United Healthcare Medicare Advantage

UnitedHealthcare Medicare Advantage
Coverage Summary Update Bulletin: October 2022

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Replaced

Coverage Summary Updates

Updated

Policy Title	Approval Date	Summary of Changes
Foot Care Services and Supportive Devices	Sep. 7, 2022	Coverage Guidelines • Updated notation pertaining to applicable coverage policies for procedures not addressed in this Coverage Summary; removed reference link to the: ○ National Coverage NCD Report ○ Local Coverage Final LCDs Report ○ Local Coverage Articles Final LCAs Report

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Policy Title	Approval Date	Summary of Changes
Chiropractic Services	Sep. 7, 2022	Coverage Guidelines • Added notation to indicate the guidelines in this Coverage Summary are for specific procedures only; for procedures not addressed in this Coverage Summary, refer to the Medicare Coverage Database to search for applicable coverage policies [National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs)] • Removed content/language addressing: ○ Power traction equipment ○ Fluidized therapy dry heat
Diabetes Management, Equipment and Supplies	Sep. 7, 2022	Coverage Guidelines • Added notation to indicate the guidelines in this Coverage Summary are for specific procedures only; for procedures not addressed in this Coverage Summary, refer to the Medicare Coverage Database to search for applicable coverage policies [National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs)] • Removed content/language addressing: ○ COVID-19 waivers and flexibilities ○ Diabetic self-management training (DSMT) ○ Modified/special blood glucose monitors ○ Implantable continuous glucose monitors (I-CGM) ○ Closed-loop blood glucose control device (CBGCD) ○ Home health benefits to a blind diabetic ○ Outpatient intravenous insulin treatment (OIVIT) *Continuous Glucose Monitors (CGMs)* • Updated list of applicable CPT codes for adjunctive CGM Devices, supplies, and accessories; removed E0784 • Removed language pertaining to *CMS-1738-F, Federal Register, Vol. 86, No. 246, December 28, 2021 Final Rule* on the

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Diabetes Management, Equipment and Supplies (continued)	Sep. 7, 2022	classification and payment of continuous glucose monitors (CGMs) under the Medicare Part B benefit for durable medical equipment (DME) ● Removed reference link to the: ○ Centers for Medicare & Medicaid Services (CMS) *1738-F, Federal Register, Vol. 86, No. 246, Dec. 28, 2021 Final Rule* ○ Joint DME MAC publication issued on Feb. 24, 2022 titled *Continuous Glucose Monitors – Correct Coding and Billing* ○ CMS *HCPCS Application Summaries and Coding Recommendations: Second Biannual, 2021 HCPCS Coding Cycle, pp 61-62* ○ *Code of Federal Regulations (CFR), Title 42, Section 414.202 Definitions, Durable Medical Equipment* *Additional Non-Covered Benefits* ● Revised list of examples of non-covered benefits; removed "insulin, except when used in conjunction with a continuous subcutaneous insulin infusion pump (CSII)" Supporting Information ● Removed list of available LCDs/LCAs for *Implantable Continuous Glucose Monitors (I-CGM)*
Dialysis Services	Sep. 7, 2022	Coverage Guidelines ● Added notation to indicate the guidelines in this Coverage Summary are for specific procedures only; for procedures not addressed in this Coverage Summary, refer to the Medicare Coverage Database to search for applicable coverage policies [National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs)] *Covered Dialysis Services and Other Related Services* ● Revised list of examples of covered dialysis services and other related services; removed: ○ Peridex continuous ambulatory peritoneal dialysis (CAPD) filter sets ○ Laboratory tests essential to monitor the progress of chronic renal dialysis patients ○ Water purification and softening systems used in conjunction with home dialysis ○ Medical nutritional therapy (MNT) ○ Ultrafiltration, hyperperfusion, and hyperfiltration procedures

