcare Medical Policy titled *Omnibus Codes* for coverage guidelines"

Revised

Approved for Immediate Implementation

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Electrical and Ultrasonic Stimulators	**Coverage Guidelines** • Removed content/language addressing: ○ Neuromuscular electrical stimulator (NMES) ○ Functional electrical stimulation (FES) (HCPCS codes E0770 and E0764) ○ Spinal cord stimulators (i.e., dorsal column stimulators and depth brain stimulators) ***Percutaneous Peripheral Nerve Stimulation (PNS) (CPT Code 64555)*** • Modified service heading **Supporting Information** • Added list of applicable *Medicare Administrative Contractors (MACs) with Corresponding States/Territories*

Coverage Summary Updates

Revised

Approved for Immediate Implementation

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Home Health Services, Home Health Visits, Respite Care, and Hospice Care	**Template Update**
	• Updated *Instructions for Use*
	Coverage Guidelines
	Home Health Services
	Coverage Criteria
	• Removed notation indicating:
	  ○ UnitedHealthcare uses the criteria [in the policy] to supplement the general Medicare criteria regarding home health care in the *Medicare Benefit Policy Manual, Chapter 7 - Home Health Services*
	  ○ UnitedHealthcare or it's delegates may utilize InterQual®, a commercially available evidence-based clinical decision tool to make medical necessity determinations, if there is no National Coverage Determination (NCD), applicable Local Coverage Determination (LCD)/Local Coverage Article (LCA), or Medicare manual guidance on coverage, or where the existing guidance provides insufficient clinical detail; refer to the InterQual® LOC: Home Care Q & A

Medications/Drugs (Outpatient/Part B)	**Coverage Guidelines**
	Other Examples of Specific Drugs/Medications
	• Removed content pertaining to individual consideration
	• Added coverage guidelines for:
	  ○ CAR-T Cellular Therapy
	  ▪ Added list of applicable drugs/medications:
	  – Abecma® (idecaptagene cicleucel)
	  – Breyanzi® (lisocabtagene maraluecel)
	  – Carvykti™ (ciltacabtagene autoleucel)
	  – Kymriah® (tisagenlecleucel)
	  – Tecartus® (brexucabtagene autoleucel)
	  – Yescarta® (axicabtagene ciloleucel)
	  ▪ Added instruction to refer to the Optum Clinical Guidelines titled *Chimeric Antigen Receptor T-cell Therapy*
	  ○ Evkeeza® (Evinacumab-Dgnb)
	  ▪ Added instruction to refer to the UnitedHealthcare Commercial Medical Benefit Drug Policy titled *Evkeeza® (Evinacumab-Dgnb)*
	  ○ Gene Therapy (Ex Vivo)
	  ▪ Added list of applicable drugs/medications:
	  – Casgevy™ (exagamglogene autotemcel)
	  – Lyfgenia™ (lovotibeglogene autotemcel)

Coverage Summary Updates

Revised

Approved for Immediate Implementation

Policy Title	Summary of Changes
Medications/Drugs (Outpatient/Part B) (continued)	– Skysona® (elivaldogene autotemcel) – Zynteglo® (betibeglogene autotemcel) ▪ Added instruction to refer to the Optum Clinical Guidelines titled *Gene Therapy* ○ Lantidra™ (Donislecel) ▪ Added instruction to refer to the Optum Clinical Guidelines titled *Solid Organ Transplantation* ● Revised coverage guidelines for: ○ Adzynma (ADAMTS13, Recombinant-Krhn) ▪ Added instruction to refer to the UnitedHealthcare Commercial Medical Benefit Drug Policy titled *Adzynma (ADAMTS13, Recombinant-Krhn)* ▪ Removed language indicating a pre-service review [Review at Launch (RAL)] is required ○ Omvoh™ (Mirikizumab-Mrkz) ▪ Added instruction to refer to the UnitedHealthcare Commercial Medical Benefit Drug Policy titled *Omvoh™ (Mirikizumab-Mrkz)* ▪ Removed language indicating a pre-service review [Review at Launch (RAL)] is required ● Updated list of applicable drugs/medications for: ○ Antiemetics (Injectable) for Oncology; replaced "Emend® (aprepitant injection)" with "Emend® (fosaprepitan injection)" ○ Botulinum toxin; added: ▪ Botox® (onabotulinumtoxinA) ▪ Daxxify® (daxibotulinumtoxinA-lanm) ▪ Dysport® (abobotulinumtoxinA) ▪ Myobloc® (rimabotulinumtoxinB) ▪ Xeomin® (incobotulinumtoxinA) ● Removed coverage guidelines for: ○ Daxxify® (daxibotulinumtoxinA-lanm) **Supporting Information** ● Updated lists of applicable LCDs/LCAs to reflect the most current information: ○ Added notation to indicate the Wisconsin Physicians Service Insurance Corporation (WPS) Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers ○ Modified reference information for *Rituximab*

