

UnitedHealthcare West Medical Management Guideline Update Bulletin: October 2024

In This Issue

Medical Management Guideline Updates

Page

Take Note

- Annual ICD-10 and Quarterly CPT/HCPCS Code Updates 3

Updated

- Breast Imaging for Screening and Diagnosing Cancer – Effective Nov. 1, 2024 4
- Cell-Free Fetal DNA Testing – Effective Oct. 1, 2024 4
- Electric Tumor Treatment Field Therapy – Effective Oct. 1, 2024 4
- Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation – Effective Oct 1, 2024 4
- Genetic Testing for Neuromuscular Disorders – Effective Oct. 1, 2024 5
- Molecular Oncology Testing for Hematologic Cancer Diagnosis, Prognosis, and Treatment Decisions – Effective Oct. 1, 2024 5
- Percutaneous Neuroablation for Pancreatic Cancer Pain, Severe Cancer Pain, and Trigeminal Neuralgia – Effective Oct. 1, 2024 5
- Preimplantation Genetic Testing and Related Services – Effective Oct. 1, 2024 5
- Spinal Fusion and Bone Healing Enhancement Products – Effective Oct. 1, 2024 5
- Surgery of the Hip – Effective Nov. 1, 2024 6
- Surgery of the Knee – Effective Nov. 1, 2024 6

Revised

- Electric Tumor Treatment Field Therapy – Effective Nov. 1, 2024 6
- Hospital Services: Observation and Inpatient – Effective Nov. 1, 2024 8
- Injectable Dermal Fillers and Bulking Agents – Effective Dec. 1, 2024 10
- Left Atrial Appendage Closure (Occlusion) – Effective Nov. 1, 2024 11
- Light and Laser Therapy – Effective Dec. 1, 2024 12
- Mechanical Stretching Devices – Effective Nov. 1, 2024 13
- Molecular Oncology Testing for Hematologic Cancer Diagnosis, Prognosis, and Treatment Decisions – Effective Dec. 1, 2024 14
- Ocular Photoscreening – Effective Dec. 1, 2024 15
- Omnibus Codes – Effective Dec. 1, 2024 16

In This Issue

- Sleep Studies – Effective Nov. 1, 2024 17
- Retired
- Total Artificial Heart and Ventricular Assist Devices – Effective Oct. 1, 2024 21

Medical Management Guideline Updates

Take Note	
Annual ICD-10 and Quarterly CPT/HCPCS Code Updates	
<p>Effective Oct. 1, 2024, the following Medical Management Guidelines have been updated to reflect the annual ICD-10 and quarterly CPT/HCPCS code additions and deletions. Refer to the following sources for information on the code updates:</p> <ul style="list-style-type: none"> American Medical Association: Current Procedural Terminology: CPT® Centers for Medicare & Medicaid Services: Healthcare Common Procedure Coding System (HCPCS) Quarterly Update Centers for Medicare & Medicaid Services: International Classification of Diseases, Tenth Revision (ICD-10) Codes 	
Policy Title	Summary of Changes
Cell-Free Fetal DNA Testing	<ul style="list-style-type: none"> Added CPT codes 0488U, 0489U, and 0494U
Chromosome Microarray Testing (Non-Oncology Conditions)	<ul style="list-style-type: none"> Added ICD-10 diagnosis codes Q23.81, Q23.82, Q23.88, and Q87.86 Removed ICD-10 diagnosis code Q23.8
Electric Tumor Treatment Field Therapy	<ul style="list-style-type: none"> Added HCPCS code E0767
Electrical Stimulation for Treatment of Pain and Muscle Rehabilitation	<ul style="list-style-type: none"> Added HCPCS codes A4543, A4544, E0721, and E0743
Molecular Oncology Testing for Hematologic Cancer Diagnosis, Prognosis, and Treatment Decisions	<ul style="list-style-type: none"> Added CPT code 0485U
Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions	<ul style="list-style-type: none"> Added CPT codes 0478U, 0485U, 0486U, 0487U, 0496U, 0497U, 0498U, 0499U, 0501U, 0507U, and 0510U
Pharmacogenetic Panel Testing	<ul style="list-style-type: none"> Added CPT codes 0476U, 0477U, and 0516U Removed CPT code 0078U
Preimplantation Genetic Testing and Related Services	<ul style="list-style-type: none"> Removed CPT code 0396U
Preventive Care Service	<p>Screening for Pre-Diabetes and Type 2 Diabetes; Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults with Cardiovascular Risk Factors: Behavioral Counseling Interventions; and Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions</p> <ul style="list-style-type: none"> Added ICD-10 diagnosis codes E66.811, E66.812, E66.813, E66.89, and E88.82 Removed ICD-10 diagnosis code E66.8 <p>Cervical Cancer Screening</p> <ul style="list-style-type: none"> Added CPT code 0502U <p>Colorectal Cancer Screening</p> <ul style="list-style-type: none"> Added ICD-10 diagnosis code Z83.72

