United Healthcare Medicare Advantage

UnitedHealthcare Medicare Advantage
Coverage Summary Update Bulletin: July 2022

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Coverage Summary Updates

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Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies	Jun. 1, 2022	Coverage Guidelines *Definitions* • Updated definition of "Corrective Appliances/Orthotic"

Revised

Policy Title	Approval Date	Summary of Changes
Cardiovascular Diagnostic and Therapeutic Procedures	Jun. 1, 2022	Coverage Rationale *Non-Invasive Test of Carotid Function (Direct and Indirect)* • Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Carotid Procedures and Testing*) to indicate: ○ Non-invasive test of carotid function (direct and indirect) is covered when criteria are met; refer to the National Coverage Determination (NCD) for *noninvasive tests of carotid function (20.17)* ○ Local Coverage Determinations (LCDs) and Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable *Carotid Body Resection* • Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Carotid Procedures and Testing*) to indicate: ○ Carotid body resection is covered when criteria are met; refer to the NCD for *carotid body resection/carotid body denervation (20.18)* *Cardiac Computed Tomography (CCT) and Coronary Computed Tomography Angiography (CCTA)* • Added instruction to refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Radiologic Diagnostic Procedures* *Computerized Tomography (CT scan)* • Added instruction to refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Radiologic Diagnostic Procedures*

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Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), Nutritional Therapy and Medical Supplies Grid	Jun. 1, 2022	**Coverage Guidelines**
		DME Face-to-Face Requirement
		• Added instruction to refer to the face-to-face encounter requirement for the following items:
		  ○ Ankle-Foot Orthosis (AFO)/Knee-Ankle-Foot Orthosis (KAFO)
		  ○ Artificial Limbs-Lower Limb
		  ○ Breast Prosthesis (External)
		  ○ Catheters and Supplies
		  ○ Commode (Without Wheels Only)
		  ○ Elbow Orthosis
		  ○ Knee Orthosis
		  ○ Scleral Shell
		  ○ Spinal Orthosis (Body Jacket)
		  ○ Splints [Foot (e.g., Denis-Browne)]
		  ○ Suction Pump or Machine
		  ○ Trapeze Bar
		• Revised language to indicate *Section 6407 of the Affordable Care Act (ACA)* established a face-to-face encounter requirement for certain items of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)
		  ○ The law requires that a physician must document that a physician, nurse practitioner, physician assistant or clinical nurse specialist has had a face-to-face encounter with the patient
		  ○ The encounter must occur within the 6 months before the order is written for the DME
		  ○ For face-to-face encounter information regarding Power Mobility Devices (PMDs), refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Mobility Assistive Equipment (MAE)*
		  ○ For the most current Medicare face-to-face encounter requirement guidance and DMEPOS List, refer to the Centers for Medicare & Medicaid Services (CMS) *Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Order Requirements*
		Bone Stimulator (Electronic or Ultrasonic)
		• Added reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Stimulators: Electrical, Osteogenic and Ultrasonic*
		• Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Osteogenic Stimulators* (retired)
		Disposable Items
		• Consolidated list of examples of non-covered disposable items to reflect/include:
		  ○ Diapers (incontinent pads)

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Policy Title	**Approval Date**	**Summary of Changes**
Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), Nutritional Therapy and Medical Supplies Grid (continued)	Jun. 1, 2022	○ Disposable sheets and bags ○ Elastic stockings ○ Incontinence pads ○ Irrigating kits ○ Support hose/fabric support (e.g., TED hose) ○ Surgical face mask ○ Surgical leggings ○ Wedge pillow ○ Syringes (ear bulb & hypodermic) ● Added instruction to refer to the: ○ National Coverage Determination (NCD) for *Durable Medical Equipment Reference List (280.1)* ○ *Medicare Benefit Policy Manual, Chapter 16, §80 – Personal Comfort Items* ○ *Social Security Act §1861(n), Social Security Act §1862(a)(6)* *Hospital Beds and Accessories* ● Consolidated and revised language pertaining to hospital beds and accessories to indicate: ○ [Hospital beds and accessories] are covered when criteria are met; refer to the NCD for *Hospital Beds (280.7)* and *DME MAC LCD for Hospital Beds and Accessories (L33820)* ○ The following are not covered: ▪ A total electric hospital bed; height adjustment feature is a convenience feature; for further details, refer to the DME MAC LCD for *Hospital Beds and Accessories (L33820)* ▪ Bed specs or prism glasses (i.e., glasses use to read while lying flat on bed); refer to the *Social Security Act §1861(n)* and the *Social Security Act §1862(a)(6)* ▪ Added reference link to the Medicare Benefit Policy Manual, Chapter 15, §110.1 (B)(2) – Equipment Presumptively Non-Medical ▪ Lounge (power or manual), oscillating, and over bed tables; refer to the NCD for *Durable Medical Equipment Reference List (280.1)* *Humidifier (for Use With the Respiratory Assist Devices)* ● Added reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Sleep Apnea: Diagnosis and Treatment* *INDEPENDENCE iBOT 4000 Mobility System (Standard)* ● Added reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Mobility Assistive Equipment (MAE)* ● Removed reference link to the NCD for Mobility Assistive Equipment (MAE) (280.3)