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Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), Nutritional Therapy and Medical Supplies Grid	Sep. 7, 2022	Coverage Guidelines
		Durable Medical Equipment (DME) Face to Face Requirement
		• Revised language pertaining to Power Mobility Devices (PMDs):
		  ○ Removed reference link to Coverage Summary titled *Mobility Assistive Equipment (MAE)*
		  ○ Added instruction to refer to the item titled *Power Mobility Devices* for face-to-face encounter information
		Electrical Stimulation Devices
		Transcutaneous Electrical Nerve Stimulator (TENS) Unit
		• Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Electrical and Ultrasonic Stimulators*) to indicate:
		  ○ Coverage criteria apply; refer to the National Coverage Determination (NCD) for *Transcutaneous Electrical Nerve Stimulation (TENS) for Acute Post-Operative Pain (10.2)*
		  ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable; refer to the DME MAC LCD for *Transcutaneous Electrical Nerve Stimulators (TENS) (L33802)*
		  ○ For coverage of supplies necessary for TENS; refer to the NCD for *Supplies Used in the Delivery of Transcutaneous Electrical Nerve Stimulation (TENS) and Neuromuscular Electrical Stimulation (NMES) (160.13)*
		  ○ For an explanation of coverage for assessing patients' suitability for electrical nerve stimulation therapy; refer to the NCD for *Assessing Patient's Suitability for Electrical Nerve Stimulation Therapy (160.7.1)*
		  ○ TENS is not reasonable and necessary for the treatment of chronic lower back pain (CLBP) under section *1862(a)(1)(A) of the Act*
		  ▪ As of Jun. 8, 2015, the Centers for Medicare & Medicaid Services (CMS) coverage for TENS for chronic low back pain (CLBP) under Coverage with Evidence Development (CED) expired
		  ▪ Refer to the NCD for *Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP) (160.27)*
		Incontinence Control Devices (Mechanical and Hydraulic)
		• Removed instruction to refer to the NCD for *Incontinence Control Devices (230.10)* for members with permanent anatomic and neurologic dysfunction of the bladder
		Mobility Assistive Equipment (MAE)
		• Reorganized content
		Canes
		  ○ Replaced language indicating "[canes are] covered when patient meets the mobility assistive equipment clinical criteria" with "coverage criteria apply"

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Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), Nutritional Therapy and Medical Supplies Grid (continued)	Sep. 7, 2022	**Crutches** (previously titled *Crutches, Crutch Tips, and Hand*) ○ Replaced language indicating "[crutches are] covered when MAE clinical criteria are met" with "coverage criteria apply" ○ Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Mobility Assistive Equipment (MAE)* **INDEPENDENCE iBOT 4000 Mobility System** ○ Added instruction [previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Mobility Assistive Equipment (MAE)*] to refer to the NCD for: ▪ *INDEPENDENCE iBOT 4000 Mobility System (280.15)* ▪ *Mobility Assistive Equipment (MAE) (280.3)* ○ Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Mobility Assistive Equipment (MAE)* **Power Mobility Device (PMDs)** ○ Added instruction to refer to the *Face-to-Face Encounter Requirement* ○ Removed instruction to refer to the item titled *Wheelchairs* ○ Added guidelines to indicate: ▪ Coverage criteria apply; refer to the: – NCD for *Mobility Assistive Equipment (MAE) (280.3)* – DME MAC LCD for *Power Mobility Devices (L33789)* ▪ For repairs, replacements, and maintenance, refer to the *Medicare Benefit Policy Manual, Chapter 15, §110.2 – Repairs, Replacement and Maintenance and Delivery* ▪ For PMD options and accessories, refer to the DME MAC LCD for *Wheelchair Options/Accessories (L33792)* ▪ For PMD seating, refer to the DME MAC LCD for *Wheelchair Seating (L33312)* ▪ For documentation and face-to-face requirements for PMDs, refer to the: – DME MAC LCD for *Power Mobility Devices (L33789)* – *Medicare Learning Network (MLN) Matters #SE1112 – Power Mobility Device Face-to-Face Examination Checklist* ▪ Prior to or at the time of delivery of a power operated vehicle (POV) or power wheelchair (PWC), the supplier or practitioner must perform an on-site evaluation of the member's home to verify that the member can adequately maneuver the device that is provided considering physical layout, doorway width, doorway thresholds, and surfaces – There must be a written report of this evaluation available on request; refer to the DME MAC LCD for *Power Mobility Devices (L33789)*