Coverage Summary Updates

Revised	
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Reproductive Services: Infertility, Family Planning, and Maternity Care	**Coverage Guidelines**
	• Removed content/language addressing in utero fetal surgery
	Infertility Tests and Treatments
	Non-Covered Infertility Services
	• Removed instruction to refer to the UnitedHealthcare Commercial Medical Policy titled *Infertility Diagnosis, Treatment, and Fertility Preservation* for coverage guidelines
	Family Planning
	• Revised list of non-covered services:
	  ○ Consolidated content addressing sterilization; removed specific examples of sterilization procedures
	  ○ Added instruction to refer to the LCAs for sterilization services
	Maternity Care
	• Revised list of non-covered services; removed "services of a lactation specialist"

Respiratory Services and Equipment	**Coverage Guidelines**
	• Removed content/language addressing bronchoscopy (CPT code 31626)
	Pulmonary Rehabilitation
	• Revised list of components required for a pulmonary rehabilitation program; replaced:
	  ○ "Physician-prescribed exercise*; some aerobic* exercise *must be included in* each pulmonary rehabilitation session" with "physician-prescribed exercise *during* each pulmonary rehabilitation session"
	  ○ "Education or training closely and clearly related to the individual's care and treatment which is tailored to the individual's needs, *including* information on respiratory problem management and, if appropriate, brief smoking cessation counseling" with "education or training closely and clearly related to the individual's care and treatment which is tailored to the individual's needs *and assists in achievement of goals toward independence in activities of daily living, adaptation to limitations and improved quality of life; education must include* information on respiratory problem management and, if appropriate, brief smoking cessation counseling"
	• Added language to indicate the number of pulmonary rehabilitation sessions are limited to a maximum of 2 1-hour sessions per day for up to 36 sessions over up to 36 weeks with the option for an additional 36 sessions over an extended period of time
	Bronchial Thermoplasty (CPT Codes 31660 and 31661)
	• Removed language pertaining to individual consideration for U.S. Food and Drug Administration (FDA) approved indications

Coverage Summary Updates

Revised

Approved for Future Implementation

Policy Title	Effective Date	Summary of Changes

Durable Medical Equipment (DME), Prosthetics, Orthotics (Non-Foot Orthotics), Nutritional Therapy, and Medical Supplies Grid	May 1, 2024	**Template Update**
		• Updated *Instructions for Use*
		DME, Prosthetics, Orthotics, and Medical Supplies Grid
		Air-Fluidized Bed (HCPCS Code E0194)
		• Added list of applicable HCPCS codes to item heading
		Alternating Pressure Pads and Mattress (HCPCS Codes E0277 and E0373)
		• Added list of applicable HCPCS codes to item heading
		Artificial Limbs – Lower Limb (HCPCS Codes L5301, L5856, L5968, L5981, and L5987)
		• Added list of applicable HCPCS codes to item heading
		Artificial Limbs – Upper Limb
		Myoelectric (Upper Limb) (HCPCS Codes L6026, L6611, L6621, L6629, L6632, L6677, L6680, L6682, L6686, L6687, L6688, L6694, L6695, L6696, L6697, L6698, L6715, L6880, L6881, L6882, L6883, L6884, L6890, L6925, L6935, L6945, L6955, L6975, L7007, L7008, L7009, L7045, L7180, L7181, L7190, L7191, L7259, L7360, L7364, L7366, L7367, L7368, L7400, L7401, L7403, L7404, and L8465) *(new to policy)*
		• Added language to indicate:
		  ○ Medicare does not have a National Coverage Determination (NCD) for myoelectric upper limbs
		  ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time
		  ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Upper Extremity Prosthetic Devices*
		  ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines
		Commode Chair with Seat Lift Mechanism (HCPCS Codes E0170 and E0171) (new to policy)
		• Added language to indicate coverage criteria apply; refer to the DME Medicare Administrative Contractor (MAC) LCD for *Commodes (L33736)*
		Continuous Positive Airway Pressure (CPAP) Devices (HCPCS Code E0618)
		• Added list of applicable HCPCS codes to item heading
		Hospital Beds and Accessories (HCPCS Codes E0302, E0304, E0316, E0328, and E0329)
		• Added list of applicable HCPCS codes to item heading