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Policy Title	**Approval Date**	**Summary of Changes**
Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), Nutritional Therapy and Medical Supplies Grid (continued)	Jun. 1, 2022	*INDEPENDENCE iBOT 4000 Mobility System (4-wheel, Balance, Stair and Remote Functions)* ● Added reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Mobility Assistive Equipment (MAE)* ● Removed reference link to the NCD for INDEPENDENCE iBOT 4000 Mobility System (280.15) *Nutritional Therapy, Parenteral* ● Added language to indicate: ○ Parenteral nutrition or intradialytic parenteral nutrition (IDPN) (for individuals with a non-functioning digestive tract) is covered under Part B drugs; otherwise, coverage would be under Part D drugs ○ Added instruction to refer to the Medicare Prescription Drug Benefit Manual, Chapter 6, Appendix C – Medicare Part B versus Part D Coverage Issues *Positioning Pillow* ● Replaced language with instruction to refer to the item titled *Vitrectomy Face Support* for applicable coverage guidelines
Genetic Testing	Jun. 1, 2022	Coverage Guidelines ● Revised list of *Molecular Diagnostic Genetic Tests Included in the Palmetto MolDX Program* ○ Added: ▪ Repeat Germline Testing ○ Removed: ▪ 4Kscore® Assay ▪ Foodborne Gastrointestinal Panels Identified by Multiplex Nucleic Acid Amplification (NAATs) ▪ Multiplex Nucleic Acid Amplified Tests for Respiratory Viral Panels ○ Updated reference links to reflect the most current program guidelines and Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs)
Medications/Drugs (Outpatient/Part B)	Jun. 1, 2022	Coverage Guidelines *Other Examples of Specific Drugs/Medications* Entyvio® (Vedolizumab) ● Added instruction to refer to the UnitedHealthcare Commercial Medical Benefit Drug policy titled *Entyvio® (Vedolizumab)* for states with no Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) Leqvio® (Inclisiran) ● Revised language to indicate a pre-service review [Review at Launch (RAL)] is no longer required Ocrevus® (Ocrelizumab)

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Medications/Drugs (Outpatient/Part B) (continued)	Jun. 1, 2022	• Added instruction to refer to the UnitedHealthcare Commercial Medical Benefit Drug policy titled *Ocrevus® (Ocrelizumab)* for states with no LCDs/LCAs **Orencia® (Abatacept)** • Added instruction to refer to the UnitedHealthcare Commercial Medical Benefit Drug policy titled *Orencia® (Abatacept)* for states with no LCDs/LCAs **Trastuzumab** • Updated list of applicable drugs/medications; added: ○ Ogivri® (Trastuzumab-Dkst) ○ Ontruzant® (Trastuzumab-Dttb) ○ Trazimera® (Trastuzumab-Qyyp) **Supporting Information** • Updated list of available LCDs/LCAs to reflect the most current reference links
Physician Services	Jun. 1, 2022	**Coverage Rationale** • Removed content/language addressing: ○ Diagnosis, therapy, surgery, and consultation services rendered by a licensed provider ○ Smoking and tobacco use cessation counseling ○ Telephone transmission of Electroencephalograms (EEGs) ***Patient-Initiated Second and Third Opinions*** (previously titled *Patient-Initiated Second Opinions*) • Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Second and Third Opinions*) to indicate: ○ Second and third opinions are covered according to the following criteria: ▪ Second opinions are covered if the opinion is provided at the member's request to determine the advisability of undergoing surgery or a major non-surgical diagnostic or therapeutic procedure. ▪ Third opinions are covered if the recommendations of the first and second physician differ regarding the need for surgery or other major procedure. ▪ Second and third opinions are covered even if the surgery or other procedure, if performed, is not covered. ▪ Second or third opinions may include, but are not limited to: ▪ A history and physical examination of the member ▪ Any diagnostic testing required for determining the need for surgery or a procedure; all services must be a UnitedHealthcare Medicare Advantage plan covered benefit ○ There is no coverage for the provider or the facility charges if the proposed surgery or procedure is a non-covered UnitedHealthcare Advantage Medicare plan benefit

