United Healthcare Medicare Advantage

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Coverage Summary Update Bulletin: January 2024

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Take Note

Implementation Cancelled: Outpatient Surgical Procedures – Site of Service

As of **Jan. 1, 2024**, site of service medical necessity review will no longer be applied to Medicare Advantage plans for outpatient surgical procedures. Prior authorization reviews for medical necessity may apply.

The new UnitedHealthcare Medicare Advantage Coverage Summary titled *Outpatient Surgical Procedures – Site of Service* will not be implemented as previously announced.

Template Update: Instructions for Use

The following Medicare Advantage Coverage Summaries have been updated to reflect the most current *Instructions for Use*:

- Blood, Blood Products, and Related Procedures
- Cardiac Procedures: Pacemakers, Pulmonary Artery Pressure Measurements, Ventricular Assistive Devices, Valve Repair, and Valve Replacements
- Complementary, Alternative Medicine, and Chiropractic Services
- Dental Services, Oral Surgery, and Treatment of Temporomandibular Joint (TMJ)
- Organ and Tissue Transplants
- Prostate Services and Procedures and Impotence Treatment
- Reproductive Services: Infertility, Family Planning, and Maternity Care
- Respiratory Services and Equipment
- Wound Treatments

Updated

Policy Title	Approval Date	Summary of Changes
Radiation and Oncologic Procedures	Dec. 13, 2023	**Template Update** • Updated *Instructions for Use* **Supporting Information** • Updated list of available Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) to reflect the most current information

Revised

Policy Title	Approval Date	Summary of Changes
Genetic Testing	Dec. 13, 2023	**Template Update** • Updated *Instructions for Use* **Coverage Guidelines** • Revised list of *Molecular Diagnostic Genetic Tests Included in the Palmetto MolDX Program*: ○ Added:

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Genetic Testing (continued)	Dec. 13, 2023	▪ Molecular Assays for the Diagnosis of Cutaneous Melanoma (CPT codes 0090U, 0314U, and 81479) ▪ Molecular Biomarkers to Risk-Stratify Patients at Increased Risk for Prostate Cancer (CPT codes 81313, 81479, 81551, and 0339U) ▪ Molecular Testing for Detection of Upper Gastrointestinal Metaplasia, Dysplasia, and Neoplasia (CPT codes 81479 and 0114U) ○ Removed: ▪ AlloMap (CPT code 81595) ▪ Arrhythmogenic Right Ventricular Dysplasia/Cardiomyopathy (ARVD/C) Testing (CPT code 81439) ▪ HERmark Assay by Monogram (CPT code 81479 ▪ myPath® Melanoma Assay (CPT codes 81479 and 0090U) ▪ ThermoFisher Oncomine Dx Target Test For Non-Small Cell Lung Cancer (CPT code 0022U) ▪ Vectra™ DA (CPT code 81490) ○ Updated list of applicable CPT codes for: ▪ Biomarkers in Cardiovascular Risk Assessment – Added 81439 ▪ Inivata™, InVisionFirst®, Liquid Biopsy for Patients with Lung Cancer – Added 0388U ▪ Minimal Residual Disease Testing for Hematologic Cancer – Removed 0040U ▪ Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing – Added 0402U, 87149, 87150, 87153, 87468, 87469, 87478, and 87484 – Removed U0003, U0004, U0005, 87483, and 87800 ▪ Pharmacogenomics Testing – Added 81401, 81418, 0411U, and 0419U ▪ Plasma-Based Genomic Profiling in Solid Tumors – Added 0326U and 0409U ▪ Repeat Germline Testing – Added 81229, 81307, 81418, 0335U, 81441, 0355U, 0378U, 0389U, 0392U, 0400U, 0401U, 0411U, 0417U, and 0419U ▪ Urine Drug Testing; previously titled *Controlled Substance Monitoring and Drugs of Abuse Testing* – Removed 0143U, 0144U, 0145U, 0146U, 0147U, 0148U, 0149U, 0150U, and 0227U ○ Updated descriptor/heading for “HBB Gene Test” (previously listed as “HBB Full Gene Sequencing”)

