United Healthcare®

UnitedHealthcare West

Medical Management Guideline Update Bulletin: April 2022

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Quarterly CPT® and HCPCS Code Updates

The following Medical Management Guidelines have been updated to reflect the quarterly Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) code additions, revisions, and deletions. Refer to the following sources for information on the code updates:

- American Medical Association. Current Procedural Terminology: CPT®
- Centers for Medicare & Medicaid Services. Healthcare Common Procedure Coding System: HCPCS Level II

Policy Title	Effective Date	Summary of Changes
Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes	Apr. 1, 2022	• Added A4238 and E2102
Gastrointestinal Pathogen Nucleic Acid Detection Panel Testing for Infectious Diarrhea	Apr. 1, 2022	• Removed 0097U
Molecular Oncology Testing for Cancer Diagnosis, Prognosis, and Treatment Decisions	Apr. 1, 2022	• Added 0306U, 0307U, 0313U, 0314U, and 0315U • Revised description for 0022U
Obstructive and Central Sleep Apnea Treatment	May 1, 2022	• Added K1028 and K1029
Omnibus Codes	Apr. 1, 2022	Cardiac Contractility Modulation using an Implantable Device • Added K1030

Updated

Policy Title	Effective Date	Summary of Changes
Cardiac Event Monitoring	Apr. 1, 2022	Documentation Requirements • Updated list of *Required Clinical Information*
Cognitive Rehabilitation	Apr. 1, 2022	Coverage Rationale • Replaced reference to "InterQual® *2021*, *Apr. 2021* Release, LOC: Outpatient Rehabilitation & Chiropractic, *Cerebrovascular Accident (CVA): Rehabilitation (Adult) and Traumatic Brain Injury (TBI): Rehabilitation (Adult)*" with "InterQual® *2022*, *Mar. 2022* Release, LOC: Outpatient Rehabilitation & Chiropractic"
Elective Inpatient Services	May 1, 2022	Coverage Rationale • Updated list of procedure-related factors that may increase risk of anesthetic complications; removed "morbid obesity (body mass index greater than 40) with hemodynamic or respiratory problems" (duplicative of "American Society of Anesthesiologists class III or greater")

Medical Management Guideline Updates

Updated		
Policy Title	**Effective Date**	**Summary of Changes**
Elective Inpatient Services (continued)	May 1, 2022	**Definitions** • Added definition of "Hemodynamic Instability" • Updated definition of "Acute Kidney Injury" **Supporting Information** • Updated *References* section to reflect the most current information
Genitourinary Pathogen Nucleic Acid Detection Panel Testing	May 1, 2022	**Coverage Rationale** • Added language to indicate screening of asymptomatic members for vaginitis is unproven and not medically necessary • Replaced language indicating "[the listed indications are] proven and medically necessary to evaluate symptomatic *women* for Vaginitis" with "[the listed indications are] proven and medically necessary to evaluate symptomatic *members* for Vaginitis" **Applicable Codes** • Added CPT codes 87800 and 87801 **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information
Proton Beam Radiation Therapy	May 1, 2022	**Applicable Codes** • Added ICD-10 diagnosis codes C69.0, C69.00, C69.01, C69.02, C69.1, C69.10, C69.11, C69.12, C69.20, C69.21, C69.22, C69.50, C69.51, C69.52, C69.6, C69.60, C69.61, C69.62, C69.8, C69.80, C69.81, C69.82, C69.9, C69.90, C69.91, and C69.92 • Replaced ICD-10 diagnosis code C61.0 with C61 **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information
Pulmonary Rehabilitation	Apr. 1, 2022	**Coverage Rationale** • Replaced reference to "InterQual® *2021*, *Apr. 2021* Release, LOC: Outpatient Rehabilitation & Chiropractic, *Pulmonary: Rehabilitation (Adult)*" with "InterQual® *2022*, *Mar. 2022 Release*, LOC: Outpatient Rehabilitation & Chiropractic"
Surgical Treatment for Spine Pain	May 1, 2022	**Applicable Codes** • Removed CPT code 20939; refer to the Medical Management Guideline titled *Spinal Fusion Enhancement Products*

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Implanted Electrical Stimulator for Spinal Cord	Jun. 1, 2022	Coverage Rationale • Replaced language indicating: ○ "Implanted electrical spinal cord stimulators, *including high-frequency spinal cord stimulators and burst spinal cord stimulators*, are proven and medically necessary for treating the [listed] indications" with "implanted electrical spinal cord stimulators are proven and medically necessary for treating the [listed] indications *in certain circumstances when performed according to U.S. Food and Drug Administration (FDA) labeled indications, contraindications, warnings and precautions*" ○ "Implanted electrical spinal cord stimulators are unproven and not medically necessary for treating refractory angina pectoris" with "implanted electrical spinal cord stimulators are unproven and not medically necessary for treating refractory angina pectoris *due to insufficient evidence of efficacy*" ○ "Dorsal root ganglion (DRG) stimulation is proven and	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 refractory angina pectoris due to insufficient evidence of efficacy. 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® 2021, Apr. 2021 Release, 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 electrical stimulator is appropriate when the individual's existing battery/generator is malfunctioning, cannot be repaired, and is no longer under warranty.

