May 2018

medical policy update bulletin

Medical Policy, Medical Benefit Drug Policy & Coverage Determination Guideline Updates

UnitedHealthcare respects the expertise of the physicians, health care professionals, and their staff who participate in our network. Our goal is to support you and your patients in making the most informed decisions regarding the choice of quality and cost-effective care, and to support practice staff with a simple and predictable administrative experience. The Medical Policy Update Bulletin was developed to share important information regarding UnitedHealthcare Medical Policy, Medical Benefit Drug Policy, Coverage Determination Guideline, Utilization Review Guideline, and Quality of Care Guideline updates.*

*Where information in this bulletin conflicts with applicable state and/or federal law, UnitedHealthcare follows such applicable federal and/or state law.

UnitedHealthcare®

Medical Policy, Medical Benefit Drug Policy & Coverage Determination Guideline Updates

Overview

This bulletin provides complete details on UnitedHealthcare Medical Policy, Medical Benefit Drug Policy, Coverage Determination Guideline (CDG), Utilization Review Guideline (URG), and/or Quality of Care Guideline (QOCG) updates. The inclusion of a health service (e.g., test, drug, device or procedure) in this bulletin indicates only that UnitedHealthcare has recently adopted 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. In the event of an inconsistency or conflict between the information provided in this bulletin and the posted policy, the provisions of the posted policy will prevail. 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.

The complete library of UnitedHealthcare Medical Policies, Medical Benefit Drug Policies, CDGs, URGs, and QOCGs is available at **UHCprovider.com** > *Policies and Protocols > Commercial Policies > Medical & Drug Policies and Coverage Determination Guidelines.*

Tips for using the Medical Policy Update Bulletin:

- From the table of contents, click the policy title to be directed to the corresponding policy update summary.
- From the policy updates table, click the policy title to view a complete copy of a new, updated, or revised policy.

Policy Update Classifications

New

New clinical coverage criteria and/or documentation review requirements 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 or documentation review requirements; 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 and/or documentation review requirements

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

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®

Medical Policy, Medical Benefit Drug Policy & Coverage Determination Guideline Updates

In This Issue

Take Note

Page

- Quick Access to Policies on UHCprovider.com 5

Medical Policy Updates

UPDATED

- Carrier Testing for Genetic Diseases – Effective Ju1. 1, 2018 6
- Hepatitis Screening – Effective Jun. 1, 2018 6
- Intrauterine Fetal Surgery – Effective May 1, 2018 6
- Macular Degeneration Treatment Procedures – Effective Jun. 1, 2018 7
- Molecular Oncology Testing for Cancer Diagnosis, Prognosis, and Treatment Decisions – Effective Jul. 1, 2018 7
- Occipital Neuralgia and Headache Treatment – Effective Jun. 1, 2018 7
- Prolotherapy for Musculoskeletal Indications – Effective May 1, 2018 7
- Transpupillary Thermotherapy – Effective May 1, 2018 7

REVISED

- Gastrointestinal Motility Disorders, Diagnosis and Treatment – Effective Jun. 1, 2018 8
- Manipulative Therapy – Effective Jun. 1, 2018 9

Medical Benefit Drug Policy Updates

NEW

- Crysvita® (Burosumab-Twza) – Effective May 1, 2018 12

UPDATED

- Benlysta® (Belimumab) – Effective May 1, 2018 12
- Entyvio® (Vedolizumab) – Effective May 1, 2018 12
- Radicava™ (Edaravone) – Effective May 1, 2018 13
- Vaccines – Effective May 1, 2018 13

Coverage Determination Guideline (CDG) Updates

UPDATED

- Cosmetic and Reconstructive Procedures – Effective Jun. 1, 2018 14
- Gynecomastia Treatment – Effective May 1, 2018 14

REVISED

- Ambulance Services – Effective Jun. 1, 2018 14

In This Issue

- Durable Medical Equipment, Orthotics, Ostomy Supplies, Medical Supplies and Repairs/Replacements – Effective Jun. 1, 2018 18
- Preventive Care Services – Effective Jun. 1, 2018 19

Utilization Review Guideline (URG) Updates

UPDATED

- Site of Service Guidelines for Certain Outpatient Surgical Procedures – Effective May 1, 2018 24

