United Healthcare Medicare Advantage

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Coverage Summary Update Bulletin: December 2023

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New

Updated

Revised

Coverage Summary Updates

New

Policy Title	Approval Date	Coverage Guidelines
Outpatient Surgical Procedures – Site of Service (effective Jan. 1, 2024)	Nov. 20, 2023	**Note**: The following coverage guidelines are effective **Jan. 1, 2024**. **Outpatient surgical procedures are covered when Medicare criteria are met.** **Ambulatory Surgical Center** The Ambulatory Surgical Center (ASC) list of covered procedures indicates procedures which are covered and paid for if performed in the ASC setting. It does not require the covered surgical procedures to be performed only in ASCs. All of the general coverage rules requiring that any procedure be reasonable and necessary for the member are applicable to ASC services in the same manner as all other covered services. The ASC list of covered surgical procedures is comprised of surgical procedures that CMS determines do not pose a significant safety risk and are not expected to require an overnight stay following the surgical procedure. The surgical codes that are included on the ASC list of covered surgical procedures are separately paid under the OPPS, have been determined to pose no significant safety risk to Medicare members when furnished in ASCs, and for which standard medical practice dictated that the member would not typically be expected to require active medical monitoring and care at midnight following the procedure (overnight stay). ASC covered surgical procedures do **not** include those surgical procedures that: • Generally result in extensive blood loss. • Require major or prolonged invasion of body cavities. • Directly involve major blood vessels. • Are generally emergent or life threatening in nature. • Commonly require systemic thrombolytic therapy. The complete lists of ASC covered surgical procedures and ASC covered ancillary services, the applicable payment indicators, payment rates for each covered surgical procedure and ancillary service before adjustments for regional wage variations, and wage indices are available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices.html. **Note**: Procedures that are included on the inpatient list used under Medicare's hospital outpatient prospective payment system are deemed to pose significant safety risk to members in ASCs and are not eligible for designation and coverage as ASC covered surgical procedures.

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Policy Title	Approval Date	Coverage Guidelines
Outpatient Surgical Procedures – Site of Service (effective Jan. 1, 2024) (continued)	Nov. 20, 2023	Refer to the Medicare Claims Processing Manual, Chapter 14 - Ambulatory Surgical Centers. To determine the appropriate site of service, refer to the UnitedHealthcare Commercial Medical Policy titled Outpatient Surgical Procedures – Site of Service. UnitedHealthcare's Medicare Advantage *Outpatient Surgical Procedures – Site of Service: CPT/HCPCS Codes* list can be found in the above referenced Medical Policy, which provides those services that are generally appropriate to be performed in an ASC. When such procedures are to be performed in a hospital outpatient department, UnitedHealthcare will review to determine whether the hospital outpatient department is a medically necessary site of service. If the hospital outpatient department is not considered medically necessary, this location will not be covered.

Updated

Policy Title	Approval Date	Summary of Changes
Nasal and Sinus Procedures	Nov. 8, 2023	**Template Update** • Updated *Instructions for Use* **Supporting Information** • Updated list of available Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) to reflect the most current information

Revised

Policy Title	Approval Date	Summary of Changes

Electrical and Ultrasonic Stimulators	Nov. 8, 2023	**Template Update**
		• Updated *Instructions for Use*
		Coverage Guidelines
		Occipital Nerve Stimulation for the Treatment of Occipital Neuralgia or Headaches (CPT Code 64590) *(new to policy)*
		• Added language to indicate:
		  ○ Medicare does not have a National Coverage Determination (NCD) that specifically addresses occipital nerve stimulation for the treatment of occipital neuralgia or headaches
		  ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable
		  ○ For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled *Occipital Nerve Injections and Ablation (Including Occipital Neuralgia and Headache*

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Policy Title	**Approval Date**	**Summary of Changes**
Electrical and Ultrasonic Stimulators (continued)	Nov. 8, 2023	**Supporting Information** • Updated list of available LCDs/LCAs to reflect the most current information

Hearing Services and Devices	Nov. 8, 2023	**Template Update**
		• Updated *Instructions for Use*
		Coverage Guidelines
		• Removed content/language addressing computerized dynamic posturography (CDP)
		Surgically Implanted Auditory Devices
		Osseointegrated Implants
		• Updated language pertaining to repair, maintenance, and replacement:
		  ○ Added instruction to refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Durable Medical Equipment, Prosthetics, Corrective Appliances/Orthotics and Medical Supplies*
		  ○ Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), Nutritional Therapy, and Medical Supplies Grid*
		Hybrid Cochlear Implants
		• Added coverage guidelines for hybrid cochlear implants (relocated from the section titled *Hearing Aids and Auditory Implants that are Not Covered*) to indicate:
		  ○ Medicare does not have a National Coverage Determination (NCD) for cochlear hybrid implants
		  ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time
		  ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Cochlear Implants*
		Hearing Aids and Auditory Implants that are Not Covered
		• Removed/relocated coverage guidelines for hybrid cochlear implants (refer to the section titled *Hybrid Cochlear Implants*)