Coverage Summary Updates

Revised

Approved for Future Implementation

Policy Title	Effective Date	Summary of Changes
Durable Medical Equipment (DME), Prosthetics, Orthotics (Non-Foot Orthotics), Nutritional Therapy, and Medical Supplies Grid (continued)	May 1, 2024	***Lifts*** Hydraulic (Hoyer) Lift/Patient Lift (HCPCS Codes E0635, E0636, E0639, E0640, E1035, and E1036) • Added list of applicable HCPCS codes to item heading ***Light Therapy Box (HCPCS Codes E0692, E0693, and E0694)*** • Added list of applicable HCPCS codes to item heading ***Mobility Assistive Equipment (MAE)*** Power Mobility Device (PMDs) (HCPCS Codes E0984, E0986, E0988, E1002, E1003, E1004, E1005, E1006, E1007, E1008, E1009, E1010, E1017, E1230, E1239, K0801, K0806, K0808, K0831, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0843, K0848, K0849, K0850, K0851, K0852, K0854, K0855, K0856, K0857, K0858, K0859, K0860, K0861, K0863, K0864, K0877, K0884, K0890, K0891, K0898, and K0899) • Added list of applicable HCPCS codes to item heading Wheelchairs (Manual) (HCPCS Codes E1161, E1232, E1233, E1234, E1235, E1236, E1237, and E1238) • Added list of applicable HCPCS codes to item heading ***Other Non-Covered Items (HCPCS Codes E0761 and E1399)*** • Added list of applicable HCPCS codes to item heading ***Pneumatic Compression Devices (HCPCS Codes E0651 and E0667)*** • Added list of applicable HCPCS codes to item heading ***Pumps, Including Medications and Necessary Supplies*** Infusion (HCPCS Code E0784) • Added list of applicable HCPCS codes to item heading ***Speech Generating Device (HCPCS Code E2510)*** • Added list of applicable HCPCS codes to item heading
Ear, Nose, and Throat Procedures	May 1, 2024	**Coverage Guidelines** ***Posterior Nasal Nerve Ablation Using Radiofrequency or Cryoablation (e.g., Clarifix) (CPT Codes 31242, 31243, and 30999)*** • Modified service heading

Coverage Summary Updates

Revised

Approved for Future Implementation

Policy Title	Effective Date	Summary of Changes

Ear, Nose, and Throat Procedures (continued)	May 1, 2024	***Repair of Nasal Valve Collapse with Subcutaneous/Submucosal Lateral Wall Implant (CPT Code 30468)*** (new to policy)
		• Added language to indicate:
		  ○ Medicare does not have a National Coverage Determination for repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant
		  ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable; for specific LCDs/LCAs, refer to the table [in the *Supporting Information* section of the policy]
		  ○ For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled *Rhinoplasty and Other Nasal Procedures*
		  ○ After checking the table [in the policy] and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines
		Supporting Information
		• Added list of applicable *Medicare Administrative Contractors (MACs) with Corresponding States/Territories*
		• Updated lists of applicable LCDs/LCAs:
		  ○ Added notation to indicate the Wisconsin Physicians Service Insurance Corporation (WPS) Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers
		  ○ Added reference information for *Repair of Nasal Valve Collapse with Subcutaneous/Submucosal Lateral Wall Implant*

Gastroesophageal and Gastrointestinal (GI) Services and Procedures	May 1, 2024	**Coverage Guidelines** ***Wireless Capsule Endoscopy (CPT Codes 91110 and 91111)*** • Added instruction to refer to the [listed] InterQual® criteria for coverage guidelines if no Local Coverage Determination (LCD)/Local Coverage Article (LCA) is found after checking the table [in the *Supporting Information* section of the policy] and searching the Medicare Coverage Database • Removed language pertaining to individual consideration review by a Medical Director for the diagnosis of esophageal varices ***Virtual Colonoscopy, also known as Computed Tomographic Colonography (CTC) (CPT Codes 74261, 74262, and 74263)*** • Removed language pertaining to individual consideration for non-screening CTC coverage for diverticulitis

