United Healthcare Medicare Advantage

UnitedHealthcare Medicare Advantage

Coverage Summary Update Bulletin: September 2022

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Policy Title	Approval Date	Summary of Changes
Cardiac Procedures: Pacemakers, Pulmonary Artery Pressure Measurements and Ventricular Assistive Devices	Aug. 3, 2022	**Title Change** • Previously titled *Cardiac Procedures: Pacemakers, Defibrillators and Pulmonary Artery Pressure Measurements* **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 following websites to search for applicable coverage policies: ○ Medicare Coverage Database ○ National Coverage NCD Report ○ Local Coverage Final LCDs Report • Removed content/language addressing: ○ Self-contained pacemaker monitors ○ Trans-telephonic cardiac pacemaker monitoring ○ Implantable cardioverter defibrillators (ICDs) ○ Subcutaneous implantable automatic defibrillators ○ Automatic external defibrillators ○ Anesthesia for cardiac pacemaker surgery ○ Intraoperative ventricular mapping ○ External counterpulsation (ECP) therapy ***Ventricular Assist Devices*** • Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Ventricular Assist Device (VAD) and Artificial Heart*) to indicate ventricular assist device (VAD) and left ventricular assist device (LVAD) may be covered: **Post-Cardiotomy** ○ Post-cardiotomy is the period following open-heart surgery ○ VADs used for support of blood circulation post-cardiotomy are covered only if they have received approval from the Food and Drug Administration (FDA) for that purpose, and the VADs are used according to the FDA-approved labeling instructions **Left Ventricular Assist Devices (LVADS)** ○ Left ventricular assist devices (LVADs) are covered if they are FDA approved for short-term (e.g., bridge-to-recovery and bridge-to-transplant) or long-term (e.g., destination therapy) mechanical circulatory support for heart failure patients who meet the following criteria: ▪ Have New York Heart Association (NYHA) Class IV heart failure; and ▪ Have a left ventricular ejection fraction (LVEF) ≤ 25%; and

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Cardiac Procedures: Pacemakers, Pulmonary Artery Pressure Measurements and Ventricular Assistive Devices (continued)	Aug. 3, 2022	▪ Are inotrope dependent, or ▪ Have a Cardiac Index (CI) < 2.2 L/min/m2, while not on inotropes, and also meet one of the following: – Are on optimal medical management (OMM), based on current heart failure practice guidelines for at least 45 out of the last 60 days and are failing to respond; or – Have advanced heart failure for at least 14 days and are dependent on an intra-aortic balloon pump (IABP) or similar temporary mechanical circulatory support for at least 7 days **Facility Criteria [for Placement of VADs]** ○ Facilities must meet the following criteria as a condition of coverage of this procedure as destination therapy (DT) under section *1862(a)(1)(A)*: ▪ Beneficiaries receiving a VAD must be managed by an explicitly identified cohesive, multidisciplinary team of medical professionals with the appropriate qualifications, training, and experience – The team embodies collaboration and dedication across medical specialties to offer optimal patient-centered care; collectively, the team must ensure that patients and caregivers have the knowledge and support necessary to participate in shared decision making and to provide appropriate informed consent – The team members must be based at the facility and must include individuals with experience working with patients before and after placement of a VAD ▪ The team must include, at a minimum: – At least one physician with cardiothoracic surgery privileges and individual experience implanting at least 10 durable, intracorporeal, left ventricular VADs as bridge to therapy (BTT) or DT over the course of the previous 36 months with activity in the last year – At least one cardiologist trained in advanced heart failure with clinical competence in medical- and device-based management including VADs, and clinical competence in the management of patients before and after heart transplant – A VAD program coordinator – A social worker – A palliative care specialist ▪ Facilities must be credentialed by an organization approved by CMS ▪ A list of facilities eligible for Medicare reimbursement for destination therapy VADs is available at http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/VAD-Destination-Therapy-Facilities.html **Non-Covered Indications for VADs** ○ All other indications for the use of VADs not otherwise listed remain non-covered, except in the context of Category B investigational device exemption clinical trials (*42 CFR 405*) or as a routine cost in clinical trials defined under