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Genetic Testing (continued)	Dec. 13, 2023	○ Updated reference links to reflect the most current program guidelines and Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs)
Home Health Services, Home Health Visits, Respite Care, and Hospice Care	Dec. 13, 2023	**Template Update** ● Updated *Instructions for Use* **Coverage Guidelines** ***Home Health Services*** Coverage Criteria ● Added language to indicate UnitedHealthcare uses the criteria [listed in the policy] to supplement the general Medicare criteria regarding home health care at *Medicare Benefit Policy Manual, Chapter 7 - Home Health Services* ○ UnitedHealthcare uses the criteria in order to ensure consistency in reviewing the conditions to be met for coverage of home health services, as well as reviewing when such services may be medically necessary ○ Use of this criteria to supplement the general provisions noted [in the policy] above provides clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services, because this additional criteria will provide greater consistency in determining when a patient's medical factors support home care ● Added reference link to the InterQual® LOC: Home Care Questions & Answers (Q&A)
Hospital, Emergency, and Ambulance Services	Oct. 30, 2023	**Title Change/Template Update** ● Reorganized and combined content previously included in the Medicare Advantage Coverage Summaries titled: ○ *Ambulance Services* ○ *Emergent/Urgent Services, Post-Stabilization Care, and Out-of-Area Services* ○ *Hospital Services (Outpatient, Observation, and Inpatient)* ● Updated *Instructions for Use* **Coverage Guidelines** ● Removed instruction to refer to the UnitedHealthcare Commercial Medical Policy titled *Outpatient Surgical Procedures – Site of Service* to determine the appropriate site of service ***Inpatient Hospital Services*** ● Added language to indicate: ○ Concurrent review for inpatient admissions is based on whether the complex medical factors documented in the medical record support medical necessity of the inpatient admission [42 CFR § 412.3(d)(1) and (d)(3); 88 Fed. Reg. 22191 (Apr. 12, 2023)] ○ Hospital care that is custodial, rendered for reasons of convenience, or not required for the diagnosis or treatment of illness or injury is not appropriate for coverage or payment; any extensive delays in the provision of medically

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Hospital, Emergency, and Ambulance Services (continued)	Oct. 30, 2023	necessary services are excluded from time counted towards the two-midnight benchmark [*Medicare Program Integrity Manual*, *Ch. 6, § 6.5.2(A)(I)(B)*] • Replaced language indicating: ○ "For coverage to be appropriate under Medicare for an inpatient admission, the *patient* must *demonstrate signs and/or symptoms severe enough* to warrant the need for medical care *and must receive* services *of such intensity that they can be furnished safely and effectively only on an* inpatient *basis*" with "for coverage to be appropriate under Medicare for an inpatient admission, the *documentation* must *clearly support the member's severity of illness and* intensity of service to warrant the need for inpatient medical care" ○ "If the physician or healthcare professional is uncertain if an inpatient admission is appropriate, then the physician or healthcare professional should consider *admitting* the patient *for* observation" with "if the physician or healthcare professional is uncertain if an inpatient admission is appropriate, then the physician or healthcare professional should consider *placing* the patient *in* observation" • Removed language pertaining to the CMS *Hospital Inpatient Patient Payment System (IPPS) Final Rule* for calendar year (CY) 2023 • Added reference link to the: ○ *Medicare Program Integrity Manual, Chapter 6, § 6.5* ○ CMS *Reviewing Hospital Claims for Admission Memo* ○ CMS Frequently Asked Questions (FAQs): *2 Midnight Inpatient Admission Guidance & Patient Status Reviews for Admissions on or after October 1, 2013* • Removed reference link to the CMS *Quality Improvement Organization Manual, Chapter 4, §4110 – Admission/Discharge Review* Additional Considerations Supporting Inpatient Stay • Added language to indicate: ○ **Medicare's Inpatient-Only List**: Inpatient admissions where a medically necessary inpatient-only procedure is performed are generally appropriate for Medicare Part A payment regardless of expected or actual length of stay ○ **Case-by-Case Exceptions to the Two-Midnight Rule**: For hospital stays that are expected to span less than 2 midnights, an inpatient admission may be payable under Medicare Part A on a case-by-case or individualized basis if the documentation supporting the severity of illness and intensity of service support medical necessity for inpatient services [42 CFR 412.3(d)(3)] ○ UnitedHealthcare uses the criteria [within the policy]: ▪ To supplement the general Medicare criteria regarding inpatient admissions at 42 CFR § 412.3(d)(1) and (3), *Chapter 1* of the *Medicare Benefit Policy Manual*, and *Chapter 6, § 6.5* of the *Medicare Program Integrity Manual*

