United Healthcare Medicare Advantage

UnitedHealthcare Medicare Advantage
Coverage Summary Update Bulletin: March 2024

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Policy Title	Effective Date	Coverage Guidelines
Experimental Procedures and Items, Investigational Devices, and Clinical Trials	Apr. 1, 2024	**Experimental and investigational procedures, items, and medications are considered not reasonable and necessary. Investigational Device Exemption (IDE) studies are only covered when the Medicare coverage requirements are met. Routine costs associated with Medicare approved clinical trials is Medicare's financial responsibility.** Refer to: • Medicare Benefit Policy Manual, Chapter 14, §20 – Food and Drug Administration (FDA) – Approved Investigational Exemption (IDE) Studies • Medicare Program Integrity Manual, Chapter 13, §13.5.4 – Reasonable and Necessary Provisions in LCDs
Omnibus Codes	Apr. 1, 2024	This UnitedHealthcare Medicare Advantage Coverage Summary is intended to be used when there are no Medicare coverage criteria or other UnitedHealthcare Medicare Advantage Coverage Summaries that include omnibus codes. Medicare does not have coverage guidelines for many of the items and services in UnitedHealthcare's Commercial Medical Policy titled *Omnibus Codes*. For coverage guidelines for items and services listed in this policy, first search the Medicare Coverage Database to confirm no applicable Medicare coverage guidelines exist. After searching the Medicare Coverage Database, if no NCD/LCD/LCA is found, then search for a Coverage Summary that specifically addresses the service/code. If none is found, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Updated

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Policy Title	Summary of Changes
Cardiac Procedures: Pacemakers, Pulmonary Artery Pressure Measurements, Ventricular Assistive Devices, Valve Repair, and Valve Replacements	**Coverage Guidelines** ***Ventricular Assist Devices (CPT Codes 33979, 33980, 33982, and 33983)*** • Added list of applicable CPT codes to service heading

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Policy Title	**Summary of Changes**
Complementary and Alternative Medicine & Chiropractic Services	**Title Change** • Previously titled *Complementary, Alternative Medicine, and Chiropractic Services* **Coverage Guidelines** ***Chiropractic Services (CPT Codes 98940, 98941, and 98942)*** • Added list of applicable CPT codes to service heading • Updated notation to clarify members in states that participate in the Chiropractic Utilization Management Program may have additional chiropractic benefits
Dental Services, Oral Surgery, and Treatment of Temporomandibular Joint (TMJ)	**Coverage Guidelines** ***Examples of TMJ Treatment*** Treatments such as the Injection of Corticosteroid, Physical Therapy, Arthroscopy, or Arthroplasty • Removed reference link to InterQual® criteria Orthognathic Surgery (CPT Codes 21120, 21121, 21122, 21123, 21125, 21127, 21141, 21142, 21143, 21145, 21146, 21147, 21150, 21151, 21154, 21155, 21159, 21160, 21188, 21193, 21194, 21195, 21196, 21198, 21199, 21206, 21210, 21215, 21244, 21245, 21246, and 21247) • Added list of applicable CPT codes to service heading • Removed instruction to refer to list of applicable Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) [in the policy] • Added language to indicate LCDs/LCAs are available in the Medicare Coverage Database **Supporting Information** • Removed list of available LCDs/LCAs for orthognathic surgery
Hospital, Emergency, and Ambulance Services	**Coverage Guidelines** ***Ambulance Services (HCPCS Codes A0425, A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, A0434, A0435, and A0436)*** • Added list of applicable HCPCS codes to service heading
Obesity: Treatment of Obesity, Non-Surgical and Surgical (Bariatric Surgery)	**Coverage Guidelines** ***Surgical Treatment-Bariatric Surgery*** Covered Services and Criteria • Added instruction to refer to the UnitedHealthcare Commercial Medical Policy titled *Bariatric Surgery* for clinical coverage guidance when the National Coverage Determination (NCD) or Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) are silent on coverage criteria for bariatric procedures (including revisions)

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Policy Title	Summary of Changes
Obesity: Treatment of Obesity, Non-Surgical and Surgical (Bariatric Surgery) (continued)	**Supporting Information** • Updated list of available LCDs/LCAs to reflect the most current information

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Medications/Drugs (Outpatient/Part B)	**Coverage Guidelines**
	Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS) (HCPCS Code Q2026)
	• Added list of applicable HCPCS codes to service heading
	Step Therapy Program
	• Revised language to indicate:
	  ○ Certain classes of medical benefit injectables covered under Medicare Part B will include preferred and non-preferred therapies
	  ▪ Non-preferred therapies will generally require history of use of a preferred therapy among other criteria
	  ▪ This step therapy requirement will apply to some, but not all, Medicare Advantage Plans
	  ○ A medical injectable is subject to step therapy when listed in the table [in the policy] with a notation to refer to the UnitedHealthcare Medicare Advantage Medical Benefit Drug Policy titled *Medicare Part B Step Therapy Programs*
	Other Specific Medications (not listed in the policy)
	• Revised language to indicate:
	  ○ Check for available National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or Local Coverage Articles (LCAs) in the Medicare Coverage Database; if there are no applicable NCDs, LCDs, or LCAs found, refer to the table [in the policy]
	  ○ For all other drugs or biologicals not listed in this Coverage Summary for which there are no applicable NCDs, LCDs, or LCAs, refer to the relevant UnitedHealthcare Commercial Medical Benefit Drug Policy
	  ○ If there is no UnitedHealthcare Commercial Medical Benefit Drug Policy, then use the compendia and evidence-based medical literature for coverage guidance
	  ○ For available UnitedHealthcare Commercial Medical Benefit Drug Policies, refer to the UnitedHealthcare Commercial Medical & Drug Policies
	  ○ For any off label drug or biological with a NCCN Category 2B indication, refer to the UnitedHealthcare Commercial Medical Benefit Drug Policy titled *Oncology Medication Clinical Coverage*