Medical Management Guideline Updates

Take Note		
Annual ICD-10 and Quarterly CPT/HCPCS Code Updates		
Preventive Care Service (continued)		<p>Screening for Obesity in Children and Adolescents</p> <ul style="list-style-type: none"> Added ICD-10 diagnosis codes E66.811, E66.812, E66.813, E66.89, E88.82, Z68.55, and Z68.56 Removed ICD-10 diagnosis code E66.8 <p>Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis</p> <ul style="list-style-type: none"> Added HCPCS codes Q0516, Q0517, Q0518, Q0519, and Q0520 <p>Diabetes Diagnosis Code List</p> <ul style="list-style-type: none"> Added ICD-10 diagnosis codes E10.A0, E10.A1, and E10.A2
Updated		
Policy Title	Effective Date	Coverage Rationale
Breast Imaging for Screening and Diagnosing Cancer	Nov. 1, 2024	<p>Medical Records Documentation Used for Reviews (previously titled <i>Documentation Requirements</i>)</p> <ul style="list-style-type: none"> Replaced list of <i>Required Clinical Information</i> with instruction to refer to the protocol titled Medical Records Documentation Used for Reviews <p>Applicable Codes</p> <ul style="list-style-type: none"> Removed CPT codes 77065, 77066, and 77067 <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>Clinical Evidence</i> and <i>References</i> sections to reflect the most current information
Cell-Free Fetal DNA Testing	Oct. 1, 2024	<p>Medical Records Documentation Used for Reviews (previously titled <i>Documentation Requirements</i>)</p> <ul style="list-style-type: none"> Replaced list of <i>Required Clinical Information</i> with instruction to refer to the protocol titled Medical Records Documentation Used for Reviews <p>Applicable Codes</p> <ul style="list-style-type: none"> Updated list of applicable CPT codes to reflect quarterly edits; added 0488U, 0489U, and 0494U
Electric Tumor Treatment Field Therapy	Oct. 1, 2024	<p>Medical Records Documentation Used for Reviews (previously titled <i>Documentation Requirements</i>)</p> <ul style="list-style-type: none"> Replaced list of <i>Required Clinical Information</i> with instruction to refer to the protocol titled Medical Records Documentation Used for Reviews <p>Applicable Codes</p> <ul style="list-style-type: none"> Updated list of applicable HCPCS codes to reflect quarterly edits; added E0767
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation	Oct. 1, 2024	<p>Medical Records Documentation Used for Reviews (previously titled <i>Documentation Requirements</i>)</p> <ul style="list-style-type: none"> Replaced list of <i>Required Clinical Information</i> with instruction to refer to the protocol titled Medical Records Documentation Used for Reviews <p>Applicable Codes</p> <ul style="list-style-type: none"> Updated list of applicable HCPCS codes to reflect quarterly edits; added A4543, A4544, E0721, and E0743

Medical Management Guideline Updates

Updated		
Policy Title	Effective Date	Coverage Rationale
Genetic Testing for Neuromuscular Disorders	Oct. 1, 2024	<p>Coverage Rationale</p> <ul style="list-style-type: none"> Added language to clarify multi-gene <i>comprehensive</i> neuromuscular disease test panels targeting multiple conditions (e.g., muscular dystrophy and mitochondrial disease) are unproven and not medically necessary <p>Medical Records Documentation Used for Reviews (previously titled <i>Documentation Requirements</i>)</p> <ul style="list-style-type: none"> Replaced list of <i>Required Clinical Information</i> with instruction to refer to the protocol titled Medical Records Documentation Used for Reviews <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>Description of Services</i>, <i>Clinical Evidence</i>, and <i>References</i> sections to reflect the most current information
Molecular Oncology Testing for Hematologic Cancer Diagnosis, Prognosis, and Treatment Decisions	Oct. 1, 2024	<p>Medical Records Documentation Used for Reviews (previously titled <i>Documentation Requirements</i>)</p> <ul style="list-style-type: none"> Replaced list of <i>Required Clinical Information</i> with instruction to refer to the protocol titled Medical Records Documentation Used for Reviews <p>Applicable Codes</p> <ul style="list-style-type: none"> Updated list of applicable CPT codes to reflect quarterly edits; added 0485U
Percutaneous Neuroablation for Pancreatic Cancer Pain, Severe Cancer Pain, and Trigeminal Neuralgia	Oct. 1, 2024	<p>Related Policies</p> <ul style="list-style-type: none"> Added reference link to the Medical Policy titled <i>Sympathetic Blockade</i> <p>Medical Records Documentation Used for Reviews (previously titled <i>Documentation Requirements</i>)</p> <ul style="list-style-type: none"> Replaced list of <i>Required Clinical Information</i> with instruction to refer to the protocol titled Medical Records Documentation Used for Reviews
Preimplantation Genetic Testing and Related Services	Oct. 1, 2024	<p>Medical Records Documentation Used for Reviews (previously titled <i>Documentation Requirements</i>)</p> <ul style="list-style-type: none"> Replaced list of <i>Required Clinical Information</i> with instruction to refer to the protocol titled Medical Records Documentation Used for Reviews <p>Applicable Codes</p> <ul style="list-style-type: none"> Updated list of applicable CPT codes to reflect quarterly edits; removed 0396U
Spinal Fusion and Bone Healing Enhancement Products	Oct. 1, 2024	<p>Related Policies</p> <ul style="list-style-type: none"> Removed reference link to the Medical Management Guideline titled: <ul style="list-style-type: none"> <i>Interspinous Fusion and Decompression Devices</i> <i>Spinal Fusion and Decompression</i> <i>Surgical Treatment for Spine Pain</i> <p>Medical Records Documentation Used for Reviews (previously titled <i>Documentation Requirements</i>)</p> <ul style="list-style-type: none"> Replaced list of <i>Required Clinical Information</i> with instruction to refer to the protocol titled Medical Records Documentation Used for Reviews