Coverage Summary Updates

Revised

Approved for Future Implementation

Policy Title	Effective Date	Summary of Changes
Gastroesophageal and Gastrointestinal (GI) Services and Procedures (continued)	May 1, 2024	***Gastric Peroral Endoscopic Myotomy (G-POEM) (CPT Codes 43497 and 43499)*** (new to policy) • Added language to indicate: ○ Medicare does not have a National Coverage Determination (NCD) for gastric peroral endoscopic myotomy; LCDs/LCAs do not exist ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Minimally Invasive Procedures for Gastric and Esophageal Diseases* ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines **Supporting Information** • Added list of applicable *Medicare Administrative Contractors (MACs) with Corresponding States/Territories* • Updated lists of applicable LCDs/LCAs; added notation to indicate the Wisconsin Physicians Service Insurance Corporation (WPS) Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers
Pain Management	May 1, 2024	**Coverage Guidelines** ***Genicular Neve Block (GNB) and RFA for the Treatment of Chronic Knee Pain (CPT Codes 64454, 64624, and 64999)*** (new to policy) • Added language to indicate: ○ Medicare does not have a National Coverage Determination (NCD) for genicular nerve block to treat chronic knee pain; Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes* ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines ***Percutaneous Cryoneurolysis for the Treatment of Chronic Pain (e.g., The iovera° System) (CPT Codes 0440T, 0441T, and 0442T)*** (new to policy) • Added language to indicate: ○ Medicare does not have a NCD for percutaneous cryoneurolysis for the treatment of chronic pain; LCDs/LCAs do not exist ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes* ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines ○ For more information, see the *CGS Billing and Coding Instructions: Cryoneurolysis* at CGS Medicare Part A Publication & News

Coverage Summary Updates

Revised

Approved for Future Implementation

Policy Title	Effective Date	Summary of Changes

Pain Management (continued)	May 1, 2024	**Supporting Information**
		• Added list of applicable *Medicare Administrative Contractors (MACs) with Corresponding States/Territories*
		• Updated lists of applicable LCDs/LCAs to reflect the most current information:
		  ○ Added notation to indicate the Wisconsin Physicians Service Insurance Corporation (WPS) Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers
		  ○ Modified reference information for:
		  ▪ *Cervical and Thoracic Epidural Injections*
		  ▪ *Infusion Pump for Chronic Pain*
		  ▪ *Lumbar and Sacral Epidural Injections*

Radiation and Oncologic Procedures	May 1, 2024	**Coverage Guidelines**
		Proton Beam Therapy (PBT) (CPT Codes 77520, 77522, 77523, and 77525)
		• Removed language pertaining to individual consideration for following diagnoses:
		  ○ Malignant lesions of the head and neck when the intent of treatment is to be curative
		  ○ Pancreatic and adrenal tumors
		  ○ Unresectable retroperitoneal sarcoma
		  ○ Cancers of the lung and upper abdominal/peri-diaphragmatic cancers
		  ○ Unresectable malignant lesions of the liver, biliary tract, anal canal, and rectum
		  ○ Skin cancer with macroscopic perineural/cranial nerve invasion of skull base
		  ○ Advanced stage, unresectable pelvic tumors including those with peri-aortic nodes or malignant lesions of the cervix
		  ○ Acoustic neuromas
		  ○ Pituitary neoplasms
		  ○ Unresectable benign or malignant central nervous system tumors to include but not be limited to primary and variant forms of astrocytoma, glioblastoma, medulloblastoma, craniopharyngioma, benign and atypical meningiomas, pineal gland tumors
		Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiation Therapy (SBRT) (CPT Codes 77371, 77372, and 77373 and HCPCS Codes G0339 and G0340)
		• Removed language pertaining to individual consideration for SBRT for the following diagnoses:
		  ○ Pelvic, head, and neck tumors that have recurred after primary irradiation
		  ○ Primary or metastatic adrenal gland cancer
		  ○ Primary central nervous system malignancies, generally under 5 cm