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Medications/Drugs (Outpatient/Part B) (continued)	***Other Examples of Specific Drugs/Medications***
	• Added coverage guidelines for Rivfloza™ (Nedosiran) to indicate a pre-service review [Review at Launch (RAL) is required
	• Updated list of applicable drugs/medications for:
	  ○ Bevacizumab; added Vegzelma® (Bevacizumab-Adcd)
	  ○ Intravitreal vascular endothelial growth factor (VEGF) inhibitors; added Eylea® HD (Aflibercept)
	Supporting Information
	• Updated list of available LCDs/LCAs to reflect the most current information

Neurologic Services and Procedures	**Notice of Revision**: The following summary of changes has been modified. Revisions to the previous policy update announcement are outlined in red below. Please take note of the amended updates to be applied on **Mar. 1, 2024**.
	
	Coverage Guidelines
	Neurologic Services and Procedures
	Vagus Nerve Stimulation for Treatment of Seizures (CPT Codes 61885, 61886, 64553, 64568, and 64570)
	• Added list of applicable CPT codes to service heading
	Vagus Nerve Stimulation for Strokes (CPT Code 64568 and HCPCS Code C1827) *(new to policy)*
	• Added language to indicate:
	  ○ Medicare does not have a National Coverage Determination (NCD) for vagus nerve stimulation for strokes; Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist
	  ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Vagus and External Trigeminal Nerve Stimulation*
	Non-Ambulatory (Standard) EEG Monitoring and Video Recording (CPT Codes 95700, 95711, 95712, 95713, 95714, 95715, 95716, 95718, 95720, 95722, 95724, and 95726)
	• Added list of applicable CPT codes to service heading
	Electromyography (EMG) and Nerve Conduction Studies (CPT Codes 51784, 51785, 92265, 95860, 95861, 95863, 95864, 95865, 95866, 95867, 95868, 95869, 95870, 95872, 95873, 95874, 95885, 95886, 95887, 95905, 95907, 95908, 95909, 95910, 95911, 95912, 95913, 95933, 95937, and 95999)
	• Added list of applicable CPT codes to service heading
	Plagiocephaly and Craniosynostosis Treatment (HCPCS Codes L0112 and L0113 ~~and S1040~~)
	• Added list of applicable HCPCS codes to service heading

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Neurologic Services and Procedures (continued)	Motor Function Mapping Using Non-Invasive Navigated Transcranial Magnetic Stimulation (nTMS) (CPT Code 64999) *(new to policy)*
	• Added language to indicate:
	  ○ Medicare does not have a NCD for motor function mapping using non-invasive navigated transcranial magnetic stimulation (nTMS); LCDs/LCAs do not exist
	  ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Transcranial Magnetic Stimulation*
	Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) (CPT Code 0398T) *(new to policy)*
	• Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Radiation and Oncologic Procedures*) to indicate:
	  ○ Medicare does not have a National Coverage Determination (NCD) for MRgFUS
	  ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist for all states/territories and compliance with these policies is required where applicable; for specific LCDs/LCAs, refer to the table [in the policy]
	Neuropsychological Testing (CPT Codes 96116, 96121, 96132, 96133, 96136, 96137, 96138, 96139, and 96146)
	• Added list of applicable CPT codes to service heading
	Magnetoencephalography (MEG) (CPT Codes 95965, 95966, and 95967) *(new to policy)*
	• Added language to indicate:
	  ○ Medicare does not have a NCD for magnetoencephalography; LCDs/LCAs do not exist
	  ○ For coverage guidelines, refer to the InterQual® CP: Imaging, Imaging, Brain
	  ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above 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 Hospital	**Title Change**
	• Previously titled *Skilled Nursing Facility, Rehabilitation, and Long-Term Acute Care Hospitalization*
	Coverage Guidelines
	• Removed content/language addressing:
	  ○ Rehabilitative therapy
	  ○ Maintenance program
	  ○ Biofeedback therapy

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Skilled Nursing Facility, Rehabilitation, and Long-Term Acute Care Hospital (continued)	***Cardiac Rehabilitation (CR) Exercise Programs (CPT Codes 93797 and 93798 and HCPCS Codes G0422 and G0423)*** • Added list of applicable CPT and HCPCS codes to service heading ***Outpatient Rehabilitation Therapy (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) (CPT Codes 92507, 92521, 92522, 92523, 92524, 92526, 92605, 92606, 92607, 92608, 92609, 92610, 93797, 93798, 94625, 94626, 96105, 96125, 97014, 97035, 97110, 97112, 97113, 97116, 97124, 97129, 97130, 97140, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97530, 97535, 97537, 97542, 97760, and 97763)*** • Added list of applicable CPT codes to service heading Conditions of Coverage • Updated language pertaining to state applicability to clarify guidelines apply to members in states that participate in the Outpatient Therapy Utilization Management Program ***Long Term Acute Care Hospitalization (LTACH)*** • Added reference link to the Medicare: ○ *Claims Processing Manual, Chapter 3 – Inpatient Hospital Billing §150 – Long Term Care Hospitals (LTCHs) PPS* ○ *Program Integrity Manual, Chapter 6, Section 6.5 – Medical Review of Inpatient Hospital Claims for Part A Payment*