Medical Management Guideline Updates

Updated			
Policy Title	Effective Date	Coverage Rationale	
Spinal Fusion and Bone Healing Enhancement Products (continued)	Oct. 1, 2024	Supporting Information <ul style="list-style-type: none"> Updated <i>Clinical Evidence</i> and <i>References</i> sections to reflect the most current information 	
Surgery of the Hip	Nov. 1, 2024	Medical Records Documentation Used for Reviews <ul style="list-style-type: none"> Updated list of Medical Records Documentation Used for Reviews; replaced “diagnostic imaging reports” with “<i>complete diagnostic imaging report(s) that are separate and distinct from the professional component of an evaluation and management office visit</i>” Definitions <ul style="list-style-type: none"> Added definition of: <ul style="list-style-type: none"> Femoroacetabular impingement (FAI) Syndrome International Hip Outcome Tool (iHOT-33) Supporting Information <ul style="list-style-type: none"> Updated <i>Clinical Evidence</i> and <i>References</i> sections to reflect the most current information 	
Surgery of the Knee	Nov. 1, 2024	Medical Records Documentation Used for Reviews <ul style="list-style-type: none"> Updated list of Medical Records Documentation Used for Reviews; replaced: <ul style="list-style-type: none"> “Complete report(s) of diagnostic imaging (<i>MRI, CT scan, X-rays, and bone scan</i>)” with “complete diagnostic imaging report(s) <i>that are separate and distinct from the professional component of an evaluation and management office visit</i>” “If the location is being requested as an inpatient stay, <i>documentation to support site of care</i>” with “if the location being requested is an inpatient stay, <i>medical notes to support at least one of the following: surgery is bilateral, member has significant co-morbidities (include the list of comorbidities and current treatment), or member does not have appropriate resources to support post-operative care after an outpatient procedure; include the barriers to care as an outpatient</i>” 	
Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Electric Tumor Treatment Field Therapy	Nov. 1, 2024	Coverage Rationale <ul style="list-style-type: none"> Revised coverage criteria for: <ul style="list-style-type: none"> Use of U.S. Food and Drug Administration (FDA) approved devices to generate electric tumor treatment fields (TTF) for treating: 	The following is proven and medically necessary for treating newly diagnosed histologically confirmed Supratentorial glioblastoma (GBM): <ul style="list-style-type: none"> The use of U.S. Food and Drug Administration (FDA) approved devices to generate electric tumor treatment fields (TTF) when used according to FDA labeled indications, contraindications, warnings, and precautions and when all of the following criteria are met: <ul style="list-style-type: none"> Debulking surgery has been completed; and Treatment with radiation therapy has been completed; and

Medical Management Guideline Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Electric Tumor Treatment Field Therapy (continued)	Nov. 1, 2024	<p>Newly Diagnosed Histologically Confirmed Supratentorial Glioblastoma (GBM)</p> <ul style="list-style-type: none"> ▪ Added criterion requiring “debulking surgery has been completed” ▪ Replaced criterion requiring “the individual has been counselled that the device must be worn at least 18 hours daily” with “the individual has been counselled that the <i>electric TTF</i> device must be worn at least 18 hours daily” <p>Radiologically Confirmed Recurrence of GBM (rGBM) in the Supratentorial Region of the Brain</p> <ul style="list-style-type: none"> ▪ Replaced criterion requiring “the individual has been counselled that the device must be worn at least 18 hours daily” with “the individual has been counselled that the <i>electric TTF</i> device must be worn at least 18 hours daily” <ul style="list-style-type: none"> ○ Subsequent approval(s) for continuation of electric TTF beyond the initial 3 months for treatment of histologically 	<ul style="list-style-type: none"> ○ Individual is receiving Temozolomide (TMZ) as the only cancer drug; and ○ Individual has a Karnofsky Performance Status (KPS) score of > 60 or Eastern Cooperative Oncology Group (ECOG) Performance Status ≤ 2; and ○ Individual has been counselled that the electric TTF device must be worn at least 18 hours daily <p>When all of the above criteria are met for newly diagnosed GBM (ndGBM), an initial 3 months of electric TTF therapy will be approved.</p> <p>The following is proven and medically necessary for treating radiologically confirmed recurrence of GBM (rGBM) in the Supratentorial region of the brain:</p> <ul style="list-style-type: none"> • The use of FDA approved devices to generate electric TTF after initial chemotherapy when used according to FDA labeled indications, contraindications, warnings, and precautions and when all of the following criteria are met: <ul style="list-style-type: none"> ○ The device is used as the only treatment; and ○ Individual has a KPS score of ≥ 60 or ECOG Performance Status ≤ 2; and ○ Individual has been counselled that the electric TTF device must be worn at least 18 hours daily <p>When all of the above criteria are met for rGBM, an initial 3 months of electric TTF therapy will be approved.</p> <p>Subsequent approval(s) for continuation beyond the initial 3 months of electric TTF for treatment of histologically confirmed Supratentorial GBM is based on:</p> <ul style="list-style-type: none"> • Magnetic resonance imaging (MRI) scan has been performed ≤ 2 months prior to request and documents no evidence of disease progression; and • Individual with ndGBM continues to receive TMZ as the only cancer drug or the device is used as the only treatment for an individual with rGBM; and • KPS score of ≥ 60 or ECOG Performance Status ≤ 2; and

Medical Management Guideline Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Electric Tumor Treatment Field Therapy (continued)	Nov. 1, 2024	<p>confirmed Supratentorial GBM; replaced criterion requiring “documentation that the individual has been using the device at least 18 hours daily” with “documentation that the individual has been using the <i>electric TTF</i> device at least 18 hours daily”</p> <p>Definitions</p> <ul style="list-style-type: none"> • Updated definition of: <ul style="list-style-type: none"> ○ Eastern Cooperative Oncology Group (ECOG) Scale of Performance Status ○ Karnofsky Performance Status (KPS) <p>Supporting Information</p> <ul style="list-style-type: none"> • Updated <i>Description of Services</i>, <i>Clinical Evidence</i>, <i>FDA</i>, and <i>References</i> sections to reflect the most current information 	<ul style="list-style-type: none"> • Documentation that the individual has been using the electric TTF device at least 18 hours daily <p>Due to insufficient evidence of efficacy, the use of devices to generate electric TTF is unproven and not medically necessary when the criteria above are not met and for all other indications including but not limited to the following:</p> <ul style="list-style-type: none"> • Treatment of tumors other than GBM • Use of electric TTF therapy with concurrent medical therapy [e.g., bevacizumab (BEV) or chemotherapy] for treatment of rGBM <p>Computer software used for therapeutic radiology clinical treatment planning in conjunction with electric TTF therapy is unproven and not medically necessary due to insufficient evidence of efficacy.</p>
Hospital Services: Observation and Inpatient	Nov. 1, 2024	<p>Coverage Rationale</p> <ul style="list-style-type: none"> • Added language to clarify observation services are medically necessary in any location within a hospital for short-term monitoring <i>for a condition</i> that is expected to require at least 6 hours of assessment or treatment and improves significantly within 24-48 hours <p>Supporting Information</p> <ul style="list-style-type: none"> • Updated <i>References</i> section to reflect the most current information 	<p>UnitedHealthcare uses InterQual® as a source of medical evidence to support medical necessity and level of care decisions, when applicable. InterQual® criteria are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.</p> <p>Click here to view the InterQual® criteria.</p> <p>Observation services are considered medically necessary for a member who requires the following care in any location within a hospital:</p> <ul style="list-style-type: none"> • Short-term monitoring for a condition that is expected to require at least 6 hours of assessment or treatment and improves significantly within 24-48 hours; and • At least one of the following: <ul style="list-style-type: none"> ○ Acute treatment and reassessment; or