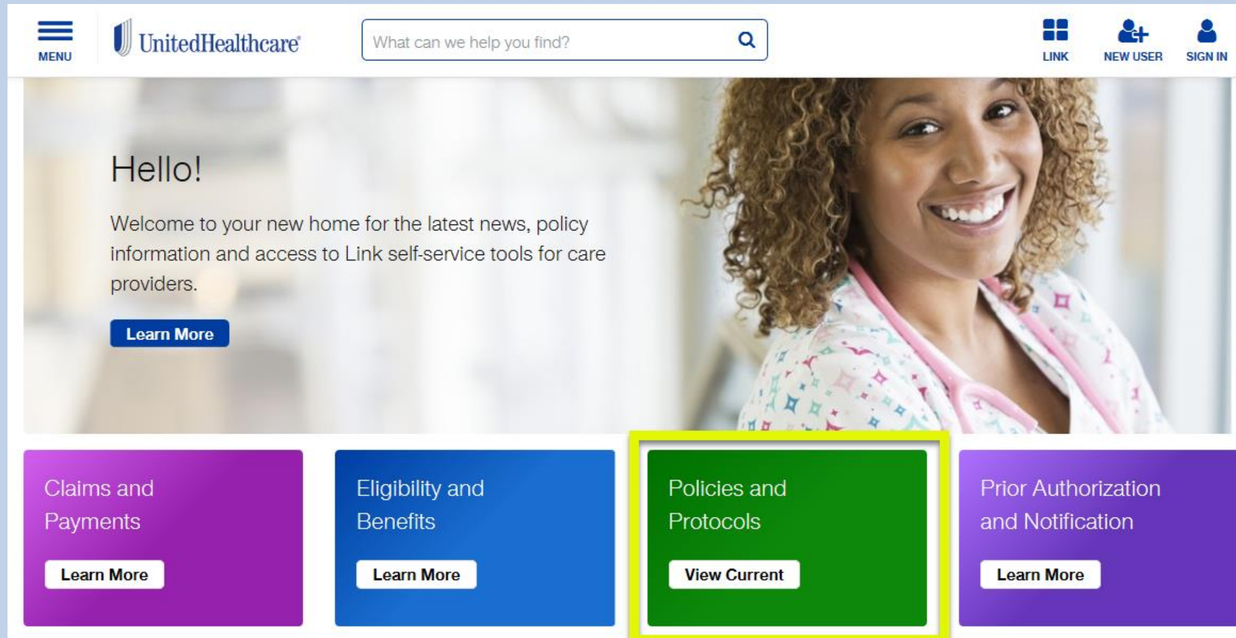
UnitedHealthcare®

Take Note

QUICK ACCESS TO POLICIES ON UHCPROVIDER.COM

Recent enhancements to UHCprovider.com have made it easier to find the UnitedHealthcare policies you need:

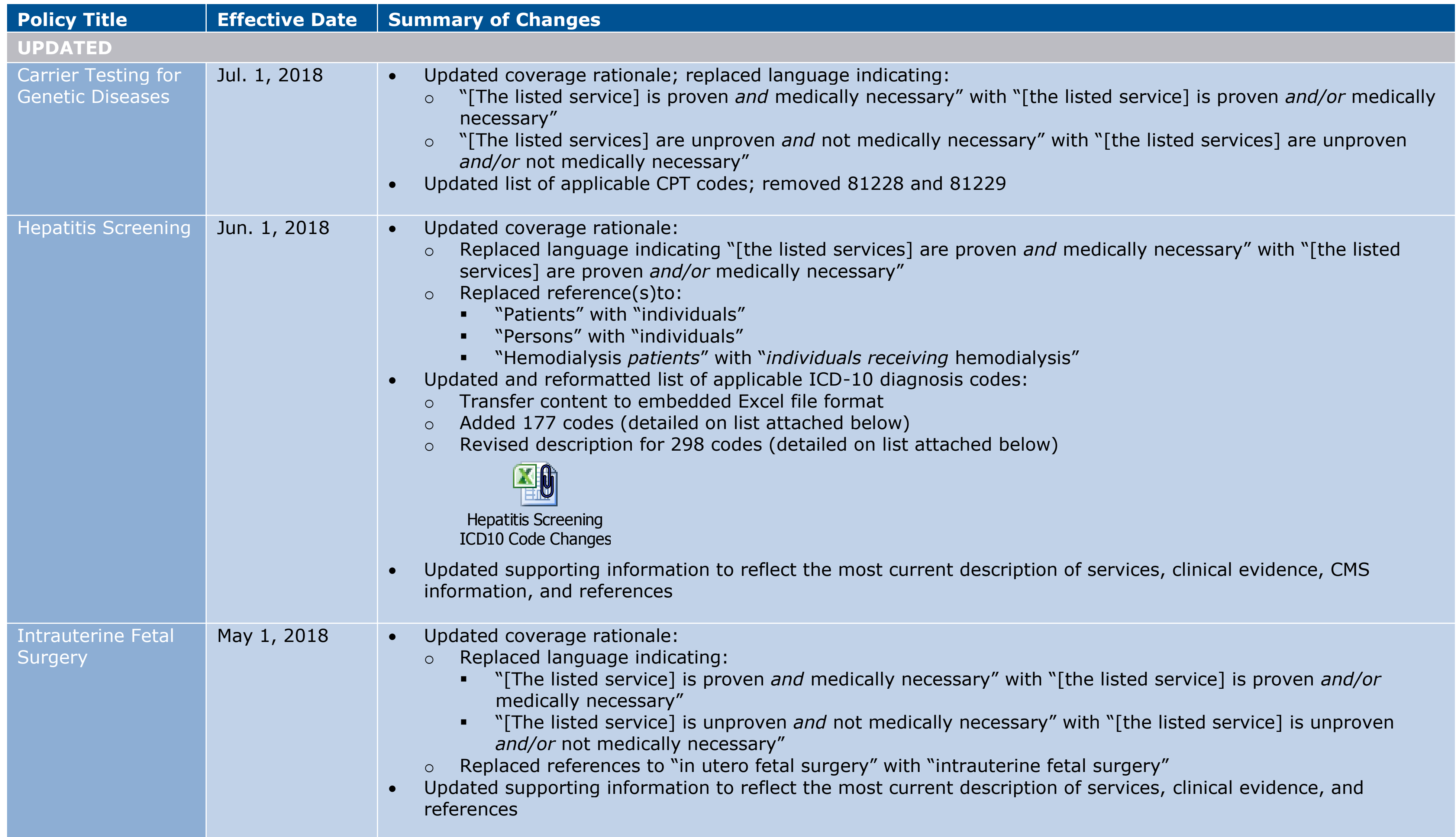
- A new green tile was added to the home page, up front and center, allowing you to access the *Policies and Protocols* library with just one click.