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Cardiovascular Diagnostic and Therapeutic Procedures	Apr. 1, 2024	**Coverage Guidelines** • Removed content/language addressing: ○ Extremity noninvasive duplex scanning (CPT codes 93925 and 93926) ○ Abdomen and pelvis angiography (CPT codes 93976, 93978, and 93979) • Added language to indicate: ○ Cardiology imaging prior authorization programs exist in some markets for cardiac imaging procedures such as cardiac MRIs, MRAs, PET scans, and nuclear medicine studies; reference materials are available at UHCprovider.com > Cardiology Prior Authorization and Notification ○ For members enrolled in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate's requirements need to be followed • Replaced instruction to "refer to the UnitedHealthcare Commercial Medical Policy titled *Cardiac Event Monitoring* for clinical coverage guidance when the National Coverage Determination (NCD) or Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) are *unclear or* silent on coverage criteria for implantable loop recorders (CPT

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Cardiovascular Diagnostic and Therapeutic Procedures (continued)	Apr. 1, 2024	code 33285, HCPCS code E0616)" with "refer to the UnitedHealthcare Commercial Medical Policy titled *Cardiac Event Monitoring* for clinical coverage guidance when the NCD or LCDs/LCAs are silent on coverage criteria for implantable loop recorders (CPT code 33285, HCPCS code E0616)" ***Aquapheresis (Ultrafiltration) [(CPT Code 37799 When Used to Report Aquapheresis (Ultrafiltration)]*** (new to policy) • Added language to indicate: ○ Medicare does not have a NCD for aquapheresis (ultrafiltration); LCDs/LCAs do not exist at this time ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes* ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines ***Lower Extremity Stenting, Atherectomy, and/or Angioplasty (CPT Codes 37220, 37221, 37224, 37225, 37226, 37227, 37228, 37229, 37230, and 37231)*** • Removed instruction to refer to list of applicable LCDs/LCAs [in the policy] • Added language to indicate LCDs/LCAs are available in the Medicare Coverage Database ***Treatment of Other Indications (e.g., Atrial Flutter) (CPT Codes 93653 and 93656)*** (new to policy) • Added language to indicate: ○ Medicare does not have a NCD for catheter ablation for treatment of other atrial flutter; LCDs/LCAs do not exist ○ For coverage guidelines, refer to the InterQual® CP: Procedures, Electrophysiology (EP) Testing +/- Radiofrequency (RFA) or Cryothermal Ablation, Cardiac ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines **Supporting Information** • Removed list of available LCDs/LCAs
Cosmetic and Reconstructive Procedures	Apr. 1, 2024	**Coverage Guidelines** ***Breast Reconstruction Following Mastectomy*** • Updated list of applicable HCPCS codes for breast implant and tissue expansion; added L8600 ***Myocutaneous Flaps for the Head, Neck, Trunk, and Extremities (CPT Codes 15731, 15733, 15734, 15736, 15738, 15740, and 15756)*** • Updated list of applicable CPT codes; added 15740

Cosmetic and Reconstructive Procedures (continued)	Apr. 1, 2024	***Gender Dysphoria Treatment (CPT Codes 14000, 14001, 14041, 15734, 15738, 15750, 15757, 15758, 15769, 15771, 15772, 15773, 15774, 15820, 15821, 15822, 15823, 15830, 15847, 15877, 15878, 15879, 17380, 17999, 19303, 19316, 19318, 19325, 19350, 21120, 21123, 21125, 21127, 21137, 21138, 21139, 21172, 21175, 21179, 21180, 21208, 21209, 21210, 30400, 30410, 30420, 30430, 30435, 30450, 31599, 31899, 53410, 53430, 54125, 54400, 54401, 54405, 54406, 54410, 54411, 54416, 54417, 54520, 54660, 54690, 55175, 55180, 55970, 55980, 56625, 56800, 56805, 57110, 57335, 58150, 58180, 58260, 58262, 58290, 58291, 58292, 58541, 58542, 58543, 58544, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58661, 58720, 58940, 58999, 64856, 64892, 64896, 67900, 92507, and 92508)*** • Added list of applicable CPT codes to service heading ***Light and Laser Therapy for Rosacea and Rhinophyma (CPT Codes 17106, 17107, and 17108)*** • Added list of applicable CPT codes to service heading ***Removal of Tissue Expander Without Insertion of Implant (CPT Code 11971)*** (new to policy) • Added language to indicate: ○ Medicare does not have an NCD for insertion tissue expander without insertion of implant; Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Breast Reconstruction* ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines ***Autogenous Graft (CPT Code 21230)*** (new to policy) • Added language to indicate: ○ Medicare does not have an NCD for autogenous graft ○ LCDs/LCAs exist and compliance with these policies is required where applicable; for specific LCDs/LCAs, refer to the table [in the policy] ○ For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled *Cosmetic and Reconstructive Procedures* ○ After checking the table [in the policy] and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines ***Cranial Reconstruction (CPT Codes 21181, 21182, 21183, and 21184)*** (new to policy) • Added language to indicate: ○ Medicare does not have an NCD for cranial reconstruction ○ LCDs/LCAs exist and compliance with these policies is required where applicable; for specific LCDs/LCAs, refer to the table [in the policy]