Medical Management Guideline Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Hospital Services: Observation and Inpatient (continued)	Nov. 1, 2024		<ul style="list-style-type: none"> ○ Event monitoring (e.g., cardiac dysrhythmia) or response to therapy (e.g., from drug ingestion) that may require immediate intervention; or ○ Diagnostic evaluation to establish a treatment plan. <p>An observation level of care is often used to manage the following clinical conditions and symptoms (list is not all-inclusive):</p> <ul style="list-style-type: none"> ● Abdominal pain ● Allergic reaction (generalized) ● Altered mental status (confusion) ● Anemia ● Asthma ● Atrial fibrillation ● Back pain ● Bronchiolitis ● Bronchitis ● Cellulitis ● Chest pain ● Chronic obstructive pulmonary disease ● Croup ● Dehydration ● Diabetes mellitus ● Epistaxis ● Febrile illness ● Gastroenteritis ● Heart failure ● Hemoptysis ● Migraine ● Pneumonia ● Poisoning/toxic ingestions ● Renal colic, kidney stone ● Seizures ● Syncope and collapse ● Transient ischemic attack (TIA) ● Urinary tract infection ● Vaginal bleeding (non-obstetrical) ● Weakness

Medical Management Guideline Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Hospital Services: Observation and Inpatient (continued)	Nov. 1, 2024		<p>If the member’s condition does not improve within 48 hours, additional clinical information should be submitted to support an inpatient level of care.</p> <p>Observation services are not medically necessary for the convenience of the hospital, physicians, members, or member’s families, or while awaiting placement to another health care facility.</p> <p>Note: The observation services portion of this policy does not apply to an obstetric member during pregnancy, childbirth, or the post-partum period.</p>
Injectable Dermal Fillers and Bulking Agents	Dec. 1, 2024	<p>Title Change</p> <ul style="list-style-type: none"> Previously titled <i>Injectables for Reconstructive Procedures</i> <p>Coverage Rationale</p> <p>Dermal Filler Injections</p> <ul style="list-style-type: none"> Revised language to indicate: <ul style="list-style-type: none"> Radiesse and Sculptra are considered: <ul style="list-style-type: none"> Reconstructive and medically necessary for the treatment of facial defects due to facial lipoatrophy in individuals living with human immunodeficiency virus (HIV) infection Cosmetic and not medically necessary for all other indications The use of all other dermal filler products is considered cosmetic and not medically necessary <p>Injectable Bulking Agents</p> <ul style="list-style-type: none"> Replaced language indicating “injectable bulking agents (e.g., Prolaryn, Prolaryn Plus®) are proven, medically necessary, and 	<p>Dermal Filler Injections</p> <p>Radiesse and Sculptra are considered reconstructive, and medically necessary for the treatment of facial defects due to facial lipoatrophy in individuals living with human immunodeficiency virus (HIV) infection.</p> <p>Radiesse and Sculptra are considered cosmetic and not medically necessary for all other indications.</p> <p>The use of all other dermal filler products is considered cosmetic and not medically necessary.</p> <p>Injectable Bulking Agents</p> <p>Injectable bulking agents are proven medically necessary for the treatment of vocal fold insufficiency/ dysfunction when used according to U.S. Food and Drug Administration (FDA) labeled indications, contraindications, warnings, and precautions.</p>

Medical Management Guideline Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Injectable Dermal Fillers and Bulking Agents (continued)	Dec. 1, 2024	<p><i>reconstructive</i> for treatment of vocal fold insufficiency/dysfunction when used according to U.S. Food and Drug Administration (FDA) labeled indications, contraindications, warnings, and precautions” with “injectable bulking agents are proven and medically necessary for the treatment of vocal fold insufficiency/dysfunction when used according to U.S. FDA labeled indications, contraindications, warnings, and precautions”</p> <p>Medical Records Documentation Used for Reviews (previously titled <i>Documentation Requirements</i>)</p> <ul style="list-style-type: none"> Replaced list of <i>Required Clinical Information</i> with instruction to refer to the protocol titled Medical Records Documentation Used for Reviews <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>Clinical Evidence</i>, <i>FDA</i>, and <i>References</i> sections to reflect the most current information 	
Left Atrial Appendage Closure (Occlusion)	Nov. 1, 2024	<p>Coverage Rationale</p> <ul style="list-style-type: none"> Added language to indicate thoroscopic closure (occlusion) of left atrial appendage (LAA) is not addressed in this policy Removed language indicating thoroscopic closure (occlusion) 	<p>Percutaneous endovascular closure (occlusion) of the left atrial appendage (LAA) is proven and medically necessary to reduce the risk of stroke when using a U.S. Food and Drug Administration (FDA) approved device, when all of the following criteria are met:</p> <ul style="list-style-type: none"> Device is used according to FDA-labeled indications, contraindications, warnings, and precautions Diagnosis of nonvalvular atrial fibrillation (AF)