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Cardiac Procedures: Pacemakers, Pulmonary Artery Pressure Measurements and Ventricular Assistive Devices (continued)	Aug. 3, 2022	Section 310.1 of the *National Coverage Determinations (NCD) Manual* Other ○ This policy does not address coverage of VADs for right ventricular support, biventricular support, use in beneficiaries under the age of 18, use in beneficiaries with complex congenital heart disease, or use in beneficiaries with acute heart failure without a history of chronic heart failure; coverage under section *1862(a)(1)(A)* for VADs in these situations will be made by local Medicare Administrative Contractors (MACs) within their respective jurisdictions ○ Refer to the NCD for *Ventricular Assist Devices (20.9.1)*
Cosmetic and Reconstructive Procedures	Aug. 3, 2022	Related Policies ● Removed reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Plastic Surgery to Correct "Moon Face" (NCD 140.4)* Coverage Guidelines ● Added language to indicate: ○ Breast reconstruction post mastectomy is covered when Medicare criteria are met ○ The guidelines in this Coverage Summary are for specific procedures only; for procedures not addressed in this Coverage Summary, refer to the following websites to search for applicable coverage policies: ▪ Medicare Coverage Database ▪ National Coverage NCD Report ▪ Local Coverage Final LCDs Report ● Removed content/language addressing: ○ Dermal injections for the treatment of facial Lipodystrophy Syndrome (LDS) ○ Surgery to correct moon face *Breast Reconstruction Following Mastectomy* ● Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Breast Reconstruction Following Mastectomy*) to indicate: ○ Reconstruction of the affected and the contralateral unaffected breast following a medically necessary mastectomy is considered a relatively safe and effective non-cosmetic procedure ▪ Accordingly, program payment may be made for breast reconstruction surgery following removal of a breast for any medical reason ▪ Refer to the National Coverage Determination (NCD) for *Breast Reconstruction Following Mastectomy (140.2)* ○ When a member elects breast reconstruction following a medically necessary mastectomy or lumpectomy, coverage in accordance with Medicare guidelines is to be provided as determined through consultation between the attending physician and the member; refer to the Women's Health and Cancer Rights Act (WHCRA)

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Cosmetic and Reconstructive Procedures (continued)	Aug. 3, 2022	○ Local Coverage Determinations (LCDs)/Local Coverage Article (LCAs) exist and compliance with these policies is required where applicable; refer to the list of available *LCDs/LCAs for Breast Implant and Tissue Expansion* in the *Supporting Information* section of the policy ○ Covered services include, but are not limited to: ▪ External breast prosthesis and bras; refer to the Coverage Summary titled *Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), Nutritional Therapy and Medical Supplies Grid* ▪ Breast Implant and Tissue Expansion (CPT codes 19340, 19342, and 19357) – Medicare does not have an NCD for breast implant and tissue expansion – LCDs/(LCAs) exist and compliance with these policies is required where applicable; refer to the list of available *LCDs/LCAs for Breast Implant and Tissue Expansion* in the *Supporting Information* section of the policy – For states with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Coverage Determination Guideline titled *Breast Reconstruction Post Mastectomy and Poland Syndrome* for coverage guidelines ▪ Pneumatic compression devices are covered for the treatment of physical complications resulting from the mastectomy or lumpectomy, including lymphedema; refer to the Coverage Summary titled *Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), Nutritional Therapy and Medical Supplies Grid* ▪ Myocutaneous flaps (CPT codes 19361, 19364, 19366, 19367, 19368, and 19369) – Medicare does not have an NCD for myocutaneous flaps – LCDs/LCAs exist and compliance with these policies is required where applicable; refer to the list of available *LCDs/LCAs for Myocutaneous Flaps* in the *Supporting Information* section of the policy – For states with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Coverage Determination Guideline titled *Breast Reconstruction Post Mastectomy and Poland Syndrome* for coverage guidelines ○ Reconstructive services are not covered for members who have not had a medically necessary mastectomy or lumpectomy and who are requesting surgery only for the purpose of creating symmetrical breasts or other cosmetic purpose ▪ Program payment may not be made for breast reconstruction for cosmetic reasons ▪ Cosmetic surgery is excluded from coverage under *§1862(a)(10) of the Act*; refer to the NCD for *Breast Reconstruction Following Mastectomy (140.2)* ○ On July 24, 2019, the Food and Drug Administration (FDA) issued a safety communication related to the voluntary recall of certain Allergan BIOCELL textured breast implants and tissue expanders; for specific information, refer to the FDA communication at https://www.fda.gov/medical-devices/safety-communications/fda-requests-allergan-