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Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), Nutritional Therapy and Medical Supplies Grid (continued)	Sep. 7, 2022	▪ Battery replacement (purchased equipment) is covered only when the member owns or is purchasing (not renting) the electric wheelchair or POV; refer to the: – *Medicare Benefit Policy Manual, Chapter 15, §110.3 – Coverage of Supplies and Accessories* – DME MAC LCD for *Wheelchair Options/Accessories (L33792)* ▪ The following are not covered: – Seat elevators (statutorily non-covered option on a power wheelchair); if a PWC with a seat elevator (HCPCS code K0830 or K0831) is provided, it will be denied as non-covered – POVs for members who are capable of ambulation within the home but require a power vehicle for movement outside of the home; refer to the DME MAC LCD for *Power Mobility Devices (L33789)* – POVs that are primarily used to allow the member to perform leisure or recreational activities; refer to the DME MAC LCD for *Power Mobility Devices (L33789)* – Replacement of a wheelchair due to malicious damage, neglect or abuse; refer to the *Medicare Benefit Policy Manual, Chapter 15, §110.2 – Repairs, Replacement and Maintenance and Delivery* – Repairs on rented DME items (DME provider is responsible for such repairs); refer to the *Medicare Benefit Policy Manual, Chapter 15, §110.2 – Repairs, Replacement and Maintenance and Delivery* **Walkers** ○ Added language [previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Mobility Assistive Equipment (MAE)*] to indicate the medical necessity for a walker with an enclosed frame (HCPCS code E0144) has not been established; therefore, if an enclosed frame walker is provided, it will be denied as not reasonable and necessary ○ Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Mobility Assistive Equipment (MAE)* **Wheelchairs (Manual)** ○ Added instruction to refer to the *Face-to-Face Encounter Requirement* ○ Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Mobility Assistive Equipment (MAE)* ○ Added guidelines [previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Mobility Assistive Equipment (MAE)*] to indicate: ▪ Coverage criteria apply; refer to the: – NCD for *Mobility Assistive Equipment (MAE) (280.3)* – DME MAC LCD for *Manual Wheelchair Bases (L33788)* ▪ For wheelchair options and accessories, refer to the DME MAC LCD for *Wheelchair Options/Accessories (L33792)*

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Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), Nutritional Therapy and Medical Supplies Grid (continued)	Sep. 7, 2022	▪ For wheelchair seating, refer to the DME MAC LCD for *Wheelchair Seating (L33312)* ▪ For repairs, replacements, and maintenance, refer to the *Medicare Benefit Policy Manual, Chapter 15, §110.2 – Repairs, Replacement and Maintenance and Delivery* ▪ Rolling chair/roll-about chair (geriatric chair) may be covered when criteria are met; refer to the NCD for: – *Durable Medical Equipment Reference List (280.1)* – *Mobility Assistive Equipment (MAE) (280.3)* ▪ Payment is made for only one wheelchair at a time – Backup chairs are denied as not reasonable and necessary – One month's rental for a standard manual wheelchair is covered if a member-owned wheelchair is being repaired – Refer to the DME MAC LCD for *Manual Wheelchair Bases (L33788)* ▪ The following are not covered: – Ramp for a wheelchair (not primarily medical in nature); refer to the Medicare Benefit Policy Manual, Chapter 15, § 110.1 (B)(2) – Equipment Presumptively Non-Medical – Wheelchair upgrades that are beneficial primarily in allowing the member to perform leisure or recreational activities; refer to the: ● *Medicare Benefit Policy Manual, Chapter 16 §20 – Services Not Reasonable and Necessary* ● *Medicare Benefit Policy Manual, Chapter 16 §10 – General Exclusions from Coverage* ● DME MAC LCD for *Power Mobility Devices (L33789)* ● LCA for *Power Mobility Devices (A52498)* – Deluxe items or features; refer to the *Medicare Benefit Policy Manual, Chapter 16*: ● *§20 – Services Not Reasonable and Necessary* ● *§10 – General Exclusions from Coverage* – Items purchased for comfort or added convenience for the member or the member's caretaker; refer to the *Medicare Benefit Policy Manual, Chapter 16*: ● *§20 – Services Not Reasonable and Necessary* ● *§10 – General Exclusions from Coverage* – Replacement of a wheelchair due to malicious damage, neglect or abuse; refer to the *Medicare Benefit Policy Manual, Chapter 15, §110.2 – Repairs, Replacement and Maintenance and Delivery* – Repairs on rented DME items (DME provider is responsible for such repairs); refer to the *Medicare Benefit Policy Manual, Chapter 15, §110.2 – Repairs, Replacement and Maintenance and Delivery* *Safety Rollers* ● Replaced language with instruction to refer to the item titled *Mobility Assistive Equipment (MAE)* for applicable