- A filter feature within each policy index is now available to aid in your searches. Just click *Refine Results*, start typing, and only those policies with matching text will appear in the list.

UnitedHealthcare®

Medical Policy Updates



Policy Title	Effective Date	Summary of Changes
UPDATED		
Carrier Testing for Genetic Diseases	Jul. 1, 2018	• Updated coverage rationale; replaced language indicating: ○ "[The listed service] is proven *and* medically necessary" with "[the listed service] is proven *and/or* medically necessary" ○ "[The listed services] are unproven *and* not medically necessary" with "[the listed services] are unproven *and/or* not medically necessary" • Updated list of applicable CPT codes; removed 81228 and 81229
Hepatitis Screening	Jun. 1, 2018	• Updated coverage rationale: ○ Replaced language indicating "[the listed services] are proven *and* medically necessary" with "[the listed services] are proven *and/or* medically necessary" ○ Replaced reference(s)to: ▪ "Patients" with "individuals" ▪ "Persons" with "individuals" ▪ "Hemodialysis *patients*" with "*individuals receiving* hemodialysis" • Updated and reformatted list of applicable ICD-10 diagnosis codes: ○ Transfer content to embedded Excel file format ○ Added 177 codes (detailed on list attached below) ○ Revised description for 298 codes (detailed on list attached below) Hepatitis Screening ICD10 Code Changes • Updated supporting information to reflect the most current description of services, clinical evidence, CMS information, and references
Intrauterine Fetal Surgery	May 1, 2018	• Updated coverage rationale: ○ Replaced language indicating: ▪ "[The listed service] is proven *and* medically necessary" with "[the listed service] is proven *and/or* medically necessary" ▪ "[The listed service] is unproven *and* not medically necessary" with "[the listed service] is unproven *and/or* not medically necessary" ○ Replaced references to "in utero fetal surgery" with "intrauterine fetal surgery" • Updated supporting information to reflect the most current description of services, clinical evidence, and references

UnitedHealthcare®

Medical Policy Updates

Policy Title	Effective Date	Summary of Changes
UPDATED		

Macular Degeneration Treatment Procedures	Jun. 1, 2018	• Replaced references to "patient" with "individual"
		• Updated coverage rationale; replaced language indicating:
		  ○ "[The listed service] is proven *and* medically necessary" with "[the listed service] is proven *and/or* medically necessary"
		  ○ "[The listed services] are unproven *and* not medically necessary" with "[the listed services] are unproven *and/or* not medically necessary"
		• Updated list of applicable CPT codes; added 67036
		• Updated supporting information to reflect the most current description of services, clinical evidence, FDA and CMS information, and references

Molecular Oncology Testing for Cancer Diagnosis, Prognosis, and Treatment Decisions	Jul. 1, 2018	• Updated list of applicable CPT codes:
		  ○ Added 0022U
		  ○ Removed 81228 and 81229

Occipital Neuralgia and Headache Treatment	Jun. 1, 2018	• Updated coverage rationale; replaced language indicating:
		  ○ "[The listed service] is proven *and* medically necessary" with "[the listed service] is proven *and/or* medically necessary"
		  ○ "[The listed services] are unproven *and* not medically necessary" with "[the listed services] are unproven *and/or* not medically necessary"
		• Updated list of applicable HCPCS codes; removed E0720 and L8683
		• Updated supporting information to reflect the most current clinical evidence, CMS information, and references

Prolotherapy for Musculoskeletal Indications	May 1, 2018	• Updated coverage rationale; replaced language indicating "[the listed service] is unproven *and* not medically necessary" with "[the listed service] is unproven *and/or* not medically necessary" • Updated supporting information to reflect the most current clinical evidence, CMS information, and references