Joint Procedures	Nov. 8, 2023	**Title Change/Template Update** • Previously titled *Joints and Joint Procedures* • Updated *Instructions for Use* **Coverage Guidelines** • Removed content/language addressing open osteochondral autograft, talus (CPT code 28446) ***Knee Replacement Surgery (Arthroplasty) (CPT Codes 27445, 27447, 27486, and 27487)*** • Removed instruction to refer to the UnitedHealthcare Commercial Medical Policy titled *Surgery of the Knee* with

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Joint Procedures (continued)	Nov. 8, 2023	individual consideration for the following: ○ Avascular necrosis of the knee ○ Proximal tibia fracture ***Autologous Chondrocyte Transplantation in the Knee (CPT Code 27412)*** ● Revised language to indicate: ○ Medicare does not have a National Coverage Determination (NCD) for autologous chondrocyte transplantation in the knee ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Surgery of the Knee* ***Osteochondral Grafting of Knee (CPT Codes 29866, 29867, 27415, and 27416)*** ● Revised language to indicate: ○ Medicare does not have a NCD for osteochondral grafting of knee ○ LCDs/LCAs do not exist ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Surgery of the Knee* ***Non-Collagen Meniscus Implant Meniscus Allograft Transplantation (MAT) with Human Cadaver Tissue (CPT Code 29868)*** *(new to policy)* ● Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Orthopedic Procedures, Devices, and Products*) to indicate: ○ Medicare does not have a NCD for non-collagen meniscus implant with human cadaver tissue ○ LCDs/LCAs do not exist ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Surgery of the Knee*
Medications/Drugs (Outpatient/Part B)	Nov. 8, 2023	**Coverage Guidelines** ***Other Examples of Specific Drugs/Medications*** ● Added coverage guidelines for **Cosentyx® (Secukinumab)** to indicate a pre-service review [Review at Launch (RAL)] is required
Orthopedic Procedures, Devices, and Products	Nov. 8, 2023	**Template Update** ● Updated *Instructions for Use* **Coverage Guidelines** ● Removed content/language addressing: ○ Autologous chondrocyte transplantation in the knee (CPT code 27412); refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Joint Procedures* for applicable coverage guidelines

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Orthopedic Procedures, Devices, and Products (continued)	Nov. 8, 2023	○ Non-collagen meniscus implant with human cadaver tissue (CPT code 29868); refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Joint Procedures* for applicable coverage guidelines ○ Open osteochondral autograft, talus (CPT code 28446) ○ Osteochondral grafting of knee (CPT codes 29866, 29867, 27415, and 27416); refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Joint Procedures* for applicable coverage guidelines ***Manipulation Under Anesthesia (MUA) for the Knee and Shoulder (CPT Codes 23700 and 27570)*** ● Modified content heading ● Replaced language indicating "Medicare does not have a National Coverage Determination (NCD) for manipulation under anesthesia (MUA) of the *elbow*, knee, and shoulder" with "Medicare does not have a National Coverage Determination (NCD) for MUA of the knee and shoulder" ● Updated list of applicable CPT codes; removed 24300
Radiologic Diagnostic Procedures (effective Jan. 1, 2024)	Nov. 20, 2023	**Note**: The following changes are effective **Jan. 1, 2024**. **Template Update** ● Updated *Instructions for Use* **Coverage Guidelines** ***Computed Tomography (CCT) and Coronary Computed Tomography Angiography (CCTA)*** ● Revised language pertaining to states/territories with no Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) for regions not involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program; replaced reference link to the WPS LCD for Coronary Computed Tomography Angiography (CCTA) (L35121) with instruction to refer to the nationally recognized guidelines (i.e., InterQual®) ***Magnetic Resonance Imaging (MRI)*** ● Updated reference link to the list of Medicare-approved clinical trials ***Positron Emission Tomography*** ● Modified content heading ● Added language to indicate: ○ For up to three PET scans to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy, refer to the NCD for Positron Emission Tomography (FDG) for Oncologic Conditions (220.6.17) ○ For coverage of more than three FDG PET scans to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy, LCDs/LCAs exist and compliance with these policies is required where applicable; for specific LCDs/LCAs, refer to the table [in the policy] for Positron Emission