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Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), Nutritional Therapy and Medical Supplies Grid (continued)	Sep. 7, 2022	guidelines *Traction Equipment* Power Traction Equipment/Devices • Removed instruction to refer to the NCD for *Vertebral Axial Decompression (VAX-D) (160.16)* *Vacuum Assisted Closure Device (VAC) or Negative Pressure Wound Therapy Pump* • Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Wound Treatments*) to indicate coverage criteria apply; refer to the DME MAC LCD for *Negative Pressure Wound Therapy Pumps (L33821)* • Removed instruction to refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Wound Treatments* *Ventilators (Including Supplies) (HCPCS codes E0465, E0466, and E0467)* • Updated language pertaining to *Coding and Billing Clarification*; added notation to indicate: ○ Using the HCPCS codes for continuous positive airway pressure (CPAP) (HCPCS code E0601) or bi-level positive airway pressure (PAP) (HCPCS code E0470 or E0471) devices for a ventilator (HCPCS code E0465, E0466, or E0467) used to provide CPAP or bi-level PAP therapy is incorrect coding; refer to the DME MAC LCD for *Respiratory Assist Devices (L33800)*
Electrical and Ultrasonic Stimulators	Sep. 7, 2022	Title Change • Previously titled *Stimulators: Electrical, Osteogenic and Supersonic* Coverage Guidelines • Added notation to indicate the guidelines in this Coverage Summary are for specific procedures only; for procedures not addressed in this Coverage Summary, refer to the Medicare Coverage Database to search for applicable coverage policies [National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs)] • Removed content/language addressing: ○ Transcutaneous electrical nerve stimulator (TENS) ○ Phrenic nerve stimulator ○ Electric nerve stimulator for the treatment of motor function disorders ○ Electrotherapy for the treatment of facial nerve paralysis (Bell's Palsy) ○ Percutaneous electrical nerve stimulation (PENS) as diagnostic procedure

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Genetic Testing	Sep. 7, 2022	**Coverage Guidelines** ● Added notation to indicate the guidelines in this Coverage Summary are for specific procedures only; for procedures not addressed in this Coverage Summary, refer to the Medicare Coverage Database to search for applicable coverage policies [National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs)] ● Removed description for Next Generation Sequencing (NGS) Test ● Revised list of *Molecular Diagnostic Tests Included in the Palmetto MolDX Program* ○ Added: ▪ Germline Testing for Use of PARP Inhibitors (CPT codes 81162 and 81479) ▪ Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer (CPT codes 81202, 81215, 81217, 81293, 81296, 81299, 81308, 81318, 81322, 81353, 81403, 81404, 81405, 81406, 81432, 81433, 81435, 81436, 81437, 81438, 81479, 0101U, 0102U, 0103U, 0129U, 81163, 81164, 81165, 81166, 81167, 81201, 81203, 81212, 81216, 81292, 81294, 81295, 81297, 81298, 81300, 81307, 81317, 81319, 81321, 81323, and 81351) ▪ Molecular Testing for Solid Organ Allograft Rejection (CPT codes 81479, 81595, 81599, and 0118U) ○ Removed: ▪ APC and MUTYH Gene Testing (CPT codes 81201, 81202, 81203, 81401, 81403, 81406, 81435, 81436, 81479, and 0157U) ▪ Avise PG (CPT code 84999) ▪ BRCA1 and BRCA2 Genetic Testing (CPT codes 81163, 81164, 81165, 81166, 81167, 81212, 81215, 81216, 81217, 81432, 81433, 81479, 0102U, 0103U, 0129U, 0131U, 0132U, 0133U, 0134U, 0135U, 0136U, 0137U, 0138U, 0157U, 0158U, 0159U, 0160U, 0161U, 0162U, and 81162) ▪ Lynch Syndrome Testing (CPT codes 81210, 81288, 81292, 81293, 81294, 81295, 81296, 81297, 81298, 81299, 81300, 81301, 81317, 81318, 81319, 81403, 81432, 81433, 81435, 81436, 81445, 81455, 81479, 88341, 88342, 0101U, 0130U, 0134U, 0157U, 0158U, 0159U, 0160U, 0161U, and 0162U) ▪ Myriad's BRACAnalysis CDx™ (CPT code 81162) ○ Replaced "minimal residual disease testing for cancer" with "minimal residual disease testing for *hematologic* cancer" ○ Updated list of applicable CPT codes for: ▪ Blood Product Molecular Antigen Typing – Added 0181U, 0182U, 0183U, 0184U, 0185U, 0186U, 0187U, 0188U, 0189U, 0190U, 0191U, 0192U, 0193U, 0194U, 0195U, 0196U, 0197U, 0198U, 0199U, and 0200U ▪ FDA-Approved KRAS Tests