Transpupillary Thermotherapy	May 1, 2018	• Updated coverage rationale:
		  ○ Replaced language indicating:
		    ▪ "[The listed service] is proven *and* medically necessary" with "[the listed service] is proven *and/or* medically necessary"
		    ▪ "[The listed service] is unproven *and* not medically necessary" with "[the listed service] is unproven *and/or* not medically necessary"
		  ○ Replaced reference to "patients" with "individuals"
		• Updated supporting information to reflect the most current clinical evidence and references

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Gastrointestinal Motility Disorders, Diagnosis and Treatment	Jun. 1, 2018	• Revised coverage rationale: ○ Replaced language indicating: ▪ "[The listed services] are proven *and* medically necessary" with "[the listed services] are proven *and/or* medically necessary" ▪ "[The listed services] are unproven *and* not medically necessary" with "[the listed services] are unproven *and/or* not medically necessary" ▪ "The [listed] tests are proven for evaluating anorectal function" with "the [listed] tests are proven *and/or medically necessary* for evaluating anorectal function" ○ Replaced references to "patient" with "member" • Updated supporting information to reflect the most current description of services, clinical evidence, FDA and CMS information, and references	**<u>Gastric Electrical Stimulation Therapy</u>** **Gastric electrical stimulation therapy is proven and/or medically necessary for treating the following conditions**: • Refractory diabetic gastroparesis that has failed other therapies • Chronic, intractable (drug-refractory) nausea and vomiting secondary to gastroparesis of diabetic or idiopathic etiology when used according to U.S. Food and Drug Administration (FDA) labeled indications. See the *U.S. Food and Drug Administration* section of the policy for information regarding FDA labeling and Humanitarian Device Exemption (HDE) for gastric electrical stimulation. **<u>Manometry and Rectal Sensation, Tone, and Compliance Test</u>** **The following tests are proven and/or medically necessary for evaluating anorectal function**: • Rectal sensation, tone, and compliance test • Anorectal manometry **Colonic manometry is unproven and/or not medically necessary for evaluating colon motility**. There is insufficient clinical evidence of efficacy in the published peer-reviewed medical literature for the use of colon motility testing or colonic manometry. Member selection criteria and the role of colonic manometry in the management of motility abnormalities such as refractory constipation must be better defined in statistically robust, well-designed clinical trials. **<u>Defecography</u>** **Defecography is proven and/or medically necessary for evaluating the following conditions**: • Intractable constipation • Constipation in members who have one or more of the following conditions that are suspected to be the cause of impaired defecation: ○ Pelvic floor dyssynergia (inappropriate contraction of the puborectalis muscle); or ○ Enterocele (e.g., after hysterectomy); or ○ Anterior rectocele **Defecography is unproven and/or not medically necessary for evaluating all other conditions, including but not limited to**:

UnitedHealthcare

Medical Policy Updates

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Gastrointestinal Motility Disorders, Diagnosis and Treatment *(continued)*	Jun. 1, 2018		• Constipation for conditions other than those listed above. Direct visualization is the preferred method of evaluating intractable constipation in the absence of the stated indications above. **MRI defecography is unproven and/or not medically necessary for evaluating constipation and anorectal or pelvic floor disorders**. There is insufficient clinical evidence of efficacy in the published peer-reviewed medical literature for the use of MRI defecography. The utility of this advanced imaging technology in the evaluation and management of refractory constipation must be better defined in statistically robust, well-designed clinical trials. **Electrogastrography and Electroenterography** **Cutaneous, mucous, or serosal electrogastrography or electroenterography are unproven and/or not medically necessary for diagnosing intestinal or gastric disorders including gastroparesis**. There is insufficient evidence to conclude that electrogastrography or electroenterography can accurately diagnose gastroparesis and other gastric or intestinal disorders. There are no data to conclude that electrogastrography or electroenterography are beneficial for health outcomes in members with gastric or intestinal disorders.

Manipulative Therapy	Jun. 1, 2018	• Updated list of related policies; removed reference link to the policy titled *Gait Analysis* (retired Jun. 1, 2018)
		• Revised coverage rationale:
		  ○ Replaced language indicating:
		    ▪ "[The listed service] is proven *and* medically necessary" with "[the listed service] is proven *and/or* medically necessary"
		    ▪ "[The listed services] are unproven *and* not medically necessary"
			Manipulative therapy is proven and/or medically necessary for treating musculoskeletal disorders, except as noted below.
			
			Manipulative therapy is unproven and/or not medically necessary for treating:
			• Non-musculoskeletal disorders, including but not limited to:
			  ○ Lungs (e.g., asthma)
			  ○ Internal organs (e.g., intestinal)
			  ○ Neurological (e.g., headaches)
			  ○ Ear, nose, and throat (e.g., otitis media)
			• Temporomandibular joint (TMJ) disorder
			• Scoliosis
			
			Manipulative therapy is unproven and/or not medically necessary for preventive or maintenance care.
			The role of manipulative therapy in preventive or maintenance care has not