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Cosmetic and Reconstructive Procedures (continued)	Apr. 1, 2024	○ For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled *Cosmetic and Reconstructive Procedures* ○ After checking the table [in the policy] and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines ***Mandible/Maxilla Reconstruction (CPT Codes 21248 and 21249)*** (new to policy) • Added language to indicate: ○ Medicare does not have an NCD for mandible reconstruction ○ LCDs/LCAs exist and compliance with these policies is required where applicable; for specific LCDs/LCAs, refer to the table [in the policy] ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Cosmetic and Reconstructive Procedures* ○ After checking the table [in the policy] and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines ***Orbital Reconstruction (CPT Codes 21255, 21256, 21260, 21261, 21263, 21267, 21268, 21275, and 21299)*** (new to policy) • Added language to indicate: ○ Medicare does not have an NCD for orbital reconstruction ○ LCDs/LCAs exist and compliance with these policies is required where applicable; for specific LCDs/LCAs, refer to the table [in the policy] ○ For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled *Cosmetic and Reconstructive Procedures* ○ After checking the table [in the policy] and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines ***Liposuction for Lipedema (CPT Codes 15877, 15878, and 15879)*** (new to policy) • Added language to indicate: ○ Medicare does not have an NCD for liposuction for lipedema ○ LCDs/LCAs exist and compliance with these policies is required where applicable; for specific LCDs/LCAs, refer to the table [in the policy] ○ For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial

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Cosmetic and Reconstructive Procedures (continued)		Medical Policy titled *Liposuction for Lipedema* ○ After checking the table [in the policy] and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines **Supporting Information** • Updated list of available LCDs/LCAs to reflect the most current information
Durable Medical Equipment (DME), Prosthetics, Orthotics (Non-Foot Orthotics), Nutritional Therapy, and Medical Supplies Grid	Apr. 1, 2024	**Title Change** • Previously titled *Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), Nutritional Therapy, and Medical Supplies Grid* **Coverage Guidelines** • Removed content/language addressing: ○ Abdominal binder ○ Ambulatory blood pressure monitoring (ABPM) ○ Ambulatory boot (also known as surgical boot) ○ Bed pan (autoclavable, hospital type) ○ Casts (plaster, fiberglass) ○ Coagulation monitor ○ Cochlear implant (external component of device) ○ Collagen implant ○ Communicators ○ Corrective appliances ○ Cranial band ○ Dental splint ○ Digital electronic pacemaker monitors ○ Fabric supports ○ Hearing aid ○ Helmet (cranial orthosis) ○ Holter monitor (cardiac event monitor) ○ Home prothrombin time international normalized ratio (INR) monitoring ○ INDEPENDENCE iBOT 4000 mobility system ○ Obturator, palatal ○ Pacemaker monitors, self-contained (audible/visible signal or digital electronic)

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Policy Title	Effective Date	Summary of Changes
Durable Medical Equipment (DME), Prosthetics, Orthotics (Non-Foot Orthotics), Nutritional Therapy, and Medical Supplies Grid (continued)	Apr. 1, 2024	○ Punctal plug ○ Self-contained pacemaker monitors ○ Stair lift ○ Surgical boot ○ ThAIRapy® vest system ○ TMJ splint ***Medical Supplies*** • Added reference link to the *Medicare Benefit Policy, Manual, Chapter 15, §110.3 – Coverage of Supplies and Accessories* • Removed reference link to the *Medicare Benefit Policy, Manual, Chapter 15, §60.1 – Incident to Physician's Professional Services* **DME, Prosthetics, Orthotics, and Medical Supplies Grid** ***Air Splint*** • Removed reference link to the *Medicare Benefit Policy Manual, Chapter 15, §60.1 – Incident to Physician's Professional Services* ***Artificial Limbs - Lower Limb*** • Added language to indicate: ○ UnitedHealthcare uses the criteria in the UnitedHealthcare Commercial Medical Policy titled *Lower Extremity Prosthetics* to supplement the general Medicare criteria regarding artificial limbs, lower limb microprocessors ○ UnitedHealthcare uses the criteria noted [in the policy] in order to ensure consistency in reviewing the conditions to be met for coverage of artificial limbs, lower limb microprocessors, as well as reviewing when such services may be medically necessary ○ Use of this criteria to supplement the general provisions noted [in the policy] 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 artificial limbs, lower limb microprocessors ***Artificial Limbs - Addition to Lower Limb Prosthesis, Vacuum Pump (HCPCS Codes L5781 and L5782)*** (new to policy) • Added language to indicate: ○ Medicare does not have a National Coverage Determination (NCD) for additions to lower limb prosthesis, vacuum pump

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Durable Medical Equipment (DME), Prosthetics, Orthotics (Non-Foot Orthotics), Nutritional Therapy, and Medical Supplies Grid (continued)	Apr. 1, 2024	○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time ○ For coverage guidelines, refer to the InterQual® CP: Durable Medical Equipment, Prosthetics, Lower Extremity ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines ***Breast Prosthesis (External)*** • Removed reference link to the *Medicare Benefit Policy Manual, Chapter 15, §100 – Surgical Dressings, Splints, Casts, and Other Devices Used for Reductions of Fractures and Dislocations* ***Crib (Pediatric) (HCPCS Code E0300)*** (new to policy) • Added language to indicate: ○ Medicare does not have a NCD for pediatric cribs; LCDs/LCAs do not exist at this time ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Beds and Mattresses* ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines ***Jaw Motion Rehabilitation System (Passive Rehabilitation Therapy)*** • Added list of applicable HCPCS codes: E1700, E1701, and E1702 ***Lymphedema Sleeve (Gradient Compression Garments)*** • Revised language to indicate coverage criteria apply ***Mobility Assistive Equipment (MAE)*** Walkers • Removed language indicating a walker with basket is not covered • Removed reference link to the *Social Security Act §1861(n), Social Security Act §1862(a)(6)* and the *Medicare Benefit Policy Manual, Chapter 16, §80 – Personal Comfort Items* Wheelchairs (Manual) • Replaced language indicating "*rolling chair/roll-about chair (geriatric chair)* may be covered when criteria are met" with "*mobile geriatric chairs* may be covered when criteria are met" ***Orthopedic Shoes*** • Removed reference link to the *Medicare Benefit Policy Manual, Chapter 15, § 290 – Foot Care* ***Pneumatic Compression Devices*** For the Treatment of Lymphedema or Chronic Venous Insufficiency with Venous Stasis Ulcer • Added instruction to refer to the following for coverage criteria:

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Durable Medical Equipment (DME), Prosthetics, Orthotics (Non-Foot Orthotics), Nutritional Therapy, and Medical Supplies Grid (continued)	Apr. 1, 2024	○ *Medicare Claims Processing Manual, Chapter 20; §181 Lymphedema Compression Treatment Benefit* ○ *Centers for Medicare & Medicaid (CMS) Lymphedema Compression Treatment Items* ○ *Medicare Learning Network (MLN) Article MM13286, Lymphedema Compression Treatment Items: Implementation* ○ *Palmetto GBA Pricing, Data Analysis, and Coding (PDAC) Lymphedema Compression Treatment Items - Correct Coding and Billing - Advisory Article* ***PureWick™ Urine Collection System (HCPCS Code E2001)*** • Updated list of applicable HCPCS codes; removed K1006 ***Stockings*** Gradient Pressure Dressings (e.g., Jobst Elasticized Heavy Duty Stockings) • Added language to indicate LCDs/LCAs exist and compliance with these policies is required where applicable; refer to the DME MAC LCD for *Surgical Dressings (L33831)* ***Ventilators (Including Supplies) (HCPCS Codes E0465, E0466, and E0467)*** • Added instruction to refer to the *Palmetto GBA PDAC: Correct Coding and Coverage of Ventilators - Advisory Article* **Definitions** • Removed definition of "Implantable Devices"
Genetic Testing	Apr. 1, 2024	**Coverage Guidelines** ***Other Molecular Diagnostic Genetic Tests*** Vectra™ DA (CPT Code 81490) *(new to policy)* • Added language to indicate: ○ Medicare does not have a National Coverage Determination (NCD) for Vectra DA ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable; these LCDs/LCAs are available in the Medicare Coverage Database ○ For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes* ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines • Revised list of molecular diagnostic genetic tests included in the Palmetto MolDX Program; added: ○ 4Kscore® assay (CPT code 81539) ○ ABL1 gene analysis (CPT code 81170)

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Policy Title	Effective Date	Summary of Changes
Genetic Testing (continued)	Apr. 1, 2024	○ Minimal residual disease testing for solid tumor (CPT codes 81445, 81479, and 0340U) ○ Targeted genomic sequence analysis panel, solid organ, or hematolymphoid neoplasm (CPT code 81455) **Supporting Information** • Updated list of available LCDs/LCAs to reflect the most current information
Glaucoma Surgical Treatments	Apr. 1, 2024	**Coverage Guidelines** ***Insertion of Aqueous Drainage Device*** *Hydrus® Microstent, iStent®, or iStent inject® (CPT Codes 66989 and 66991)* • Modified service heading • Updated list of applicable CPT codes; removed 0253T • Reorganized and revised language to indicate: ○ Medicare does not have a National Coverage Determination (NCD) for insertion of aqueous drainage device (Hydrus® Microstent, iStent®, or iStent inject®) ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable; for specific LCDs/LCAs, refer to the table [in the policy] ○ For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled *Glaucoma Surgical Treatments* ○ After checking the table [in the policy] and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines ○ In Sep. 2018, Alcon Research issued a voluntary market withdrawal of the CyPass® Micro-Stent from the global market ***Implantation of Glaucoma Drainage Devices (e.g., ExPRESS™ Mini Glaucoma Shunt, Molteno Implant, Baerveldt Tube Shunt, Krupin Eye Valve, or the Ahmed Glaucoma Valve Implant) (CPT Codes 66179, 66180, and 66183 and HCPCS Codes C1783 and L8612)*** • Updated list of applicable codes; added: ○ CPT codes 66179 and 66180 ○ HCPCS code C1783 ***Dexamethasone Intracanalicular Ophthalmic Insert (e.g., Dextenza®) (CPT Code 68841)*** (new to policy) • Added language to indicate: ○ Medicare does not have a NCD for dexamethasone intracanalicular ophthalmic insert ○ LCDs/LCAs exist and compliance with these policies is required where applicable; for specific LCDs/LCAs, refer

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Policy Title	Effective Date	Summary of Changes
Glaucoma Surgical Treatments (continued)	Apr. 1, 2024	to the table [in the policy] ○ UnitedHealthcare considers the use of the Dextenza® dexamethasone insert reasonable and necessary for the treatment of ocular inflammation and pain following ophthalmic surgery ○ Dextenza® is contraindicated in patients with the following conditions: ▪ Active corneal, conjunctival, or canalicular infections including epithelial herpes simplex keratitis (dendritic keratitis), vaccinia, and varicella ▪ Mycobacterial infections of the eye ▪ Fungal diseases of the eye ▪ Dacryocystitis ○ UnitedHealthcare uses the criteria above: ▪ To supplement the general Medicare criteria regarding Dexamethasone intracanalicular ophthalmic inserts ▪ In order to ensure consistency in reviewing the conditions to be met for coverage of Dexamethasone Intracanalicular Ophthalmic Inserts, 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 Dexamethasone intracanalicular ophthalmic inserts ○ After checking the table [in the policy] and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the criteria referenced above for coverage guidelines **Supporting Information** • Added *Clinical Evidence* and *References* sections • Updated list of available LCDs/LCAs to reflect the most current information
Joint Procedures	Apr. 1, 2024	**Coverage Guidelines** • Added language to indicate ankle, hand, wrist, elbow, and shoulder procedures may be covered when Medicare coverage criteria are met ***Core Decompression for Avascular Necrosis (CPT Codes 21299, 23929, 27299, 27599, and 27899)*** • Updated list of applicable CPT/HCPCS codes; removed S2325 • Reorganized and revised language to indicate: ○ Medicare does not have a National Coverage Determination (NCD) for core decompression for avascular necrosis; 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 *Core Decompression for*