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Genetic Testing (continued)	Sep. 7, 2022	– Added 81276 and 81479 ▪ HLA Testing for Transplant Histocompatibility – Added 81373 ▪ Melanoma Risk Stratification Molecular Testing – Added 81479 ▪ Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing – Removed 87505 ▪ Pharmacogenomic Testing for Warfarin Response (CYP2C9 and VKORC1) – Added G9143 ▪ Repeat Germline Testing – Added 81179, 81293, 81299, 0175U, and 0181U ▪ TP53 Gene Test – Added 81351 and 81352 – Removed 81404 and 81405 ○ Updated reference links to reflect the most current program guidelines and LCDs/LCAs
Medications/Drugs (Outpatient/Part B)	Sep. 7, 2022	Coverage Guidelines ● Updated notation pertaining to applicable coverage policies for procedures not addressed in this Coverage Summary; removed reference link to the: ○ National Coverage NCD Report ○ Local Coverage Final LCDs Report *Other Examples of Specific Drugs/Medication* Enjaymo™ (Sutimlimab-Jome), Korsuva™ (Difelikefalin), and Tezspire™ (Tezepelumab-Ekko) ● Revised language to indicate a pre-service review [Review at Launch (RAL)] is no longer required Onpattro® (Patisiran), Radicava® (Edaravone), Reblozyl® (Luspatercept-Aamt), and Saphnelo™ (Anifrolumab-Fnia) ● Revised language to indicate Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) no longer exist Supporting Information ● Updated list of available LCDs/LCAs to reflect the most current guidelines
Organ and Tissue Transplants	Sep. 7, 2022	Coverage Guidelines ● Added notation to indicate the guidelines in this Coverage Summary are for specific procedures only; for procedures not addressed in this Coverage Summary, refer to the Medicare Coverage Database to search for applicable coverage policies [National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs)]

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Organ and Tissue Transplants (continued)	Sep. 7, 2022	• Removed content/language addressing:
		  ○ Heart and heart-lung transplants
		  ○ Adult liver transplants
		  ○ Pediatric liver transplants
		  ○ Intestinal and multi-visceral transplantation
		  ○ Dental/oral examination
		  ○ Thoracic duct drainage (TDD)
		  ○ Histocompatibility testing (HLA typing)
		  ○ Heartsbreath test for heart transplant rejection

Orthopedic Procedures, Devices and Products	Sep. 7, 2022	Coverage Guidelines • Removed content/language addressing allograft or synthetic bone graft materials (refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Spine Procedures*) for coverage guidelines