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Manipulative Therapy *(continued)*	Jun. 1, 2018	with "[the listed services] are unproven *and/or* not medically necessary" ▪ "Manipulative therapy is unproven *and* not medically necessary for treating non-musculoskeletal disorders (e.g., asthma, otitis media, *infantile colic, etc.)* and internal organ *disorders* (e.g., *gallbladder, spleen,* intestinal, *kidney, or* lung *disorders*)" with "manipulative therapy is unproven *and/or* not medically necessary for treating non-musculoskeletal disorders*, including but not limited to* lungs (e.g., asthma), internal organs (e.g., intestinal), *neurological (e.g., headaches),* and *ear, nose, and throat* (e.g., otitis media)" ▪ "Manipulative therapy is unproven *and* not medically necessary for *treating prevention/*maintenance/*custodial* care" with "manipulative therapy is unproven *and/or* not medically necessary for *preventive or*	been established in scientific literature. A beneficial impact on health outcomes has not been established. **Craniosacral therapy (cranial manipulation/Upledger technique) or manipulative services that utilize nonstandard techniques including but not limited to applied kinesiology, National Upper Cervical Chiropractic Association (NUCCA), and neural organizational technique are unproven and/or not medically necessary for any indication**. The role of manipulation for the above has not been established in scientific literature. A beneficial impact on health outcomes, e.g., improved physical function, durable pain relief, has not been established. **Manipulative therapy is unproven and/or not medically necessary when ANY of the following apply**: • The member's condition has returned to the pre-symptom state. • Little or no improvement is demonstrated within 30 days of the initial visit despite modification of the treatment plan. • Concurrent manipulative therapy, for the same or similar condition, provided by another health professional whether or not the healthcare professional is in the same professional discipline. This policy does not address manipulation under anesthesia; refer to the policy titled *Manipulation Under Anesthesia*.

Medical Policy Updates

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Manipulative Therapy *(continued)*	Jun. 1, 2018	maintenance care” ○ Added language to indicate the role of manipulative therapy in preventive or maintenance care has not been established in scientific literature; a beneficial impact on health outcomes has not been established ○ Replaced reference to: ▪ “Scoliosis *correction*” with “scoliosis” ▪ “*Patient’s* condition” with “*member’s* condition” • Updated supporting information to reflect the most current description of services, clinical evidence, FDA and CMS information, and references	

UnitedHealthcare®

Medical Benefit Drug Policy Updates

<table>
<tr><th>Policy Title</th><th>Effective Date</th><th>Coverage Rationale</th></tr>
<tr><td colspan="3">NEW</td></tr>
<tr><td>Crysvita®
(Burosumab-Twza)</td><td>May 1, 2018</td><td>Crysvita (burosumab) is proven for the treatment of X-linked hypophosphatemia (XLH).

Crysvita (burosumab) is medically necessary for the treatment of XLH when the following criteria are met:
I. For initial therapy, all of the following:
A. Diagnosis of XLH, confirmed by one of the following:
1. Genetic testing
2. Elevated Serum fibroblast growth factor 23 (FGF23) level > 30 pg/mL
and
B. Prescribed by, or in consultation with, a specialist experienced in the treatment of metabolic bone disorders; and
C. Serum phosphorus is below the normal range for age; and
D. Presence of clinical signs and symptoms of the disease (e.g., rickets, growth retardation, musculoskeletal pain, bone fractures); and
E. Dosing is in accordance with the United States Food and Drug Administration approved labeling; and
F. Initial authorization will be for no more than 12 months.
II. For continuation therapy, all of the following:
A. Patient has previously received treatment with burosumab; and
B. Prescribed by, or in consultation with, a specialist experienced in the treatment of metabolic bone disorders; and
C. Patient has experienced normalization of serum phosphate while on therapy; and
D. Patient has experienced a positive clinical response to burosumab (e.g., enhanced height velocity, improvement in skeletal deformities, reduction of fractures, reduction of generalized bone pain); and
E. Dosing is in accordance with the United States Food and Drug Administration approved labeling; and
F. Reauthorization will be for no more than 12 months.</td></tr>
</table>

<table>
<tr><th>Policy Title</th><th>Effective Date</th><th>Summary of Changes</th></tr>
<tr><td colspan="3">UPDATED</td></tr>
<tr><td>Benlysta®
(Belimumab)</td><td>May 1, 2018</td><td>• Updated coverage rationale; added language to clarify:
○ This policy refers only to Benlysta (belimumab) injection for intravenous infusion for the treatment of systemic lupus erythematosus (SLE)
○ Benlysta (belimumab) for self-administered subcutaneous injection is obtained under the pharmacy benefit and is indicated systemic lupus erythematosus
• Updated supporting information to reflect the most current references</td></tr>
<tr><td>Entyvio®
(Vedolizumab)</td><td>May 1, 2018</td><td>• Updated supporting information to reflect the most current references; no change to coverage rationale or lists of applicable codes</td></tr>
</table>