Medical Management Guideline Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Left Atrial Appendage Closure (Occlusion) (continued)	Nov. 1, 2024	<p>of the LAA as a stand-alone procedure or as an adjunct to thoracoscopic atrial fibrillation ablation is unproven and not medically necessary due to insufficient evidence of safety and/or efficacy</p> <p>Applicable Codes</p> <ul style="list-style-type: none"> Removed CPT codes 33269 and 33999 <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>Description of Services, Clinical Evidence, FDA, and References</i> sections to reflect the most current information 	<ul style="list-style-type: none"> Moderate to high risk of embolic stroke (CHA₂DS₂-VASc Score ≥ 2) Documented medical contraindication to long-term anticoagulation <p>Surgical closure (occlusion) of the LAA as part of cardiac surgery with cardiopulmonary bypass for a different indication is proven and medically necessary to reduce the risk of stroke when all of the following criteria are met:</p> <ul style="list-style-type: none"> Age 18 years or above History of AF CHA₂DS₂-VASc Score ≥ 2 Device is used according to FDA-labeled indications, contraindications, warnings, and precautions, when applicable <p>Note: Thoracoscopic closure (occlusion) of the LAA is not addressed in this policy.</p>
Light and Laser Therapy	Dec. 1, 2024	<p>Coverage Rationale</p> <ul style="list-style-type: none"> Replaced language indicating “laser hair removal is proven and medically necessary for the treatment of pilonidal sinus disease that has been or is being treated with surgery <i>performed to debride an accumulation of fluid or pus causing the formation of a cyst or abscess</i>” with “laser hair removal is proven and medically necessary for the treatment of pilonidal sinus disease that has been or is being treated with surgery <i>for control of hair regrowth</i>” Revised list of conditions for which treatment with light and laser therapy is unproven and not medically necessary; added “onychomycosis” 	<p>Pulsed dye laser therapy is proven and medically necessary for treating the following:</p> <ul style="list-style-type: none"> Port-wine stains Cutaneous hemangioma/hemangiomata <p>Laser hair removal is proven and medically necessary for the treatment of pilonidal sinus disease that has been or is being treated with surgery for control of hair regrowth.</p> <p>Fractional ablative laser fenestration [e.g., carbon dioxide (CO₂) laser, Erbium-Yttrium Aluminum Garnet (Er:YAG) laser] of hypertrophic burn scars is proven and medically necessary when both of the following criteria are met:</p> <ul style="list-style-type: none"> The burn scar is causing functional impairment (i.e., limiting range of motion) and the treatment can be reasonably expected to improve the functional impairment; and The individual has tried and failed at least one conventional treatment (e.g., hypoallergenic paper tape, pressure garments, or silicone kits with gel/sheeting)

Medical Management Guideline Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Light and Laser Therapy (continued)	Dec. 1, 2024	<ul style="list-style-type: none"> Added language to indicate excimer laser therapy is considered cosmetic and not medically necessary for treatment of vitiligo <p>Medical Records Documentation Used for Reviews (previously titled <i>Documentation Requirements</i>)</p> <ul style="list-style-type: none"> Replaced list of <i>Required Clinical Information</i> with instruction to refer to the protocol titled Medical Records Documentation Used for Reviews <p>Applicable Codes</p> <ul style="list-style-type: none"> Added CPT code 17999 and 96999 Removed CPT code 17380 <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>Description of Services, Clinical Evidence, FDA, and References</i> sections to reflect the most current information 	<p>Light and laser therapy including but not limited to intense pulsed light, light phototherapy, photodynamic therapy, Neodymium: Yttrium-Aluminum-Garnet (Nd:YAG), excimer, and pulsed dye laser are unproven and not medically necessary for treating the following due to insufficient evidence of efficacy:</p> <ul style="list-style-type: none"> Acne vulgaris Onychomycosis Rhinophyma Rosacea <p>Excimer laser therapy is considered cosmetic and not medically necessary for treatment of vitiligo.</p>
Mechanical Stretching Devices	Nov. 1, 2024	<p>Coverage Rationale</p> <ul style="list-style-type: none"> Revised list of unproven and not medically necessary devices; replaced “patient actuated serial stretch (PASS) devices” with “patient actuated serial stretch (PASS) devices (<i>patient controlled mechanical stretching</i>)” <p>Medical Records Documentation Used for Reviews (previously titled <i>Documentation Requirements</i>)</p>	<p>Low-load prolonged-duration stretch devices (LLPS) as an adjunct to therapy are proven and medically necessary for treating existing joint contractures of the upper and lower extremities.</p> <p>The following are unproven and not medically necessary, alone or combined with standard physical therapy (PT), for treating joint contractures of the upper and lower extremities due to insufficient evidence of efficacy:</p> <ul style="list-style-type: none"> Static progressive stretch (SPS) splint devices Patient actuated serial stretch (PASS) devices (patient controlled mechanical stretching)