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Physician Services (continued)	Jun. 1, 2022	○ Once the second opinion is provided, regardless of where it was rendered, all diagnostic testing, treatment and/or surgical intervention must meet the UnitedHealthcare Medicare Advantage plan medical necessity and or benefit criteria to be covered ○ For Medicare Advantage plan members required to get referrals through the Primary Care Physician/IPA or UnitedHealthcare: ▪ All second and third opinions, whenever possible, should be provided in-network and must be authorized by the member's medical group/IPA or UnitedHealthcare ▪ Out-of-network second/third opinion will be considered if there is no available or appropriate in-network provider and must be authorized by the member's medical group/IPA or UnitedHealthcare ● Added reference link to the *Medicare Benefit Policy Manual, Chapter 15, §30 – C (Consultations) & D (Patient Initiated Second Opinions)* *Physician Consultations by Phone* ● Added instruction to refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Telemedicine/Telehealth Services* for coverage guidelines *Critical Care Visits and Neonatal Intensive Care* (previously titled *Physicians and Non-Physician Practitioners*) ● Modified content heading; no change to coverage guidelines *Institutional or Home Care Educational Programs* ● Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Educational Programs*) to indicate: ○ Institutional or home care educational programs may be covered under for such programs furnished by providers of services (i.e., hospitals, SNFs, HHAs, and OPT providers) to the extent that the programs are appropriate, integral parts in the rendition of covered services which are reasonable and necessary for the treatment of the individual's illness or injury; refer to the National Coverage Determination (NCD) for *Institutional and Home Care Patient Education Programs (170.1)* ○ Teaching and training services (also referred to as educational services) can be covered only where they provide knowledge essential for the chronically ill patient's participation in his or her own treatment and only where they can be reasonably related to such treatment or diagnosis ○ Educational services that provide more elaborate instruction than is necessary to achieve the required level of patient education are not covered ○ After essential information has been provided, the patient should be relied upon to obtain additional information on his or her own ○ Refer to the *Medicare Benefit Manual, Chapter 15, §60.4 – Services Incident to a Physician's Service to Homebound Patients Under General Physician Supervision*

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Physician Services (continued)	Jun. 1, 2022	*Non-Covered Physician/Practitioner Services*
		• Revised list of examples of non-covered physician/practitioner services:
		  ○ Added:
		  ▪ Educational activities not closely related to the care and treatment of the patient, such as programs directed toward instructing patients or the public generally in preventive health care activities are not covered since these are not reasonable and necessary for the treatment of an illness or injury
		  – Examples of non-covered programs include those designed to prevent illness by instructing the general public in the importance of good nutritional habits, exercise regimens, and good hygiene are not covered
		  – Refer to the National Coverage Determination (NCD) for *Institutional and Home Care Patient Education Programs (170.1)*
		  ○ Removed:
		  ▪ Tobacco cessation counseling when tobacco dependency is the primary co-morbidity
		Definitions
		• Updated definition of "Critical Care"