UnitedHealthcare®

Medical Benefit Drug Policy Updates

Policy Title	Effective Date	Summary of Changes
UPDATED		
Radicava™ (Edaravone)	May 1, 2018	• Updated coverage rationale; reformatted/clarified coverage criterion addressing applicable diagnosis and treating physician
Vaccines	May 1, 2018	• Updated coverage rationale; replaced reference to "ACIP definitive ('shall') recommendation" with "ACIP definitive (*e.g., should,* shall*, is*) recommendation" • Updated supporting information to reflect the most current references

UnitedHealthcare®

Coverage Determination Guideline (CDG) Updates

Policy Title	Effective Date	Summary of Changes
UPDATED		
Cosmetic and Reconstructive Procedures	Jun. 1, 2018	• Updated list of related policies; added reference link to policies titled: ○ *Breast Reduction Surgery* ○ *Breast Repair/Reconstruction Not Following Mastectomy* • Updated definitions: ○ Added definition of "Adjacent Tissue Transfer" ○ Replaced references to "Functional/Physical Impairment" with "Functional *or* Physical Impairment" • Updated list of applicable CPT codes that may be cosmetic (review is required to determine if considered cosmetic or reconstructive); added 14000, 14001, 14020, 14021, 14040, 14041, 14060, 14061, 14301, and 14302
Gynecomastia Treatment	May 1, 2018	• Replaced references to "Functional/Physical Impairment" with "Functional *or* Physical Impairment" • Updated supporting information to reflect the most current references

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Ambulance Services	Jun. 1, 2018	• Revised coverage rationale: ○ Replaced references to "patient" with "member" **Indications for Coverage** ○ Modified language pertaining to ***Non-Emergency Ambulance (Ground or Air) Between Facilities*** to indicate coverage includes non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities *only* when the transport *meets one* of the following: ▪ From an out-of-Network Hospital to the closest Network Hospital *when Covered Health Care Services are required* ▪ To the closest Network	<u>**Indications for Coverage**</u> ***Emergency Ambulance (Ground, Water, or Air)*** Coverage includes Emergency ambulance transportation (including wait time and treatment at the scene) by a licensed ambulance service from the location of the sudden illness or injury, to the nearest hospital where Emergency health services can be performed. Check the member specific benefit plan document for prior authorization and notification requirements. The following Emergency ambulance services are covered: • Ground ambulance or air ambulance transportation requiring basic life support or advanced life support • Treatment at the scene (paramedic services) without ambulance transportation • Wait time associated with covered ambulance transportation • To a hospital that provides a required higher level of care that was not available at the original hospital ***Air Ambulance*** As a general guideline, when it would take a ground ambulance 30-60 minutes or more to transport a member whose medical condition at the time of pick-up required immediate and rapid transport due to the nature and/or severity of the member's illness/injury, air transportation may be

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Ambulance Services *(continued)*	Jun. 1, 2018	Hospital or facility that provides *the required* Covered Health *Care* Services that were not available at the original Hospital or facility ▪ From a Short-Term Acute Care Facility to the closest Network Long-Term Acute Care Facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network Sub-Acute Facility *where the required Covered Health Care Services can be delivered* ○ Updated reference to applicable Certificate of Coverage (COC) in language pertaining to: ▪ ***Medically Necessary*** non-Emergency ambulance transportation; replaced "UHIC 2011 COC" with "UHIC 2011-*2018* COC" ▪ ***Benefit Level for Non-Emergency Ambulance***; replaced "UHIC 2007 *and 2011* COC" with "UHIC 2007-*2018* COC" **Coverage Limitations and Exclusions** ○ Replaced reference to "air ambulance" with "air ambulance *transportation*" ○ Modified list of examples of	appropriate. Air ambulance transportation should meet the following criteria: • The member's destination is an acute care hospital; and • The member's condition is such that the ground ambulance (basic or advanced life support) would endanger the member's life or health; or • Inaccessibility to ground ambulance transport or extended length of time required to transport the member via ground ambulance transportation could endanger the member; or • Weather or traffic conditions make ground ambulance transportation impractical, impossible, or overly time consuming. Refer to Medicare Benefit Policy Manual in the *References* section of the policy. **Additional Information** For covered Emergency ambulance, supplies that are needed for advanced life support or basic life support to stabilize a member's medical condition are covered under the ambulance benefit. ***Non-Emergency Ambulance (Ground or Air) Between Facilities*** Coverage includes non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities only when the transport meets one of the following: • From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required. • To the closest Network Hospital or facility that provides the required Covered Health Care Services that were not available at the original Hospital or facility. • From a Short-Term Acute Care Facility to the closest Network Long-Term Acute Care Facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network Sub-Acute Facility where the required Covered Health Care Services can be delivered. ***Cost Effective Alternatives (UHIC 2007 COC and 2009 Amendment)*** If an alternate method of ambulance transportation is clinically appropriate and more cost effective, we reserve the right to adjust the Allowed Amounts. As we determine to be appropriate, the coverage determination is based on