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Hospital, Emergency, and Ambulance Services (continued)	Oct. 30, 2023	▪ In order to ensure consistency in reviewing the complex medical factors on which a physician may reasonably base their decision to admit a patient as an inpatient, including factors such as: patient history and comorbidities; the severity of signs and symptoms; the patient's current medical needs; and the risk of an adverse event ○ Use of [the listed] criteria to supplement the general provisions noted above provides clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services, because this additional criteria will provide greater consistency in determining when a patient's complex medical factors support inpatient admission ○ Use of [the listed] criteria will also further CMS's goal of reducing inpatient admission errors ○ UnitedHealthcare uses InterQual® as a source of medical evidence to support medical necessity and level of care decisions; InterQual® criteria are intended to be used in connection with the independent professional medical judgment of a qualified health care provider ● Removed language pertaining to the elimination of the *CMS Inpatient Only (IPO) List* ● Added reference link to the: ○ UnitedHealthcare Commercial Medical Policy titled *Hospital Services: Observation and Inpatient* for more detailed definitions/clinical criteria and guidelines ○ *Medicare Program Integrity Manual Chapter 6, § 6.5 - Medical Review of Inpatient Hospital Claims for Part A Payment* ● Removed reference link to the: ○ *Inpatient Only (IPO)* list for CY 2021 ○ *Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule with Comment Period (CMS 1772-FC)* for CY 2023 ***Outpatient Hospital Services*** ● Added reference link to the *Medicare Program: Contract Year 2024 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule (CMS 1786-P)* ***Outpatient Observation Services*** ● Removed language indicating the patient must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis for coverage to be appropriate for an inpatient admission; refer to the *Quality Improvement Organization Manual, Chapter 4, §4110 - Admission/Discharge Review* ***Emergency and Urgently Needed Services*** ● Revised language to indicate emergency and urgently needed services are covered when criteria are met:

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Policy Title	**Approval Date**	**Summary of Changes**
Hospital, Emergency, and Ambulance Services (continued)	Oct. 30, 2023	○ For coverage guidelines, refer to the *Medicare Managed Care Manual, Chapter 4, §20.2 – Definitions of Emergency and Urgently Needed Services* ○ We note that a Medicare Advantage (MA) organization may choose to cover services outside the network at higher cost-sharing for non-emergency services obtained outside network providers' normal business hours (e.g., covering services at an urgent care center on weekends or holidays) ***Post-Stabilization Care Services*** ● Revised language to indicate post-stabilization care services are covered when criteria are met; for coverage guidelines, refer to the *Medicare Managed Care Manual, Chapter 4, §20.5.1 – Definition of Post - Stabilization* ***Ambulance Services*** ● Revised language to indicate ambulance for emergency transportation, including ambulance services dispatched through 911 or its local equivalent, when either an emergency situation exists as defined [in the policy] or other means of transportation would endanger the member's health, are covered ○ For coverage guidelines, refer to the: ▪ *Medicare Benefits Policy Manual, Chapter 10 – Ambulance Services* ▪ National Coverage Determination (NCD) for *Pronouncement of Death (NCD 70.4)* ▪ *Medicare Managed Care Manual, Chapter 4, §20.1 – Ambulance Services* ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable ○ Depending on the plan, some members have additional routine transportation benefit (not a Medicare covered benefit); refer to the member's evidence of coverage or contact the customer service department to determine eligibility for this additional benefit **Supporting Information** ● Added *References* section ● Removed *Definitions* section
Medications/Drugs (Outpatient/Part B)	Dec. 13, 2023	**Coverage Guidelines** ***Other Examples of Specific Drugs/Medications*** ● Added coverage guidelines for: ○ **Adzynma (ADAMTS13, Recombinant-Krhn)** and **Omvoh™ (Mirikizumab-Mrkz)** ▪ Added language to indicate a pre-service review [Review at Launch (RAL)] is required ● Revised coverage guidelines for: ○ **Daxxify® (DaxibotulinumtoxinA-lanm)** ▪ Added language to indicate all states/territories have Local Coverage Determinations (LCDs)/Local Coverage