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Cosmetic and Reconstructive Procedures (continued)	Aug. 3, 2022	voluntarily-recall-natrelle-biocell-textured-breast-implants-and-tissue ○ For guidelines on services related to and required as a result of services which are not covered under Medicare, refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Non-Covered Services (Including Services/Complicated Related to Non-Covered Services)* *Mastopexy (CPT code 19316)* ● Removed language addressing the FDA voluntary recall of certain Allergan BIOCELL textured breast implants and tissue expanders *Gender Dysphoria Treatment* ● Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Impotence Treatment*
Dental Services, Oral Surgery and Treatment of Temporomandibular Joint (TMJ)	Aug. 3, 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 following websites to search for applicable coverage policies: ○ Medicare Coverage Database ○ National Coverage NCD Report ○ Local Coverage Final LCDs Report ● Removed content/language addressing manipulation of the head
Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), Nutritional Therapy and Medical Supplies Grid	Aug. 3, 2022	Coverage Guidelines *Bras (Mastectomy)* and *Breast Prosthesis (External)* ● Added reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Cosmetic and Reconstructive Procedures* ● Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Breast Reconstruction Following Mastectomy* *Orthopedic Shoes*, *Shoes*, and *Toe Filler* ● Added reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Foot Care Services and Supportive Devices* ● Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Shoes and Foot Orthotics* *Penile Prosthesis* ● Added reference link to the National Coverage Determination (NCD) for *Diagnosis and Treatment of Impotence (230.4)* ● Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Impotence Treatment* *Vacuum Pump or Device (e.g., ErecAid)* ● Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled

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Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), Nutritional Therapy and Medical Supplies Grid (continued)	Aug. 3, 2022	*Impotence Treatment*) to indicate: ○ Vacuum erection devices and related accessories are statutorily non-covered based on the *Achieving a Better Life Experience (ABLE) Act of 2014* ○ Refer to the Durable Medicare Equipment (DME) Medicare Administrative Contractor (MAC) Local Coverage Determination (LCD) for *Vacuum Erection Devices (L34824)*
Foot Care Services and Supportive Devices	Aug. 3, 2022	**Title Change** ● Previously titled *Foot Care Services* **Coverage Guidelines** ● Added language to indicate: ○ Supportive devices (for feet) are only covered when Medicare coverage criteria are met ○ The guidelines in this Coverage Summary are for specific procedures only; for procedures not addressed in this Coverage Summary, refer to the following websites to search for applicable coverage policies: ▪ Medicare Coverage Database ▪ National Coverage NCD Report ▪ Local Coverage Final LCDs Report ● Removed content/language addressing: ○ Diabetic sensory neuropathy with loss of protective sensation ○ Consultation services rendered by a podiatrist in a skilled nursing facility ***Supportive Devices for Feet*** ● Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Shoes and Foot Orthotics*) to indicate: **Orthopedic Shoe** ○ Orthopedic shoes are covered only if an integral part of a covered leg brace, including shoe inserts, heel/sole replacements, or shoe modification, when medically necessary for the proper functioning of the brace ○ Orthopedic shoes for subluxations of the foot are not covered **Therapeutic Shoe** ○ Therapeutic shoes, along with inserts, are covered for diabetics when the following criteria are met: ▪ The shoes must be prescribed, fitted, and furnished by a podiatrist or other qualified individual (e.g., a