Coverage Summary Updates

Revised

Approved for Future Implementation

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Radiation and Oncologic Procedures (continued)	May 1, 2024	○ Primary and secondary tumors involving the brain parenchyma, meninges/dura, or immediately adjacent bony structures ○ Tumors arising in or near previously irradiated regions when a high level of precision and accuracy is required to minimize the risk of injury to surrounding normal tissues ○ Refractory epilepsy ***Intraoperative Radiation Treatment (IORT) (CPT Codes 77424, 77425, and 77469)*** (new to policy) • Added language to indicate: ○ Medicare does not have a National Coverage Determination (NCD) for intraoperative radiation treatment (IORT) ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable; for specific LCDs/LCAs, refer to the table [in the *Supporting Information* section of the policy] ○ For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes* ○ After checking the table [in the policy] and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines **Supporting Information** • Added list of applicable *Medicare Administrative Contractors (MACs) with Corresponding States/Territories* • Updated lists of applicable LCDs/LCAs: ○ Added notation to indicate the Wisconsin Physicians Service Insurance Corporation (WPS) Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers ○ Added reference information for *Intraoperative Radiation Treatment (IORT)*
Spine Procedures	May 1, 2024	**Coverage Guidelines** ***Annular Closure Devices (ACDs) (e.g., Barricaid Annular Closure Device) (CPT Code 22899)*** (new to policy) • Added language to indicate: ○ Medicare does not have a National Coverage Determination (NCD) for annular closure devices; Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Discogenic Pain Treatment* ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then refer to the policy referenced above for coverage guidelines

Coverage Summary Updates

Revised		
Approved for Future Implementation		
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Spine Procedures (continued)	May 1, 2024	**Supporting Information** • Added list of applicable *Medicare Administrative Contractors (MACs) with Corresponding States/Territories* • Updated lists of applicable LCDs/LCAs; added notation to indicate the Wisconsin Physicians Service Insurance Corporation (WPS) Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers
Uterine Services and Procedures	May 1, 2024	**Coverage Guidelines** • Removed content/language addressing: ○ Radical hysterectomy (CPT codes 58210, 58285, 58548, 58952, 58953, and 58954) ○ Hysteroscopy, diagnostic (CPT codes 58120, 58555, 58558, 59160, 59812, 59820, 59821, 59830, 59840, 59841, 59851, and 59870) ○ Hysteroscopy, dilation, and curettage (D&C) (CPT codes 58558, 58559, 58560, 58561, 58562, 58563, and 58565) ○ Endometriosis surgery (CPT code 58662) ***Hysterectomy for Purpose of Sterilization*** (new to policy) • Added instruction to refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Reproductive Services: Infertility, Family Planning, and Maternity Care* ***Use of Intrauterine Devices (IUD) for Treatment of Endometrial Hyperplasia*** • Removed list of applicable CPT codes from service heading • Removed notation pertaining to appropriate billing and coding ***Transvaginal Biochemical Mapping (CPT Code 58999)*** (new to policy) • Added language to indicate: ○ Medicare does not have National Coverage Determination (NCD) for transvaginal biomechanical mapping; Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes* ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines **Supporting Information** • Added list of applicable *Medicare Administrative Contractors (MACs) with Corresponding States/Territories* • Updated lists of applicable LCDs/LCAs; added notation to indicate the Wisconsin Physicians Service Insurance Corporation (WPS) Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers

General Information

The inclusion of a health service (e.g., test, drug, device, or procedure) in this bulletin indicates only that UnitedHealthcare is adopting a new policy and/or updated, revised, replaced, or retired an existing policy; it does not imply that UnitedHealthcare provides coverage for the health service. Note that most benefit plan documents exclude from benefit coverage health services identified as investigational or unproven/not medically necessary. Physicians and other health care professionals may not seek or collect payment from a member for services not covered by the applicable benefit plan unless first obtaining the member's written consent, acknowledging that the service is not covered by the benefit plan and that they will be billed directly for the service.

UnitedHealthcare respects the expertise of the physicians, health care professionals, and their staff who participate in our network. Our goal is to support you and your patients in making the most informed decisions regarding the choice of quality and cost-effective care, and to support practice staff with a simple and predictable administrative experience. The Policy Update Bulletin was developed to share important information regarding changes to our Medicare Advantage Coverage Summaries. When information in this bulletin conflicts with applicable state and/or federal law, UnitedHealthcare follows such applicable federal and/or state law.

Note: The absence of a policy does not automatically indicate or imply coverage. As always, coverage for a health service must be determined in accordance with the member's benefit plan and any applicable CMS, federal, or state regulatory requirements. Additionally, UnitedHealthcare reserves the right to review the clinical evidence supporting the safety and effectiveness of a medical technology prior to rendering a coverage determination.

Policy Update Classifications

New

New coverage guidelines have been adopted for a health service (e.g., test, drug, device, or procedure)

Updated

An existing policy has been reviewed and changes have not been made to the coverage guidelines; however, items such as the definitions or references may have been updated

Revised

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

Replaced

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

Retired

An existing policy has been retired

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