Radiologic Diagnostic Procedures	Jun. 1, 2022	Coverage Guidelines
		• Removed content/language addressing:
		  ○ Diagnostic mammogram
		  ○ Ultrasonography/ultrasound
		  ○ UltraFast or multislice CT scan
		  ○ Percutaneous image-guided breast biopsy
		  ○ Portable hand-held x-ray instrument
		  ○ Thermography
		  ○ Infrared therapy devices
		  ○ Transillumination light scanning or diaphanography
		Cardiac Computed Tomography (CCT) and Coronary Computed Tomography Angiography (CCTA)
		• Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Computed Tomographic Angiography (CTA)/Electron Beam Computed Tomography (EBCT) of the Chest*) to indicate:
		  ○ Multi-detector (multi-detector-row/multi-slice) computed cardiac tomography (MDCT) is also known as cardiac computed tomographic coronary angiography (CCTA) or computed tomography of the heart and coronary arteries
		  ○ Medicare does not have a National Coverage Determination (NCD) for *cardiac computed tomography (CCT) and coronary computed tomography angiography (CCTA)*

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Radiologic Diagnostic Procedures (continued)	Jun. 1, 2022	○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable; see the list of available LCDs/LCAs for CCT and CCTA in the *Supporting Information* section of the policy ○ For states/territories with no LCDs/LCAs in regions involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program, 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 ○ For states/territories with no LCDs/LCAs in regions not involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program, refer to the Wisconsin Physician Insurance Corporation (WPS) LCD titled *Coronary Computed Tomography Angiography (CCTA) (L35121)* ***UltraFast CT Scanning for Screening Purposes*** ● Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Computed Tomographic Angiography (CTA)/Electron Beam Computed Tomography (EBCT) of the Chest* (retired)
Rehabilitation: Cardiac Rehabilitation Services (Outpatient)	Jun. 1, 2022	Related Policies ● Removed reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled: ○ *Benson-Henry Institute Cardiac Wellness Program (NCD 20.31.3)* ○ *Ornish Program for Reversing Heart Disease (NCD 20.31.2)* ○ *The Pritikin Program (NCD 20.31.1)* Coverage Guidelines ***Intensive Cardiac Rehabilitation (ICR) Programs*** ● Removed language pertaining to *Section 51004 of the Bipartisan Budget Act (BBA) of 2018, Pub. L. No. 115-123 (2018)* which amended *Section 1861(eee)(4)(B) of the Social Security Act* to expand coverage for intensive cardiac rehabilitation programs to additional conditions effective Feb. 9, 2018 ● Removed reference link to the *Medicare Benefit Policy Manual, Chapter 15 § 232 – Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Services Furnished on or After Jan. 1, 2010*
Reproductive Services: Infertility, Family Planning and Maternity Care	Jun. 1, 2022	Title Change ● Previously titled *Maternity and Newborn Care* Coverage Guidelines ● Revised language to indicate *infertility, family planning and* maternity care is covered when Medicare criteria are met ***Infertility Tests and Treatments*** ● Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Infertility Services*) to indicate reasonable and necessary tests and treatments for infertility when fertility would be expected are

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Policy Title	Approval Date	Summary of Changes
Reproductive Services: Infertility, Family Planning and Maternity Care (continued)	Jun. 1, 2022	covered; refer to the *Medicare Benefit Policy Manual, Chapter 15, §20.1 – Physician Expense for Surgery, Childbirth, and Treatment for Infertility* ● Examples include but are not limited to: ○ Medical history ○ General physical examination ▪ Females: Examples include, but are not limited to: – Pelvic exam – Routine laboratory investigation for hormonal disturbances (e.g., FSH, LH, prolactin) – Cultures for infectious agents – Serum progesterone determination – Hysterosalpingogram ▪ Males: Examples include, but are not limited to: – Semen analysis 2 to 3 times following 5 days of abstinence – Laboratory studies (e.g., FSH, LH, prolactin, serum testosterone) – Testicular biopsy when member has demonstrated azoospermia – Scrotal ultrasound, when appropriate for azoospermia *Non-Covered Infertility Services* ● Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Infertility Services*) to indicate: ○ Medicare does not have a National Coverage Determination (NCD) which specifically addresses *infertility services* ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time ○ For coverage guidelines, see the UnitedHealthcare Commercial Medical Policy titled *Infertility Diagnosis and Treatment* ○ Infertility services that are not reasonable and necessary for the treatment of illness or injury are not covered ▪ Refer to the *Social Security Act Sec.1862 (a)(1)(A)* and the *Medicare Benefit Policy Manual, Chapter 16, §20 – Services Not Reasonable and Necessary* ▪ Examples include, but are not limited to: – Infertility from a previous elective vasectomy or tubal ligation – Inoculation of women with husband's white cells – Microdissection of the zona or sperm microinjection – For post-menopausal women – Reversal of a previous elective vasectomy or tubal ligation – Treatment of female sterility in which a donor ovum would be necessary (e.g., post-menopausal