Medical Management Guideline Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Mechanical Stretching Devices (continued)	Nov. 1, 2024	<ul style="list-style-type: none"> Replaced list of <i>Required Clinical Information</i> with instruction to refer to the protocol titled Medical Records Documentation Used for Reviews <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>Description of Services</i>, <i>Clinical Evidence</i>, and <i>References</i> sections to reflect the most current information 	
Molecular Oncology Testing for Hematologic Cancer Diagnosis, Prognosis, and Treatment Decisions	Dec. 1, 2024	<p>Coverage Rationale</p> <ul style="list-style-type: none"> Updated list of examples of Comprehensive Genomic Profiling (CGP) tests; added “Neo Comprehensive™ - Heme Cancers” Replaced reference to “MRD testing” with “MRD assessment” Added language to indicate the use of molecular tests other than clonoSEQ® MRD is unproven and not medically necessary for assessment of MRD; this includes but is not limited to the following: <ul style="list-style-type: none"> FoundationOne® products Guardant products IntelliGEN® Myeloid LeukoVantage®, Myeloid MayoComplete Myeloid Neoplasms Neo Comprehensive™ - Heme Cancers Replaced language indicating “all other molecular testing for hematologic cancer [not listed in the policy as proven and medically necessary] is unproven 	<p>The use of multigene panels (50 genes or fewer) at initial diagnosis and/or recurrence or relapse is proven and medically necessary when ordered by a hematologist or oncologist for individuals with:</p> <ul style="list-style-type: none"> Acute lymphoblastic leukemia; or Acute myeloid leukemia; or Multiple myeloma; or Myelodysplastic syndrome or myeloproliferative neoplasm is strongly suspected (as evidenced by order from hematologist/oncologist) <p>The use of Comprehensive Genomic Profiling (CGP) in an individual with relapsed/recurrent acute myeloid leukemia is proven and medically necessary (e.g., FoundationOne® Heme, Neo Comprehensive™ - Heme Cancers).</p> <p>Clonality assessment with clonoSEQ® Clonality ID at initial diagnosis and MRD assessment with clonoSEQ® MRD are proven and medically necessary when ordered by a hematologist or oncologist for individuals with:</p> <ul style="list-style-type: none"> Acute lymphoblastic leukemia; or Multiple myeloma <p>The use of molecular tests other than clonoSEQ® MRD is unproven and not medically necessary for assessment of MRD. This includes but is not limited to the following:</p> <ul style="list-style-type: none"> IntelliGEN® Myeloid LeukoVantage®, Myeloid MayoComplete Myeloid Neoplasms

Medical Management Guideline Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Molecular Oncology Testing for Hematologic Cancer Diagnosis, Prognosis, and Treatment Decisions (continued)	Dec. 1, 2024	<p>and not medically necessary due to insufficient evidence of efficacy” with “all other molecular <i>test panels</i> for hematologic cancer [not listed in the policy as proven and medically necessary] are unproven and not medically necessary due to insufficient evidence of efficacy; <i>this includes but is not limited to optical genome mapping and whole transcriptome sequencing</i>”</p> <p>Definitions</p> <ul style="list-style-type: none"> Updated definition of “Measurable Residual Disease (MRD)” <p>Applicable Codes</p> <ul style="list-style-type: none"> Added CPT codes 0298U, 0299U, 0300U, and 0413U Removed CPT codes 0285U and 0296U <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>Clinical Evidence</i> and <i>References</i> sections to reflect the most current information 	<ul style="list-style-type: none"> Neo Comprehensive™ - Heme Cancers FoundationOne® products Guardant products <p>Due to insufficient evidence of efficacy, all other molecular testing panels for hematologic cancer are unproven and not medically necessary. This includes but is not limited to the following:</p> <ul style="list-style-type: none"> Optical genome mapping Whole transcriptome sequencing <p>For companion diagnostic testing, refer to the Medical Management Guideline titled Molecular Oncology Companion Diagnostic Testing.</p>
Ocular Photoscreening	Dec. 1, 2024	<p>Template Update</p> <ul style="list-style-type: none"> Created service-specific policy version for content previously included in the Medical Management Guideline titled <i>Omnibus Codes</i> <p>Related Policies</p> <ul style="list-style-type: none"> Added reference link to the Medical Management Guideline titled <i>Preventive Care Services</i> 	<p>Instrument-based ocular photoscreening is proven and medically necessary for the following:</p> <ul style="list-style-type: none"> As a mass screening instrument for children 1-5 years of age (ends on 6th birthday); or In individuals 6 years of age and older who are developmentally delayed and are unable or unwilling to cooperate with routine visual acuity screening <p>Instrument-based ocular photoscreening is unproven and not medically necessary for all other individuals including children less than 1 year of age due to insufficient evidence of safety and/or efficacy.</p>

Medical Management Guideline Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Ocular Photoscreening (continued)	Dec. 1, 2024	<p>Applicable Codes</p> <ul style="list-style-type: none"> Added ICD-10 diagnosis codes R62.0, Z91.198, Z91.199, and Z91.A98 <p>Supporting Information</p> <ul style="list-style-type: none"> Added <i>Description of Services</i>, <i>Benefit Considerations</i>, and <i>FDA</i> sections Updated <i>Clinical Evidence</i> section to reflect the most current information 	<p>Retinal birefringence scanning/retinal polarization scanning is unproven and not medically necessary for the detection of eye misalignment or strabismus due to insufficient evidence of safety and/or efficacy.</p>
Omnibus Codes	Dec. 1, 2024	<p>Coverage Rationale</p> <ul style="list-style-type: none"> Added coverage guidelines for: <ul style="list-style-type: none"> <i>Non-Invasive Bimodal Neuromodulation for Tinnitus (HCPCS code E1399)</i> <ul style="list-style-type: none"> Added language to indicate non-invasive bimodal neuromodulation (e.g., Lenire or Neosensory) for tinnitus is unproven and not medically necessary due to insufficient evidence of safety and/or efficacy <i>Subcutaneous Peritoneal Ascites Pump System (CPT codes 0870T, 0871T, 0872T, 0873T, 0874T, and 0875T)</i> <ul style="list-style-type: none"> Added language to indicate the use of a subcutaneous peritoneal ascites pump system is unproven and not medically necessary due to insufficient evidence of safety and/or efficacy Revised coverage guidelines for: <ul style="list-style-type: none"> <i>Female External Urine Management Systems (HCPCS code E2001)</i> <ul style="list-style-type: none"> Revised language to indicate female external urine management systems (including but not limited to QiVi™ Female External Urine Management System, CareDry® System, PrimaFit External Urine Management Device, PureWick™ System, Versette® external catheter) are unproven and not medically necessary for managing urinary incontinence due to insufficient evidence of efficacy <i>Intracardiac Ischemia Monitoring Systems (CPT codes 0525T, 0526T, 0527T, 0528T, 0529T, 0530T, 0531T, and 0532T)</i> <ul style="list-style-type: none"> Replaced reference to “AngelMed Guardian System” with “Guardian System” <i>Radiostereometric Analysis (RSA) (CPT codes 0347T, 0348T, 0349T, and 0350T)</i> <ul style="list-style-type: none"> Added language to clarify radiostereometric analysis (RSA) is unproven and not medically necessary <i>for all indications</i> due to insufficient evidence of safety and/or efficacy <i>Sinus Tarsi Implant (CPT/HCPCS codes 0335T, 0510T, 0511T, and S2117)</i> <ul style="list-style-type: none"> Added language to clarify the use of a sinus tarsi implant is unproven and not medically necessary <i>for any indication</i> due to insufficient clinical evidence of safety and/or efficacy 	