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Radiologic Diagnostic Procedures (effective Jan. 1, 2024) (continued)	Nov. 20, 2023	Tomography (PET) (FDG) ○ For greater than three FDG PET scans to guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Medicare Advantage Plans Radiology and Cardiology Clinical Guidelines at https://www.uhcprovider.com/en/prior-auth-advance-notification/radiology-prior-authorization.html ○ After checking the Positron Emission Tomography (PET) (FDG) table and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the UnitedHealthcare Medicare Advantage Plans Radiology and Cardiology Clinical Guidelines for coverage guidelines **Supporting Information** • Updated list of available LCDs/LCAs to reflect the most current information
Skilled Nursing Facility, Rehabilitation, and Long-Term Acute Care and Hospitalization (effective Jan. 1, 2024)	Nov. 20, 2023	**Note**: The following changes are effective **Jan. 1, 2024**. **Title Change** • Previously titled *Rehabilitation: Cardiac and Medical* **Template Update** • Updated *Instructions for Use* **Coverage Guidelines** ***Outpatient Rehabilitation Therapy (Physical Therapy, Occupational Therapy and Speech-Language Pathology Services)*** • Added notation to indicate: ○ UnitedHealthcare uses the criteria [listed in the policy] to supplement the general Medicare criteria regarding rehabilitation services at *Medicare Benefit Policy Manual, Chapter 15, §220.1 – Conditions of Coverage and Payment for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services* in order to ensure consistency in reviewing the conditions to be met for coverage of rehabilitation services, as well as reviewing when such services may be medically necessary ○ Use of this criteria to supplement the general provisions noted above provides clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services, because this additional criteria will provide greater consistency in determining when a patient's medical factors support rehabilitation services ○ Where the existing guidance provides insufficient clinical detail, refer to the InterQual® LOC: Outpatient Rehabilitation & Chiropractic • Removed instruction to refer to the Optum Care Guidelines located at https://www.myoptumhealthphysicalhealth.com

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Policy Title	Approval Date	Summary of Changes
Skilled Nursing Facility, Rehabilitation, and Long-Term Acute Care and Hospitalization (effective Jan. 1, 2024) (continued)	Nov. 20, 2023	to determine maximum therapeutic benefit for therapy services ***Long Term Acute Care Hospitalization (LTACH)*** (new to policy) ● Added language to indicate: ○ LTACH admission is considered for members who no longer have acute inpatient hospital needs, are not appropriate for lower level-of-care setting, but who are expected to improve to lower level-of-care status in the LTACH time frame (average length of stay greater than 25 days) ○ UnitedHealthcare uses the criteria below to supplement the general Medicare criteria regarding inpatient hospital care services at *Medicare Benefit Policy Manual Chapter 1 - Inpatient Hospital Services Covered Under Part A* in order to ensure consistency in reviewing the complex medical factors on which a physician may reasonably base their decision, including factors such as: ▪ Patient history and comorbidities ▪ The severity of signs and symptoms ▪ The patient's current medical needs ▪ The risk of an adverse event ○ Use of this criteria to supplement the general provisions noted above provides clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services, because this additional criteria will provide greater consistency in determining when a patient's complex medical factors support long-term acute care hospitalization ○ UnitedHealthcare may utilize InterQual®, an evidence-based clinical decision tool to make medical necessity determinations, if there is no NCD, applicable Local Coverage Determination (LCD)/Local Coverage Article (LCA), or Medicare manual guidance on coverage, or where the existing guidance provides insufficient clinical detail ○ Refer to the: ▪ InterQual® LOC: Long-Term Acute Care ▪ Medicare.gov *Long Term Hospital Care Coverage* website ▪ CMS Medicare Learning Network: *Long-Term Care Hospital Prospective Payment System* (MLN6922507)
Spine Procedures	Nov. 8, 2023	**Coverage Guidelines** ***Thoracic Spinal Procedures (CPT Codes 63003, 63016, 63046, 63055 63064, 63077, 63085, 63087, 63090, and 63101)*** *(new to policy)* ● Added language to indicate: ○ Medicare does not have a National Coverage Determination (NCD) for thoracic spinal procedures ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Spinal Fusion and Decompression*

Coverage Summary Updates

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Policy Title	**Approval Date**	**Summary of Changes**

Urinary and Fecal Incontinence, Diagnosis, and Treatments	Nov. 8, 2023	**Template Update**
		• Updated *Instructions for Use*
		Coverage Guidelines
		Urodynamic Studies - Non-Invasive (e.g., UroCuff®) (CPT Code 55899)
		• Revised language to indicate Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) *exist* and compliance with these policies is required where applicable
		Sacral Nerve Stimulation (SNS) for Fecal Incontinence
		• Revised default guidelines for sacral nerve stimulation for the treatment of fecal incontinence:
		  ○ Added reference link to the UnitedHealthcare Commercial Medical Policy titled *Sacral Nerve Stimulation for Urinary and Fecal Indications*
		  ○ Removed reference link to the Noridian LCA for *Billing and Coding: Sacral Nerve Stimulation for Urinary and Fecal Incontinence (A53017)*
		Supporting Information
		• Updated list of available LCDs/LCAs to reflect the most current information

General Information

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

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

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

Policy Update Classifications

New

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

Updated

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

Revised

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

Replaced

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

Retired

An existing policy has been retired

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