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Reproductive Services: Infertility, Family Planning and Maternity Care (continued)	Jun. 1, 2022	syndrome) – Other infertility treatment when continued treatment has no reasonable chance to produce a pregnancy – Medications that promote fertility ○ Some members may have coverage for Part D drugs under UnitedHealthcare; refer to the Member's Pharmacy Booklet or contact the Prescription Solutions Customer Service Department to determine coverage eligibility for Part D prescription drug plan benefit *Non-Member Infertility Services* • Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Infertility Services*) to indicate infertility services for non-members (e.g., surrogate mothers who are not UnitedHealthcare Medicare members) are not covered *Family Planning* • Added language [previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Family Planning (Birth Control)*] to indicate: ○ The following are examples of covered family planning services: ▪ Office visits for general education, counseling, and instruction on birth control methods ▪ Routine pregnancy testing is covered as reasonable and necessary to determine a patient's status; refer to the *Medicare Benefit Policy Manual, Chapter 15, § 20.1 – Physician Expense for Surgery, Childbirth, and Treatment for Infertility* ▪ Sterilization is covered only, when necessary, as a part of the treatment of an illness or injury; refer to the NCD for *Sterilization (230.3)* ○ The following are examples of non-covered services, but are not limited to: ▪ Birth control devices and procedures (e.g., IUD, diaphragm and other implantable birth control devices); refer to the *Medicare Benefit Policy Manual, Chapter 16, §20 – Services Not Reasonable and Necessary* ▪ Over-the-counter supplies or prescription devices or drugs for birth control; refer to the *Medicare Benefit Policy Manual, Chapter 16, §20 – Services Not Reasonable and Necessary* ▪ Non-prescription contraceptive supplies; refer to the member's EOC ▪ Reversal of sterilization procedures; refer to the member's EOC ▪ Elective hysterectomy, tubal ligation or vasectomy if the sole reason for the procedure is sterilization ▪ Sterilization performed because the physician believes another pregnancy would endanger the overall general health of the woman; refer to the NCD for *Sterilization (230.3)* ▪ Sterilization performed only as a means to prevent the possible development of, or an effect on, a mental condition should the individual become pregnant; refer to the NCD for *Sterilization (230.3)* ▪ Sterilization performed only to prevent conception in a mentally challenged member; refer to the NCD for

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Policy Title	**Approval Date**	**Summary of Changes**
Reproductive Services: Infertility, Family Planning and Maternity Care (continued)	Jun. 1, 2022	*Sterilization (230.3)* *Maternity Care* ● Removed notation pertaining to: ○ Network lock-in ○ Licensure and other state requirements applicable to nurse-midwives ● Revised list on non-covered services; removed: ○ Any procedure intended solely for sex determination (e.g., amniocentesis, ultrasound and chorionic villi sampling [CVS]) ○ Blood testing to determine paternity
Stimulators: Electrical, Osteogenic and Ultrasonic	Jun. 1, 2022	Title Change ● Previously titled *Electrical Stimulators* Coverage Guidelines *Electrical Osteogenic Stimulator* Invasive (Implantable) Stimulator (HCPCS code E0749) ● Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Osteogenic Stimulators*) to indicate: ○ The invasive stimulator device is covered only for the following indications: ▪ Nonunion of long bone fractures ▪ As an adjunct to spinal fusion surgery for patients at high risk of pseudarthrosis due to previously failed spinal fusion at the same site or for those undergoing multiple level fusions; a multiple level fusion involves 3 or more vertebrae (e.g., L3-L5, L4-S1, etc.) ○ Effective Apr. 1, 2000, nonunion of long bone fractures is considered to exist only when serial radiographs have confirmed that fracture healing has ceased for 3 or more months prior to starting treatment with the electrical osteogenic stimulator ○ Serial radiographs must include a minimum of 2 sets of radiographs, each including multiple views of the fracture site, separated by a minimum of 90 days Noninvasive Stimulator (HCPCS codes E0747 and E0748) ● Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Osteogenic Stimulators*) to indicate: ○ The noninvasive stimulator device is covered only for the following indications: ▪ Nonunion of long bone fractures ▪ Failed fusion, where a minimum of 9 months has elapsed since the last surgery