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Medications/Drugs (Outpatient/Part B) (continued)	Dec. 13, 2023	Articles (LCAs) ○ **Izervay™ (Avacincaptad Pegol Intravitreal Solution), Roctavian™ (Valoctocogene Roxaparvovec-Rvox)**, and **Rystiggo® (Rozanolixizumab-Noli), Vyvgart® Hytrulo (Efgartigimod Alfa and Hyaluronidase-Qvfc)** ▪ Removed language indicting a pre-service review [Review at Launch (RAL)] is required ○ **Leqvio® (Inclisiran)** and **Vyepti® (Eptinezumab- Jjmr)** ▪ Added instruction to refer to the UnitedHealthcare Medicare Advantage Medical Benefit Drug Policy titled *Medicare Part B Step Therapy Programs* **Supporting Information** ● Updated list of available LCDs/LCAs to reflect the most current guidelines
Obesity: Treatment of Obesity, Non-Surgical and Surgical (Bariatric Surgery)	Dec. 13, 2023	**Coverage Guidelines** ***Surgical Treatment-Bariatric Surgery*** Covered Services and Criteria ● Updated language pertaining to states with no LCDs/LCAs: ○ Added instruction to refer to the UnitedHealthcare Commercial Medical Policy titled *Bariatric Surgery* for utilization guidelines for all other procedures not listed as nationally non-covered in the NCD for *Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity (NCD 100.1)* ○ Removed reference link to the Novitas Local Coverage Determination (LCD) for *Bariatric Surgical Management of Morbid Obesity (L35022)*
Radiologic Diagnostic Procedures	Dec. 13, 2023	**Notice of Revision:** The following summary of changes has been modified. Revisions to the previous policy update announcement are outlined in red below. Please take note of the amended updates. **Template Update** ● Updated *Instructions for Use* **Coverage Guidelines** ***Computed Tomography (CCT) and Coronary Computed Tomography Angiography (CCTA)*** ● Revised language pertaining to states/territories with no Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) for regions not involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program; replaced reference link to the WPS LCD for Coronary Computed Tomography Angiography (CCTA) (L35121) with instruction to refer to the nationally recognized guidelines (i.e., InterQual®) ***Magnetic Resonance Imaging (MRI)*** ● Updated reference link to the list of Medicare-approved clinical trials

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Radiologic Diagnostic Procedures (continued)	Dec. 13, 2023	***Positron Emission Tomography*** • Modified content heading • Added language to indicate: ○ For up to three PET scans to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy, refer to the NCD for Positron Emission Tomography (FDG) for Oncologic Conditions (220.6.17) ○ For coverage of more than three FDG PET scans to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy, LCDs/LCAs exist and compliance with these policies is required where applicable; for specific LCDs/LCAs, refer to the table [in the policy] for Positron Emission Tomography (PET) (FDG) ○ For greater than three FDG PET scans to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Medicare Advantage Plans Radiology and Cardiology Clinical Guidelines at https://www.uhcprovider.com/en/prior-auth-advance-notification/radiology-prior-authorization.html ○ After checking the Positron Emission Tomography (PET) (FDG) table and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the UnitedHealthcare Medicare Advantage Plans Radiology and Cardiology Clinical Guidelines for coverage guidelines ***Beta Amyloid Positron Emission Tomography in Dementia and Neurodegenerative Disease*** • Revised language to indicate: ○ Medicare does not have a National Coverage Determination (NCD) for beta amyloid positron emission tomography; Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist ○ UnitedHealthcare considers an amyloid positron emission tomography (PET) scan [including, but not limited to, florbetapir F18 (Amyvid), florbetaben F18 (Neuraceq), flortaucipir F18 injection (Tauvid), flutemetamol F18 (Vizamyl)] reasonable and medically necessary for members with a clinical diagnosis of mild cognitive impairment due to Alzheimer disease or mild Alzheimer Dementia who are being considered for enrollment in a clinical trial of Food and Drug Administration (FDA) approved monoclonal antibodies [(e.g., aducanumab (Aduhelm) or lecanemab-irmab (Leqembi)] ○ Effective Oct. 13, 2023, Centers for Medicare & Medicaid (CMS) removed NCD for *Beta Amyloid Positron Tomography in Dementia and Neurodegenerative Disease (220.6.20)* from *Publication 100-03*, of the *NCD Manual*, ending coverage with evidence development (CED) for positron emission tomography (PET) beta amyloid imaging and permitting Medicare coverage determinations for PET beta amyloid imaging to be made by the Medicare Administrative Contractors under section *1862(a)(1)(A) of the Social Security Act*

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Policy Title	Approval Date	Summary of Changes
Radiologic Diagnostic Procedures (continued)	Dec. 13, 2023	**Supporting Information** • Added *Clinical Evidence* and *References* sections • Updated list of available LCDs/LCAs to reflect the most current information

Retired

The Coverage Summary has been retired effective Aug. 29, 2023:

- Diabetes Management, Equipment, and Supplies

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 UnitedHealthcare Medicare Advantage Coverage Summary updates. 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

The complete library of UnitedHealthcare Medicare Advantage Coverage Summaries is available at **UHCprovider.com** > Policies and Protocols > Medicare Advantage Policies > Coverage Summaries.