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Ambulance Services *(continued)*	Jun. 1, 2018	excluded ambulance transportation for member convenience or other miscellaneous reasons to reflect/include: ▪ Member is in foreign country, or out of state, *and* wants to come home *for* a surgical procedure or treatment (this includes those recently discharged from inpatient care) ▪ Member is going *for* a routine service and is medically able to use another mode of transportation ▪ Member is deceased *and family wants* transportation to the coroner's office or mortuary • Updated definitions: ○ Added definition of "Medically Necessary (2018 Generic COC)" ○ Modified definition of "Medically Necessary (UHIC 2011 COC)"	the member's medical condition, and geographic location. ***Medically Necessary (UHIC 2011- 2018 COC)*** Non-Emergency ambulance transportation is Medically Necessary when the member's condition requires treatment at another facility and when another mode of transportation would endanger the member's medical condition. If another mode of transportation could be used safely and effectively, then ambulance transportation is not Medically Necessary. ***Benefit Level for Non-Emergency Ambulance*** The applicable benefit for eligible non-Emergency ambulance transportation depends on the member pick-up location (origin) as follows: • If the member is inpatient and is transported from a hospital to another hospital or inpatient facility, coverage levels for these ambulance services may vary. Please refer to the member specific benefit plan document to determine benefits. The following are UHIC examples for inpatient ambulance transfer: ○ UHIC 2001 COC: The Hospital Inpatient Stay section of the COC ○ UHIC 2007–2018 COC: The Ambulance Services section of the COC • If the member is in a sub-acute setting and is transported to an outpatient facility and back (outpatient hospital, outpatient facility, or physician's office), these ambulance services are covered under the benefits that apply to that sub-acute setting. For example, if the member is at a Skilled Nursing Facility, the ambulance transport to an outpatient facility (dialysis facility or radiation whether or not it is attached to a hospital) and back is covered under the Skilled Nursing Facility/Inpatient Rehabilitation Facility Services section of the COC. ***Member Pre-Service Notification Requirements for Non-Emergency Ambulance*** • If UHIC initiates the non-Emergency ambulance transportation, member notification is not required. • If UHIC does not initiate the non-Emergency ambulance transportation, certain plans may require the member or the provider to call in for notification. Please see the member specific benefit plan document for details on the notification requirements. **Additional Information** • Provider notification requirements are not addressed by this document.

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			

Ambulance Services *(continued)*	Jun. 1, 2018		• Ambulance transportation that is done for convenience of the member is not covered. Please see the Coverage Limitations and Exclusions section below for more information on non-covered ambulance transportation.
			
			Benefit Level for Out-of-Network Ambulance (Emergency)
			If the ambulance transportation is covered, out-of-Network Emergency ambulance (ground, water, or air) is covered at the Network level of deductible and coinsurance.
			
			Additional Information
			• For UHIC Choice, Choice+, and Options PPO Plans: out-of-Network Emergency ambulance is covered at a negotiated rate, or, at billed charges if a negotiated rate is not reached.
			• For UHIC Non-Differential PPO Plans: The benefits for Network and out-of-Network are the same level but these plans do not require billed charges to be paid on out-of-Network ambulance.
			• For UHIC Plans Without a Network (e.g., Managed Indemnity): These plans do not have Network benefit levels. These plans do not require billed charges to be paid on ambulance services.
			
			<u>Coverage Limitations and Exclusions</u>
			The following services are not eligible for coverage:
			• Ambulance services from providers that are not properly licensed to be performing the ambulance services rendered.
			• Air ambulance transportation that does not meet the covered indications in the Air Ambulance criteria listed above.
			• Non-ambulance transportation. Non-ambulance transportation is not covered even if rendered in an Emergency situation. Examples include but are not limited to:
			  ○ Commercial or private airline or helicopter
			  ○ A police car ride to a hospital
			  ○ Medi-van or wheel-chair van transportation
			  ○ Taxi ride, bus ride, etc.
			• Ambulance transportation when other mode of transportation is appropriate. Except as indicated under the Indications for Coverage section of this policy, ambulance services when transportation by other means would not endanger the member's health are not covered.
			• Ambulance transportation to a home, residential, domiciliary or custodial facility is not covered.

Coverage Determination Guideline (CDG) Updates

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Ambulance Services *(continued)*	Jun. 1, 2018		• Ambulance transportation that violates the notification criteria listed in the Indications for Coverage section above. • Ambulance transportation for member convenience or other miscellaneous reasons for member and/or family. • Examples include but are not limited to: ○ Member wants to be at a certain hospital or facility for personal/preference reasons ○ Member is in foreign country, or out of state, and wants to come home for a surgical procedure or treatment (this includes those recently discharged from inpatient care) ○ Member is going for a routine service and is medically able to use another mode of transportation ○ Member is deceased and family wants transportation to the coroner’s office or mortuary • Ambulance transportation deemed not appropriate. Examples include but are not limited to: ○ Hospital to home ○ Home to physician’s office ○ Home (e.g., residence, nursing home, domiciliary or custodial facility) to a hospital for a scheduled service ***Additional Information*** If the member is at a Skilled Nursing Facility/Inpatient Rehabilitation Facility and has met the annual day/visit limit on Skilled Nursing Facility/Inpatient Rehabilitation Facility Services, ambulance transports (during the non-covered days) are not eligible.
Durable Medical Equipment, Orthotics, Ostomy Supplies, Medical Supplies and Repairs/ Replacements	Jun. 1, 2018	• Updated list of related policies; added reference link to policy titled *Attended Polysomnography for Evaluation of Sleep Disorders* • Revised coverage rationale/indications for coverage; added language pertaining to the evaluation of PAP therapy to indicate hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds	Refer to the policy for complete details on the coverage guidelines for *Durable Medical Equipment, Orthotics, Ostomy Supplies, Medical Supplies and Repairs/Replacements*.