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Policy Title	Effective Date	Summary of Changes
Joint Procedures (continued)	Apr. 1, 2024	*Avascular Necrosis* ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines ***Surgery of the Hip (CPT Codes 27120, 27125, 27130, 27132, 27134, 27137, 27138, 29860, 29861, 29862, 29863, 29914, 29915, and 29916)*** • Modified service heading • Reorganized and revised language to indicate: ○ Medicare does not have a NCD for surgery of the hip ○ LCDs/LCAs may exist and compliance with these policies is required where applicable; these LCDs/LCAs are available in the Medicare Coverage Database ○ For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled *Surgery of the Hip* ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines ***Other Hip Procedures Not Addressed [in the policy] (CPT Code 27122)*** (new to policy) • Added language to indicate: ○ Medicare does not have a NCD for CPT code 27122; LCDs/LCAs do not exist at this time ○ For coverage guidelines, refer to the InterQual® CP: Procedures, Arthrotomy, Hip ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines ***Surgery of the Knee (CPT Codes 27412, 27415, 27416, 27445, 27446, 27447, 27486, 27487, 29866, 29867, and 29868 and HCPCS Code J7330)*** • Modified service heading • Reorganized and revised language to indicate: ○ Medicare does not have a NCD for surgery of the knee ○ LCDs/LCAs may exist and compliance with these policies is required where applicable; these LCDs/LCAs are available in the Medicare Coverage Database ○ For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled *Surgery of the Knee* ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines

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Joint Procedures (continued)	Apr. 1, 2024	***Surgery of the Ankle (CPT Codes 27700, 29891, 29892, 29894, 29895, 29897, 29898, and 29899)*** (new to policy) • Added language to indicate: ○ Medicare does not have a NCD for surgery of the ankle; LCDs/LCAs do not exist at this time ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Surgery of the Ankle* ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines ***Surgery of the Hand and Wrist (CPT Codes 25441, 25442, 25444, 25446, 25449, 29840, 29844, 29845, 29846, and 29847)*** (new to policy) • Added language to indicate: ○ Medicare does not have a NCD for surgery of the hand and wrist; LCDs/LCAs do not exist at this time ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Surgery of the Hand and Wrist* ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines ***Endoscopic Cubital Tunnel Release, Elbow (CPT Codes 64718 and 29999)*** (new to policy) • Added language to indicate: ○ Medicare does not have a NCD for endoscopic cubital tunnel release, elbow; LCDs/LCAs do not exist at this time ○ For coverage guidelines, refer to the InterQual® CP: Procedures, Ulnar Nerve Decompression or Transposition, Elbow ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines ***Surgery of Elbow (CPT Codes 24360, 24361, 24362, 24365, 24363, 29837, and 29834)*** • Modified service heading • Updated list of applicable CPT codes: ○ Added 24365, 29837, and 29834 ○ Removed 24370 and 24372 • Replaced language indicating "Medicare does not have a NCD for *elbow replacement (arthroplasty)*" with "Medicare does not have a NCD for *surgery of elbow*" ***Surgery of Shoulder (CPT Codes 23470 and 23472)***

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Policy Title	Effective Date	Summary of Changes
Joint Procedures (continued)	Apr. 1, 2024	• Modified service heading • Updated list of applicable CPT codes; removed 23473 and 23474 • Replaced language indicating "Medicare does not have a NCD for *shoulder replacement* (*arthroplasty)*" with "Medicare does not have a NCD for *surgery of shoulder*" ***Radiofrequency Ablation of Shoulder, Hip or Knee (CPT Codes 23929, 27299, and 27599)*** (new to policy) • Added language to indicate: ○ Medicare does not have a NCD for radiofrequency ablation of shoulder, hip, or knee; LCDs/LCAs do not exist at this time ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes* ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines
Orthopedic Procedures, Devices, and Products	Apr. 1, 2024	**Coverage Guidelines** ***Kinesio Taping (CPT Codes 29799, 97139, and 97799 and HCPCS Code A9999)*** (new to policy) • Added language to indicate: ○ Medicare does not have a National Coverage Determination (NCD) for kinesio taping; 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 *Omnibus Codes* ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines ***Platelet-Rich Plasma (PRP) (CPT Code 0232T and HCPCS Code P9020)*** • Updated list of applicable CPT/HCPCS codes; added P9020 ***Computer-Assisted Surgical Navigation for Musculoskeletal Procedures (CPT Codes 0054T, 0055T, 20985, and 27599)*** (new to policy) • Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Radiation and Oncologic Procedures*) to indicate: ○ Medicare does not have a NCD for computer-assisted surgical navigation for musculoskeletal procedures; LCDs/LCAs do not exist at this time ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Computer-Assisted Surgical Navigation for Musculoskeletal Procedures* ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines

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Policy Title	Effective Date	Summary of Changes
Pain Management	Apr. 1, 2024	**Coverage Guidelines** • Removed content/language addressing injections of tendon sheaths, ligaments, ganglion cysts, carpal and tarsal tunnels, and Morton's neuroma (CPT codes 20526, 20550, 20551, 20612, and 28899) ***Epidural Injections*** Implanted Infusion Pump for Chronic Pain (CPT Codes 62324, 62325, 62326, 62327, 62350, 62351, 62360, 62361, and 62362) • Modified service heading • Updated list of applicable CPT codes; added 62350, 62351, 62360, 62361, and 62362 • Revised language to indicate: ○ Medicare does not have a National Coverage Determination (NCD) for implanted infusion pump for chronic pain ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable; for specific LCDs/LCAs, refer to the table [in the policy] ○ For coverage guidelines for states/territories with no LCDs/LCAs, refer to the United Healthcare Commercial Medical Policy titled *Implanted Spinal Drug Delivery Systems* ○ After checking the table [in the policy] and searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines **Supporting Information** • Updated list of available LCDs/LCAs to reflect the most current information
Radiation and Oncologic Procedures	Apr. 1, 2024	**Coverage Guidelines** • Removed content/language addressing: ○ Computer-assisted surgical navigation for musculoskeletal procedures (CPT code 20985); refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Orthopedic Procedures, Devices and Products* for applicable coverage guidelines ○ Magnetic resonance image guided high intensity focused ultrasound (MRgFUS) (CPT code 0398T); refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Neurologic Services and Procedures* ***Intraoperative Hyperthermic Intraperitoneal Chemotherapy (HIPEC) (CPT Code 96549)*** (new to policy) • Added language to indicate: ○ Medicare does not have a National Coverage Determination (NCD) for intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC) ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Intraoperative*

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Radiation and Oncologic Procedures (continued)	Apr. 1, 2024	*Hyperthermic Intraperitoneal Chemotherapy (HIPEC)* ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines **Supporting Information** • Updated list of available LCDs/LCAs to reflect the most current information
Radiologic Diagnostic Procedures	Apr. 1, 2024	**Coverage Guidelines** ***Single Photon Emission Computed Tomography (SPECT) (CPT Codes 78071, 78072, 78451, 78452, 78469, 78494, and 78803)*** • Added list of applicable CPT codes to service heading ***Positron Emission Tomography (CPT Codes 78429, 78430, 78431, 78432, 78433, 78434, 78459, 78491, 78492, 78608, 78811, 78812, 78813, 78814, 78815, and 78816)*** • Added list of applicable CPT codes to service heading ***Positron Emission Tomography (PET) for Other Conditions*** • Added language to indicate Local Coverage Determinations (LCDs)/Local Coverage Article (LCAs) exist and compliance with these policies is required where applicable; these LCDs/LCAs are available in the Medicare Coverage Database ***Other Nuclear Medicine (CPT Codes 78012, 78013, 78014, 78015, 78016, 78018, 78070, 78071, 78072, 78075, 78099, 78199, 78226, 78227, 78299, 78399, 78499, 78579, 78580, 78582, 78597, 78598, 78599, 78699, 78799, 78800, 78801, 78802, 78804, 78830, 78831, 78832, and 78999)*** (new to policy) • Added language to indicate: ○ LCDs/LCAs exist and compliance with these policies is required where applicable; these LCDs/LCAs are available in the Medicare Coverage Database ○ For regions/states/territories involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program, refer to the Medicare Advantage Radiology & Cardiology Clinical Guidelines at UHCprovider.com > Radiology Prior Authorization and Notification ○ For regions/states/territories not involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program, refer to the nationally recognized guidelines (i.e., InterQual® guidelines) ***3D Rendering (CPT Codes 76376 and 76377)*** (new to policy) • Added language to indicate: ○ LCDs/LCAs exist and compliance with these policies is required where applicable; these LCDs/LCAs are

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Radiologic Diagnostic Procedures (continued)	Apr. 1, 2024	available in the Medicare Coverage Database ○ For regions/states/territories involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program, refer to the Medicare Advantage Radiology & Cardiology Clinical Guidelines at UHCprovider.com > Radiology Prior Authorization and Notification ○ For regions/states/territories not involved in the UnitedHealthcare Radiology Prior Authorization and Notification Program, refer to the nationally recognized guidelines (i.e., InterQual® guidelines)
Spine Procedures	Apr. 1, 2024	**Coverage Guidelines** • Reorganized content • Removed content/language addressing stereotactic computer assisted volumetric and/or navigational procedure ***Cervical Spine*** Cervical Spine Surgery (CPT Codes 22210, 22216, 22220, 22226, 22548, 22551, 22552, 22554, 22590, 22595, 22600, 22800, 22802, 22804, 22808, 22810, 22812, 22830, 63001, 63015, 63020, 63040, 63045, 63050, 63051, 63056, 63075, 63081, 63170, 63172, 63185, 63190, and 63191) • Modified service heading and added list of applicable CPT codes • Replaced language indicating "Medicare does not have a National Coverage Determination (NCD) for cervical *spinal fusion*" with "Medicare does not have a NCD for cervical *spine surgery*" Cervical Artificial Disc (CPT Codes 22856, 22858, 22861, and 22899) • Updated list of applicable CPT codes: ○ Added 22899 ○ Removed 0098T • Updated instruction to clarify the UnitedHealthcare Commercial Medical Policy titled *Total Artificial Disc Replacement for the Spine* should be referenced for coverage guidelines *for states/territories with no Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs)* ***Thoracic Spine*** Thoracic Spine Surgery (CPT Codes 22206, 22212, 22222, 22532, 22556, 22558, 22610, 22800, 22802, 22804, 22808, 22810, 22812, 22830, 22842, 63003, 63016, 63046, 63048, 63050, 63051, 63055, 63056, 63064, 63077, 63085, 63087, 63090, 63101, 63170, 63173, 63185, 63190, 63191, and 63197) • Modified service heading • Updated list of applicable CPT codes; added 22206, 22212, 22222, 22532, 22556, 22558, 22610, 22800, 22802, 22804, 22808, 22810, 22812, 22830, 22842, 63048, 63050, 63051, 63056, 63170, 63173, 63185, 63190, 63191, and