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Stimulators: Electrical, Osteogenic and Ultrasonic (continued)	Jun. 1, 2022	▪ Congenital pseudarthroses ▪ As an adjunct to spinal fusion surgery for patients at high risk of pseudarthrosis due to previously failed spinal fusion at the same site or for those undergoing multiple level fusions; a multiple level fusion involves 3 or more vertebrae (e.g., L3-L5, L4-S1, etc.) ○ Effective Apr.1, 2000, nonunion of long bone fractures is considered to exist only when serial radiographs have confirmed that fracture healing has ceased for 3 or more months prior to starting treatment with the electrical osteogenic stimulator ○ Serial radiographs must include a minimum of 2 sets of radiographs, each including multiple views of the fracture site, separated by a minimum of 90 days Ultrasonic Osteogenic Stimulator (HCPCS code E0760) ● Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Osteogenic Stimulators*) to indicate: ○ Effective Apr. 27, 2005, noninvasive ultrasound stimulators are covered as medically reasonable and necessary for the treatment of nonunion bone fractures prior to surgical intervention; in demonstrating non-union fractures, the following must be met: ▪ A minimum of 2 sets of radiographs, obtained prior to starting treatment with the osteogenic stimulator, separated by a minimum of 90 days ▪ Each radiograph set must include multiple views of the fracture site accompanied with a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the 2 sets of radiographs ○ Non-invasive ultrasonic stimulator is not covered for any of the following: ▪ Nonunion fractures of the skull, vertebrae and those that are tumor related ▪ Fresh fractures and delayed unions ▪ For use concurrently with other non-invasive osteogenic devices ○ Refer to the National Coverage Determination (NCD) for *Osteogenic Stimulators (150.2)* ○ Local Coverage Determination (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable ○ Refer the Durable Medical Equipment (DME) MAC LCD/LCA for *Osteogenesis Stimulators (L33796)*
Transcatheter Heart Valve Procedures	Jun. 1, 2022	Coverage Guidelines *Transcatheter Edge-to-Edge Repair (TEER) for Mitral Valve Regurgitation* (previously titled *Transcatheter Mitral Valve Repair (MitraClip®)* ● Replaced language indicating “the Centers for Medicare and Medicaid Services (CMS) covers *transcatheter mitral valve repair (TMVR)* under coverage with evidence development (CED)” with “Medicare covers *transcatheter edge-to-*

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Transcatheter Heart Valve Procedures (continued)	Jun. 1, 2022	*edge repair (TEER) for mitral valve regurgitation* under coverage with evidence development (CED)" • Removed language pertaining to the CMS Decision Memo (dated Jan. 19, 2021) addressing the National Coverage Determination (NCD) for *Transcatheter Edge-to-Edge Repair (TEER) for Mitral Valve Regurgitation (20.33)*

Replaced

Policy Title	Approval Date	Summary of Changes
Carotid Procedures and Testing	Jun. 1, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled Cardiovascular Diagnostic and Therapeutic Procedures
Computed Tomographic Angiography (CTA)/Electron Beam Computed Tomography (EBCT) of the Chest	Jun. 1, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled Radiologic Diagnostic Procedures
Educational Programs	Jun. 1, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled Physician Services
Family Planning (Birth Control)	Jun. 1, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled Reproductive Services: Infertility, Family Planning and Maternity Care
Infertility Services	Jun. 1, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled Reproductive Services: Infertility, Family Planning and Maternity Care
Osteogenic Stimulators	Jun. 1, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled Stimulators: Electrical, Osteogenic and Ultrasonic
Second and Third Opinions	Jun. 1, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled Physician Services

Retired

The following Coverage Summaries have been retired effective Jun. 1, 2022:

- Cochleostomy with Neurovascular Transplant for Meniere's Disease
- Evaluation and Management Services
- Extracranial-Intracranial (EC-IC) Arterial Bypass Surgery
- Fabric Wrapping of Abdominal Aneurysms
- Renal Services and Procedures
- Thermogenic Therapy

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 because national and local coverage determinations from the Centers for Medicare and Medicaid Services (CMS) are no longer available or the applicable coverage guidelines are documented in another policy

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