Medical Management Guideline Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Omnibus Codes (continued)	Dec. 1, 2024	<p>Surgical Treatment of a Sacral Perineural Tarlov Cyst (CPT code 63268)</p> <ul style="list-style-type: none"> Replaced language indicating “surgical treatment (e.g., laminectomy and sacral reconstruction) of a sacral perineural Tarlov cyst is proven and medically necessary for individuals [who meet] the [listed criteria]” with “surgical treatment (e.g., laminectomy and sacral reconstruction) of a sacral perineural Tarlov cyst is proven and medically necessary for individuals [who meet] all the [listed criteria]” <p>Uterus Transplantation (CPT codes 0664T, 0665T, 0666T, 0667T, 0668T, 0669T, and 0670T)</p> <ul style="list-style-type: none"> Removed language indicating uterus transplantation is investigational <ul style="list-style-type: none"> Updated list of applicable CPT codes for: <p>Laboratory Measurement of Antibodies and Serum Levels of Biologic Agents (CPT codes 80145, 80230, 80280, 80299, and 84999)</p> <ul style="list-style-type: none"> Revised description for 84999 Removed coverage guidelines for: <p>Balloon Dilation for Treating Eustachian Tube Dysfunction (ETD) (CPT codes 69705, 69706, and 69799)</p> <ul style="list-style-type: none"> CPT codes 69705, 69706, and 69799 no longer require clinical review <p>Instrument-Based Ocular Photo Screening (CPT codes 99174 and 99177)</p> <ul style="list-style-type: none"> Refer to the Medical Policy titled Ocular Photoscreening <p>Intraoperative Optical Coherence Tomography of the Breast (CPT codes 0351T, 0352T, 0353T, and 0354T)</p> <ul style="list-style-type: none"> CPT codes 0351T, 0352T, 0353T, and 0354T no longer require clinical review <p>Retinal Birefringence Scanning/Retinal Polarization Scanning (CPT code 0469T)</p> <ul style="list-style-type: none"> Refer to the Medical Policy titled Ocular Photoscreening <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>Clinical Evidence</i> and <i>References</i> sections to reflect the most current information <p>Refer to the guideline for complete details.</p>	
Sleep Studies	Nov. 1, 2024	<p>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 to be applied on Nov. 1, 2024.</p>	<p>Home Sleep Apnea Testing</p> <p>Home Sleep Apnea Testing (HSAT), using a portable monitor, is medically necessary for evaluating adults with suspected Obstructed Sleep Apnea (OSA). Where HSAT is indicated, an autotitrating Positive Airway Pressure (APAP) device is an option to determine a fixed PAP pressure.</p>

Medical Management Guideline Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Sleep Studies (continued)	Nov. 1, 2024	<p>Coverage Rationale Attended Full-Channel Polysomnography, Performed in a Healthcare Facility or Laboratory Setting</p> <ul style="list-style-type: none"> Revised list of comorbid medical conditions which prohibit the use of Home Sleep Apnea Testing (HSAT) when using attended full-channel polysomnography for evaluating individuals with suspected Obstructive Sleep Apnea (OSA): <ul style="list-style-type: none"> Added “chronic opiate medication use (> 3 months)” Replaced “body mass index (BMI) > 50” with “body mass index (BMI) ≥ 30 kg/m²” Added language to clarify attended full-channel polysomnography is medically necessary to rule out Central Sleep Apnea prior to implantation and/or calibration of an implantable hypoglossal nerve stimulator, <i>when the device is indicated</i> <p>Daytime Sleep Studies</p> <ul style="list-style-type: none"> Added language to indicate Maintenance of Wakefulness Testing (MWT) is unproven and not medically necessary in children and adolescents less than 18 years of age 	<p>Attended Full-Channel Polysomnography, Performed in a Healthcare Facility or Laboratory Setting</p> <p>Attended full-channel polysomnography is medically necessary for evaluating members with suspected OSA when:</p> <ul style="list-style-type: none"> Results of previous HSAT are negative, indeterminate, or technically inadequate to make a diagnosis of OSA; or The member is a child or adolescent (i.e., less than 18 years of age); or The member is known to have one or more of the following comorbid medical conditions that prohibits the use of a HSAT: <ul style="list-style-type: none"> Significant Chronic Pulmonary Disease as defined by a forced expiratory volume (FEV₁) % predicted of < 60 (Pellegrino et al, 2005) Progressive neuromuscular disease/neurodegenerative disorder (examples include, but are not limited to Parkinson’s disease, myotonic dystrophy, amyotrophic lateral sclerosis, multiple sclerosis with associated pulmonary disease, and history of stroke with persistent neurological sequelae) Moderate to severe heart failure; [New York Heart Association class III or IV (NYHA, 1994) or left ventricular ejection fraction ≤ 40 (Yancy et al., 2013; Yancy et al., 2017)] Body mass index (BMI) > 50 (DeMaria et al., 2007; Blackstone and Cortés, 2010) Obesity Hypoventilation Syndrome Documented ongoing epileptic seizures in the presence of symptoms of sleep disorder Chronic opiate medication use (> 3 months) (Dowell et al., 2022) <p>Also, refer to the Repeat Testing section below.</p> <p>Attended full-channel polysomnography is medically necessary following an appropriate clinical assessment either because OSA has been excluded, OSA has been adequately treated, or documented symptoms suggest one of the following conditions:</p> <ul style="list-style-type: none"> Periodic Limb Movement Disorder (PLMD) (not leg movements associated with another disorder such as sleep disordered breathing) Restless Legs Syndrome (RLS)/Willis-Ekbom Disease that has not responded to treatment