Pain Management and Pain Rehabilitation	Sep. 7, 2022	Coverage Guidelines
		• Added notation to indicate the guidelines in this Coverage Summary are for specific procedures only; for procedures not addressed in this Coverage Summary, refer to the Medicare Coverage Database to search for applicable coverage policies [National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs)]
		• Removed content/language addressing:
		  ○ Inpatient pain rehabilitation programs
		  ○ Outpatient pain rehabilitation programs
		  ○ Autogenous epidural blood graft
		  ○ Trigger point injections
		  ○ Prolotherapy, joint sclerotherapy and ligamentous injections with sclerosing agents
		Sacroiliac (SI) Joint Injections (CPT codes 27096 and 64451 and HCPCS code G0260)
		• Revised default guidelines for sacroiliac (SI) joint injections:
		  ○ Added reference link to the UnitedHealthcare Commercial Medical Policy titled *Sacroiliac Joint Interventions*
		  ○ Removed reference link to the National Government Services LCD for *Pain Management (L33622)*
		Supporting Information
		• Updated list of available LCDs/LCAs to reflect the most current guidelines

Preventive Health Services and Procedures	Sep. 7, 2022	Coverage Guidelines *Medicare Covered Preventive Services and Screening* Bone Mass Measurement

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Preventive Health Services and Procedures (continued)	Sep. 7, 2022	• Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Bone Density Studies/Bone Mass Measurements*) to indicate: ○ Bone (mineral) density studies/mass measurements are covered when Medicare coverage criteria are met ○ Qualified individuals are individuals who meet at least one of the following: ▪ An estrogen deficient woman at clinical risk for osteoporosis based upon her medical history or other findings, as determined by her physician (or a qualified non-physician practitioner) ▪ An individual with vertebral abnormalities as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia, or vertebral fracture ▪ An individual receiving (or expected to receive) glucocorticoid (steroid) therapy equivalent to an average of 5 mg of prednisone, or greater, per day, for more than 3 months ▪ An individual with primary hyperparathyroidism ▪ An individual being monitored to assess the response to, or efficacy of, an FDA approved osteoporosis drug therapy regime ○ Refer to the: ▪ National Coverage Determination (NCD) for *Bone (Mineral) Density Studies (150.3)* ▪ *Medicare Benefit Policy Manual, Chapter 15, §80.5 – Bone Mass Measurements (BMMs)* ▪ *Medicare Learning Network (MLN) Preventive Services Educational Tool* ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable • Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Bone Density Studies/Bone Mass Measurements*
Spine Procedures	Sep. 7, 2022	Coverage Guidelines • Added notation to indicate the guidelines in this Coverage Summary are for specific procedures only; for procedures not addressed in this Coverage Summary, refer to the Medicare Coverage Database to search for applicable coverage policies [National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs)] *Allograft or Synthetic Bone Graft Materials (CPT codes 20930, 20931, 20932, 20933, 20934 and 22899)* • 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 bone healing and fusion enhancement products ○ LCDs/LCAs do not exist ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Spinal Fusion Enhancement Products*

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Spine Procedures (continued)	Sep. 7, 2022	• Removed content/language addressing thermal intradiscal procedures (TIPs) *Lumbar Artificial Disc* For Members Over 60 Years of Age • Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Artificial Disc Replacement, Cervical and Lumbar*) to indicate lumbar artificial disc replacement (LADR) is not covered for members over 60 years of age; refer to the NCD for *Lumbar Artificial Disc Replacement (LADR) (150.10)* For Members Age 60 and Younger (CPT Codes 22857, 0163T, 22862, and 0165T) • Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Artificial Disc Replacement, Cervical and Lumbar*) to indicate: ○ Medicare does not have a NCD for members 60 years of age and younger; coverage determination is to be made by the local contractor ○ LCDs/LCAs exist and compliance with these policies is required where applicable ○ For specific LCDs/LCAs, refer to the list of available LCDs/LCAs for lumbar artificial disk in the *Supporting Information* section of the policy ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Total Artificial Disc Replacement for the Spine* Cervical Artificial Disc (CPT Codes 22856, 22858, 22861, 0098T, 22864, and 0095T) • Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Artificial Disc Replacement, Cervical and Lumbar*) to indicate: ○ Medicare does not have a NCD for cervical artificial disc replacement ○ LCDs/LCAs exist and compliance with these policies is required where applicable ○ For specific LCDs/LCAs, refer to the list of available LCDs/LCAs in the *Supporting Information* section of the policy ○ For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Total Artificial Disc Replacement for the Spine* Supporting Information • Added list of available LCDs/LCAs for *Lumbar Artificial Disc*
Uterine Services and Procedures	Sep. 7, 2022	Coverage Guidelines • Added notation to indicate the guidelines in this Coverage Summary are for specific procedures only; for procedures not addressed in this Coverage Summary, refer to the Medicare Coverage Database to search for applicable coverage policies [National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs)] • Removed content/language addressing:

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Policy Title	**Approval Date**	**Summary of Changes**
Uterine Services and Procedures (continued)	Sep. 7, 2022	○ Diagnostic pap smear ○ Gravlee jet washer ○ Vabra aspirator ○ Therapeutic embolization *Hysterectomy* (previously titled *Hysterectomy for Benign Conditions*) ● Replaced language indicating "Medicare does not have a NCD for hysterectomy *for benign conditions*" with "Medicare does not have a NCD for hysterectomy" Supporting Information ● Updated list of available LCDs/LCAs to reflect the most current guidelines
Wound Treatments	Sep. 7, 2022	Coverage Guidelines ● Added notation to indicate the guidelines in this Coverage Summary are for specific procedures only; for procedures not addressed in this Coverage Summary, refer to the Medicare Coverage Database to search for applicable coverage policies [National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs)] ● Removed content/language addressing: ○ Hyperbaric oxygen ○ Wound care suction device, non-electric powered, disposable (e.g., Spiracur SNaP) ○ Wound care suction pump therapy ○ Blood-derived products for chronic non-healing wound ○ Infrared therapy devices ○ Negative pressure wound therapy (NPWT) [refer 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* for applicable coverage guidelines] *Skin Substitutes (Non-Porcine Based)* ● Updated list of applicable HCPCS codes; removed A2002, A2005, A2006, A2007, A2009, A2011, A2012, A4100, Q4100, Q4104, Q4105, Q4107, Q4108, Q4110, Q4411, Q4112, Q4114, Q4115, Q4117, Q4121, Q4122, Q4123, Q4125, Q4126, Q4127, Q4128, Q4132, Q4133, Q4134, Q4137, Q4138, Q4139, Q4140, Q4141, Q4143, Q4145, Q4146, Q4147, Q4148, Q4149, Q4150, Q4151, Q4152, Q4153, Q4154, Q4155, Q4156, Q4157, Q4158, Q4159, Q4160, Q4161, Q4162, Q4163, Q4164, Q4165, Q4167, Q4168, Q4169, Q4170, Q4171, Q4173, Q4174, Q4176, Q4177, Q4178, Q4179, Q4180, Q4181, Q4182, Q4183, Q4184, Q4185, Q4186, Q4187, Q4188, Q4189, Q4190, Q4191, Q4192, Q4193, Q4194, Q4198, Q4199, Q4200, Q4201, Q4202, Q4204, Q4205, Q4206, Q4208, Q4209, Q4210, Q4211, Q4212, Q4213, Q4214, Q4215, Q4216, Q4217, Q4218, Q4219, Q4220, Q4221, Q4224, Q4225, Q4230, Q4233, Q4235, Q4240, Q4241, Q4242, Q4244, Q4245, Q4247, Q4248, Q4250, Q4251, Q4252, Q4254, Q4255, Q4256, Q4257, and Q4258

Coverage Summary Updates

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Wound Treatments (continued)	Sep. 7, 2022	*Topical Application of Oxygen* • Removed reference link to the NCD for *Hyperbaric Oxygen Therapy (20.29)* Supporting Information • Removed list of available LCDs/LCAs for *Wound Care Suction Pump Therapy*

Replaced		
Policy Title	**Approval Date**	**Summary of Changes**
Artificial Disc Replacement, Cervical and Lumbar	Sep. 7, 2022	Policy replaced; refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Spine Procedures*
Bone Density Studies/Bone Mass Measurements	Sep. 7, 2022	Policy replaced; refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Preventive Health Services and Procedures*
Mobility Assistive Equipment (MAE)	Sep. 7, 2022	Policy replaced; refer 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*

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.