UnitedHealthcare®

Coverage Determination Guideline (CDG) Updates

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Durable Medical Equipment, Orthotics, Ostomy Supplies, Medical Supplies and Repairs/ Replacements *(continued)*	Jun. 1, 2018	associated with at least a 30% reduction in airflow and with at least a 3% decrease in oxygen saturation from pre-event baseline or the event is associated with an arousal	
Preventive Care Services	Jun. 1, 2018	• Revised coverage rationale for **Women's Health**; added language to indicate the following services are covered under the Preventive Care Services benefit effective Jun. 1, 2018: ○ Screening for diabetes mellitus for those with a history of gestational diabetes ○ Screening for urinary continence, annually • Revised list of applicable procedure and diagnosis codes for: **Preventive Care Services** *Diabetes Screening* ○ Updated service description; added instruction to refer to the *Screening for Diabetes Mellitus After Pregnancy* section of the policy for information on additional diabetes screening benefits *Gestational Diabetes Mellitus Screening* ○ Updated service description; added instruction to refer to the *Screening for Gestational*	Refer to the policy for complete details on the coverage guidelines for *Preventive Care Services*.

UnitedHealthcare®

Coverage Determination Guideline (CDG) Updates

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Preventive Care Services *(continued)*	Jun. 1, 2018	*Diabetes Mellitus* and *Screening for Diabetes Mellitus After Pregnancy* sections of policy for information on additional diabetes screening benefits *Wellness Examinations* ○ Updated service description/language pertaining to Health Resources and Services Administration (HRSA) coverage requirements; added "screening for urinary incontinence" to list of services included in codes for wellness examinations **Expanded Women's Preventive Health** *Screening for Gestational Diabetes Mellitus* ○ Updated service description; added instruction to refer to the *Screening for Diabetes Mellitus After Pregnancy* section of the policy for additional information *Screening for Diabetes Mellitus After Pregnancy* (new to policy) ○ Added service description to indicate: ▪ The Women's Preventive Services Initiative [HRSA Requirement (Dec. 2017)] recommends: – Women with a history of gestational diabetes mellitus (GDM) who are not	

Coverage Determination Guideline (CDG) Updates

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Preventive Care Services *(continued)*	Jun. 1, 2018	currently pregnant and who have not previously been diagnosed with type 2 diabetes mellitus should be screened for diabetes mellitus – Initial testing should ideally occur within the first year postpartum and can be conducted as early as 4-6 weeks postpartum – Women with a negative initial postpartum screening test result should be rescreened at least every 3 years for a minimum of 10 years after pregnancy ▪ See the *Gestational Diabetes Mellitus Screening*, *Diabetes Screening*, and *Screening for Gestational Diabetes Mellitus* sections of policy for additional information ○ Added list of applicable CPT codes: 36415, 36416, 82947, 82948, 82950, 82951, 82952, and 83036 ○ Added list of applicable ICD-10 diagnosis codes: ▪ Z00.00, Z00.01, **or** Z13.1; **and**	

Coverage Determination Guideline (CDG) Updates

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Preventive Care Services *(continued)*	Jun. 1, 2018	▪ Z86.32 ○ Added preventive benefit instructions to indicate: ▪ The service is payable when the listed diagnosis code requirements are met ▪ No benefit age limit applies ▪ CPT codes 36415 and 36416 are payable when billed with all of the following: – One of the [listed/required] diabetes screening procedure codes; and – The [listed/required] diagnosis codes ▪ If a diabetes diagnosis code is present in any position, the preventive benefit will **not** be applied; see the list of applicable diabetes diagnosis codes *Screening for Urinary Incontinence* (new to policy) ○ Added service description to indicate the Women's Preventive Services Initiative recommends screening women for urinary incontinence annually ○ Added instruction to see the *Wellness Examinations* section of the policy for applicable codes and	

UnitedHealthcare®

Coverage Determination Guideline (CDG) Updates

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
REVISED			
Preventive Care Services *(continued)*	Jun. 1, 2018	preventive benefit instructions • Updated supporting information to reflect the most current references	

Utilization Review Guideline (URG) Updates

Policy Title	Effective Date	Summary of Changes
UPDATED		
Site of Service Guidelines for Certain Outpatient Surgical Procedures	May 1, 2018	• Updated supporting information to reflect the most current references