Medical Management Guideline Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Sleep Studies (continued)	Nov. 1, 2024	<p>Medical Records Documentation Used for Reviews (previously titled <i>Documentation Requirements</i>)</p> <ul style="list-style-type: none"> Replaced list of <i>Required Clinical Information</i> with instruction to refer to the protocol titled Medical Records Documentation Used for Reviews <p>Definitions</p> <ul style="list-style-type: none"> Updated definition of: <ul style="list-style-type: none"> Central Disorders of Hypersomnolence Central Sleep Apnea (CSA) Circadian Rhythm Circadian Rhythm Sleep-Wake Disorders Hypersomnolence Insomnia Maintenance of Wakefulness Test (MWT) Obesity Hypoventilation Syndrome (OHS) Parasomnia Periodic Limb Movement Disorder (PLMD) Rapid Eye Movement Sleep Behavior Disorder (RBD) Restless Legs Syndrome (RLS)/Willis-Ekbom Disease <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>Description of Services, Clinical Evidence, FDA, and References</i> sections to reflect the most current information 	<ul style="list-style-type: none"> Parasomnia with documented disruptive, violent, or potentially injurious sleep behavior suspicious of Rapid Eye Movement Sleep Behavior Disorder (RBD) Narcolepsy, once other causes of Excessive Sleepiness have been ruled out by appropriate clinical assessment (also refer to Daytime Sleep Studies section below) Central Sleep Apnea <p>Attended full-channel polysomnography is medically necessary to rule out Central Sleep Apnea prior to implantation and/or calibration of an implantable hypoglossal nerve stimulator, when the device is indicated. Refer to the Medical Management Guideline titled Obstructive and Central Sleep Apnea Treatment for implantable hypoglossal nerve stimulator indications.</p> <p>The following studies are not medically necessary due to insufficient evidence of efficacy:</p> <ul style="list-style-type: none"> Attended full-channel polysomnography for evaluating any of the following conditions: <ul style="list-style-type: none"> Circadian Rhythm Disorders Depression Insomnia Actigraphy for any sleep disorders <p>Daytime Sleep Studies</p> <p>Note: The following sleep studies may be performed during the night if necessary to match an individual's normal sleep pattern.</p> <p>Multiple Sleep Latency Testing (MSLT) is medically necessary when it is indicated by all of the following:</p> <ul style="list-style-type: none"> Suspected Narcolepsy or idiopathic Hypersomnia; and Other causes of Excessive Sleepiness have been excluded by appropriate clinical assessment <p>For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures:</p> <ul style="list-style-type: none"> Sleep Studies

Medical Management Guideline Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Sleep Studies (continued)	Nov. 1, 2024		<ul style="list-style-type: none"> Sleep Studies (Pediatric) <p>Click here to view the InterQual® criteria.</p> <p>Maintenance of Wakefulness Testing (MWT) is medically necessary for evaluating the following:</p> <ul style="list-style-type: none"> An adult who is unable to stay awake, resulting in a safety issue; or Assessing response to treatment in adults with sleep disorders <p>For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Sleep Studies.</p> <p>Click here to view the InterQual® criteria.</p> <p>MWT is unproven and not medically necessary in children and adolescents less than 18 years of age.</p> <p>Abbreviated daytime sleep studies (e.g., PAP-Nap) are not medically necessary due to insufficient evidence of efficacy.</p> <p>Attended PAP Titration</p> <p>When a member meets the above criteria for an attended full-channel polysomnography sleep study, the following are medically necessary:</p> <ul style="list-style-type: none"> A split-night sleep study, performed in a healthcare facility or laboratory setting, for diagnosis and PAP titration; or A full night study for PAP titration, when a split-night sleep study is inadequate or not feasible and the member has a confirmed diagnosis of OSA <p>Also refer to the Repeat Testing section below.</p> <p>Attended Repeat Testing</p> <p>Repeat attended full-channel polysomnography and repeat PAP titration are medically necessary for certain members who have persistent or new symptoms, despite documented appropriate current treatment or PAP therapy (e.g., equipment failure, improper mask fit,</p>

Medical Management Guideline Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Sleep Studies (continued)	Nov. 1, 2024		<p>pressure leaks, unsuccessful titration, inadequate pressure, and medical problems including nasal congestion have been addressed and appropriately managed).</p> <p>Repeat testing and repositioning/adjustments for oral sleep appliances can be done in the home unless the member meets criteria for an attended sleep study.</p>
Retired			
Policy Title	Effective Date	Summary of Changes	
Total Artificial Heart and Ventricular Assist Devices	Oct. 1, 2024	<ul style="list-style-type: none"> Retired policy; refer to the Optum Clinical Guideline titled Mechanical Circulatory Support Devices 	

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 changes to our Medical Policies and Medical Benefit Drug Policies. 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 > For Commercial Plans > [UnitedHealthcare West Medical Management Guidelines](#).