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Implanted Electrical Stimulator for Spinal Cord (continued)	Jun. 1, 2022	medically necessary for treating complex regional pain syndrome (CRPS I, CPRS II) when *used* according to U.S. Food and Drug Administration (FDA) *guidelines*" with "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*" • Revised list of indications for which implanted electrical spinal cord stimulators are proven and medically necessary; replaced "diabetic neuropathy" with "*painful lower limb* diabetic neuropathy" Supporting Information • Updated *Clinical Evidence* and *References* sections to reflect the most current information	
Manipulation Under Anesthesia	Jun. 1, 2022	Coverage Rationale • Replaced language indicating "manipulation under anesthesia (MUA) is proven and medically necessary for shoulder joint for	Manipulation under anesthesia (MUA) is proven and medically necessary for: • Knee joint for arthrofibrosis following total knee arthroplasty, knee surgery, or fracture • Shoulder joint for adhesive capsulitis (frozen shoulder) when certain criteria are met. For medical necessity clinical coverage criteria, refer to the

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Manipulation Under Anesthesia (continued)	Jun. 1, 2022	adhesive capsulitis (frozen shoulder)" with "MUA is proven and medically necessary for shoulder joint for adhesive capsulitis (frozen shoulder) *when certain criteria are met*" • Added instruction to refer to the InterQual® 2021, Apr. 2021 Release, CP: Manipulation Under Anesthesia, Shoulder for medical necessity clinical coverage criteria • Removed language indicating MUA is unproven and not medically necessary for any shoulder condition other than adhesive capsulitis (frozen shoulder) **Applicable Codes** • Removed pelvis ICD-10 diagnosis codes M99.14, S32.10XA, S32.111A, S32.112A, S32.119A, S32.121A, S32.122A, S32.129A, S32.131A, S32.132A, S32.139A, S32.14XA, S32.15XA, S32.16XA, S32.17XA, S32.19XA, S32.2XXA, S32.301A, S32.302A, S32.309A, S32.311A, S32.312A, S32.313A, S32.391A, S32.392A, S32.399A, S32.401A, S32.402A, S32.409A, S32.411A, S32.412A, S32.413A, S32.421A, S32.422A, S32.423A, S32.431A, S32.432A, S32.433A, S32.441A, S32.442A, S32.443A, S32.451A, S32.452A, S32.453A,	InterQual® 2021, Apr. 2021 Release, CP: Manipulation Under Anesthesia, Shoulder. Click here to view the InterQual® criteria. MUA is unproven and not medically necessary for all other conditions (whether for single or serial manipulations) including but not limited to the following, due to insufficient evidence of efficacy: • Ankle • Finger • Hip joint or adhesive capsulitis of the hip • Knee joint - any condition other than for arthrofibrosis following total knee arthroplasty, knee surgery, or fracture • Pelvis • Spine • Temporomandibular joint (TMJ) • Toe • Wrist This policy does not apply to the following: • Manipulation of the finger on the day following the injection of collagenase clostridium histolyticum (Xiaflex®) to treat Dupuytren's contracture • Closed reduction of a fracture or joint dislocation unless specified • Elbow joint for arthrofibrosis following elbow surgery or fracture

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Manipulation Under Anesthesia (continued)	Jun. 1, 2022	S32.461A, S32.462A, S32.463A, S32.471A, S32.472A, S32.473A, S32.481A, S32.482A, S32.483A, S32.491A, S32.492A, S32.499A, S32.501A, S32.502A, S32.509A, S32.511A, S32.512A, S32.519A, S32.591A, S32.592A, S32.599A, S32.601A, S32.602A, S32.609A, S32.611A, S32.612A, S32.613A, S32.614A, S32.615A, S32.616A, S32.691A, S32.692A, S32.699A, S32.810A, S32.811A, S32.82XA, S32.89XA, S32.9XXA, and S33.2XXA **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information	
Spinal Fusion Enhancement Products	May 1, 2022	**Coverage Rationale** • Revised list of products proven and medically necessary for the enhancement of spinal fusion; replaced "Autografts" with "Autografts *(including bone marrow aspirate used for bone grafting)*" **Applicable Codes** • Added CPT code 20939 **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, and *References* section to reflect the most current information	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 ○ 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

Revised			
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Spinal Fusion Enhancement Products (continued)	May 1, 2022		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 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 due to insufficient evidence of efficacy: • Allograft based products ○ Cell-based (e.g., mesenchymal stem cells (MSC)) ○ Ceramic-Based Products (e.g., beta tricalcium phosphate (b-TCP), calcium phosphate, calcium sulfate and bioactive glass) used alone or in combination with other grafts including bone marrow aspirate ○ Human amniotic tissue materials, including amniotic fluid stem cell substitutes for the treatment of spine disease or in spine surgery • 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 • The OptiMesh® Expandable Interbody Fusion System

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 Management Guideline Update Bulletin was developed to share important information regarding UnitedHealthcare West Medical Management 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 West Medical Management Guidelines is available at UHCprovider.com > Policies and Protocols > Commercial Policies > UnitedHealthcare West Medical Management Guidelines.