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Policy Title	Effective Date	Summary of Changes
Spine Procedures (continued)	Apr. 1, 2024	63197 • Replaced language indicating "Medicare does not have a NCD for thoracic *spinal procedures*" with "Medicare does not have a NCD for thoracic *spine surgery*" Percutaneous Vertebroplasty and Percutaneous Vertebral Augmentation (also known as Balloon-Assisted Percutaneous Vertebroplasty, Kyphoplasty) (CPT Codes 22510, 22511, 22512, 22513, 22514, and 22515) • Revised language to indicate: ○ Medicare does not have a NCD for percutaneous vertebroplasty and percutaneous vertebral augmentation ○ LCDs/LCAs exist for all states/territories and compliance with these policies is required where applicable; for specific LCDs/LCAs, refer to the table [in the policy] Scoliosis or Kyphosis Surgery (CPT Codes 22818 and 22819) *(new to policy)* • Added language to indicate: ○ Medicare does not have a NCD for scoliosis or kyphosis surgery; LCDs/LCAs do not exist at this time ○ For coverage guidelines, refer to the InterQual® CP: Procedures, Scoliosis or Kyphosis Surgery ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines ***Lumbar Spine*** Lumbar Spine Surgery (CPT Codes 22207, 22214, 22224, 22533, 22558, 22612, 22630, 22633, 22800, 22802, 22804, 22808, 22810, 22812, 22830, 22849, 22850, 22852, 22854, 22855, 22859, 63005, 63012, 63017, 63030, 63042, 63047, 63050, 63051, 63056, 63087, 63090, 63091, 63102, 63170, 63185, 63190, 63191, and 63200) • Added language to indicate: ○ Medicare does not have a NCD for lumbar spine surgery ○ LCDs/LCAs may exist and compliance with these policies is required where applicable; these LCDs/LCAs are available in the Medicare Coverage Database ○ For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled *Spinal Fusion and Decompression* ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then refer to the policy referenced above for coverage guidelines ○ When Coflex-F® implant system is used as part of spinal fusion, refer to the *Interlaminar Lumbar Instrumented Fusion (ILIF)* [section of the policy] ***Lumbar Artificial Disc***

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Policy Title	Effective Date	Summary of Changes
Spine Procedures (continued)	Apr. 1, 2024	For Members Age 60 and Younger (CPT Codes 22857, 22860, 22862, 22899, and 0165T) • Updated list of applicable CPT codes; added 22899 • Updated instruction to clarify the UnitedHealthcare Commercial Medical Policy titled *Total Artificial Disc Replacement for the Spine* should be referenced for coverage guidelines *for states/territories with no LCDs/LCAs* ***Spinal Decompression and Interspinous Process Decompression Systems for the Treatment of Lumbar Spinal Stenosis [e.g., Interspinous Process Decompression (IPD)] (CPT Codes 22853, 22854, 22859, 22867, 22868, 22869, 22870, and 22899)*** • Updated list of applicable CPT codes; added 22854 and 22899 ***Percutaneous Lumbar Decompression of Nucleus Pulposus (CPT Code 62287)*** (new to policy) • Added language to indicate: ○ Medicare does not have a NCD for percutaneous lumbar Decompression of nucleus pulposus; LCDs/LCAs do not exist ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Minimally Invasive Spine Surgery Procedures* ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then refer to the policy referenced above for coverage guidelines ***Allograft or Synthetic Bone Graft Materials (CPT Codes 20930, 20931, 20939, and 22899)*** • Updated list of applicable CPT codes; removed 20932, 20933, and 20934 ***Epidural Lysis (CPT Codes 62264 and 62290)*** (new to policy) • Added language to indicate: ○ Medicare does not have a NCD for epidural lysis; LCDs/LCAs do not exist at this time ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Epiduroscopy, Epidural Lysis of Adhesions and Discography* ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines ***Percutaneous Minimally Invasive Fusion/Stabilization of the Sacroiliac Joint for the Treatment of Back Pain (CPT Codes 27278, 27279, and 27280)*** • Updated list of applicable CPT codes: ○ Added 27278 ○ Removed 0775T

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Urinary and Fecal Incontinence: Diagnosis and Treatment	Apr. 1, 2024	**Title Change**
		• Previously titled *Urinary and Fecal Incontinence, Diagnosis, and Treatments*
		Coverage Guidelines
		• Removed content/language addressing:
		  ○ Biofeedback therapy
		  ○ Sacral nerve stimulation (SNS) for urinary incontinence
		  ○ Non-implantable pelvic floor electrical stimulators
		  ○ Electrical continence aid
		  ○ Bladder stimulators (pacemakers)
		  ○ Solesta® for fecal incontinence (HCPCS code L8605)
		Radiofrequency (RF) Therapy for Treatment of Stress Urinary Incontinence (e.g., Viveve System) (CPT Codes 0672T, 53860, 53899, and 58999) (new to policy)
		• Added language to indicate:
		  ○ Medicare does not have a National Coverage Determination (NCD) for radiofrequency (RF) therapy for treatment of stress urinary incontinence; 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 *Omnibus Codes*
		  ○ After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines
		Sacral Nerve Stimulation (SNS) for Fecal Incontinence (CPT Codes 64561, 64581, 64590, and 64595)
		• Added list of applicable CPT codes to service heading
		PureWick™ Urine Collection System (HCPCS Code E2001)
		• Updated list of applicable HCPCS codes:
		  ○ Added E2001
		  ○ Removed K1006
		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 changes to our Medicare Advantage Coverage Summaries. 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.