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Foot Care Services and Supportive Devices (continued)	Aug. 3, 2022	pedorthist, orthotist or prosthetist) ▪ The shoes must meet this policy's definition for depth or custom-molded shoes: – Custom-molded shoes are shoes that are constructed over a positive model of the member's foot; made from leather or other suitable material of equal quality, have removable inserts that can be altered or replaced as the member's condition warrants; and have some form of shoe closure – Depth shoes are shoes that have a full-length heel-to-toe filler that, when removed, provides a minimum of 3/16 inch of additional depth used to accommodate custom molded or customized inserts, are made of leather or other suitable material of equal quality, have some form of foot closure, and are available in full and half sizes with a minimum of 3 widths so that the sole is graded to the size and width of the upper portions of the shoes according to the American standard last sizing schedule (the numerical shoe sizing system used for shoes sold in the United States or its equivalent) ○ The managing physician who is responsible for diagnosing and treating the member's systemic condition must do all the following: ▪ Document in the medical record that the member has diabetes ▪ Certify that the member is being treated under a comprehensive plan of care for his/her diabetes ▪ Certify that the member needs therapeutic shoes ▪ Document in the member's record that the member has one or more of the following conditions: – Peripheral neuropathy with the evidence of callus formation – History of previous ulceration – History or pre-ulcerative calluses – Foot deformity – Previous amputation of the foot or part of the foot – Poor Circulation Inserts ○ Inserts may be covered and dispensed independently of diabetic shoes if the supplier of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed; this footwear must meet the definitions found [in the policy] above for depth shoes and custom-molded shoes ○ Inserts are total contact, multiple density, removable inlays that are directly molded to the patient's foot or a model of the patient's foot or directly carved from a patient-specific, rectified electronic model and that are made of suitable material with regard to the patient's condition Substitution of Modifications for Inserts ○ An individual may substitute modification(s) of custom-molded or depth shoes instead of obtaining a pair of inserts in any combination

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Foot Care Services and Supportive Devices (continued)	Aug. 3, 2022	○ Payment for the modification(s) may not exceed the limit set for the inserts for which the individual is entitled; examples include but are not limited to: ▪ Rigid rocker bottoms ▪ Roller bottoms (sole or bar) ▪ Metatarsals bars ▪ Wedges (posting) ▪ Offset heels ▪ Flared heels, ▪ Velcro closures ▪ Inserts for missing toes Limitations ○ For each individual, coverage of the footwear and inserts is limited to one of the following within one calendar year: ▪ No more than one (1) pair of custom-molded shoes (which includes inserts provided with the shoes) and two (2) additional pairs of inserts ▪ No more than one (1) pair of depth shoes and three (3) pairs of inserts (not including the non-customized removal inserts provided with such shoes) ○ Notes: ▪ A pair of therapeutic shoes is covered even if only one foot suffers from diabetic foot disease (each shoe is equally equipped so that the affected limb, as well as the remaining limb, is protected) ▪ Therapeutic shoes for diabetics are not durable medical equipment (DME) and are not considered DME nor orthotics, but a separate category of coverage under Part B ▪ In situations in which an individual qualifies for both diabetic shoes and a leg brace, these items are covered separately ○ Refer to the *Medicare Benefit Policy Manual, Chapter 15, §140 - Therapeutic Shoes for Individuals with Diabetes* ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable; refer to the Durable Medicare Equipment (DME) Medicare Administrative Contractor (MAC) MAC LCD for *Therapeutic Shoes for Persons with Diabetes (L33369)* *Non-Covered Services* • Removed reference link to the National Coverage Determination (NCD) for *Vitamin B12 Injection to Strengthen Tendons, Ligaments, etc., of the Foot (150.6)*

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Laboratory Tests and Services	Aug. 3, 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 following websites to search for applicable coverage policies:
		  ○ Medicare Coverage Database
		  ○ National Coverage NCD Report
		  ○ Local Coverage Final LCDs Report
		• Removed content/language addressing:
		  ○ HIV serologic testing
		  ○ Sweat test for diagnosis of cystic fibrosis
		  ○ Obsolete and unreliable diagnostic tests
		  ○ Hair analysis
		  ○ Cytotoxic food tests
		  ○ Heartsbreath Test for heart transplant rejection
		Covered Clinical Diagnostic Laboratory Tests and Services
		• Removed list of examples of covered clinical diagnostic laboratory tests and services (duplicative to information provided in the *Lab National Coverage Determinations Alphabetical Index*)

Medications/Drugs (Outpatient/Part B)	Aug. 3, 2022	Related Policies
		• Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Coverage of Drugs and Biologicals for Label and Off-Label Uses*
		Coverage Guidelines
		Medications Covered Under Part B
		Drugs for Chelation Therapy for the Treatment of Heavy Metal Toxicity and Non-Overload Conditions
		• Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Chelation Therapy*) to indicate:
		  ○ Medicare does not have a National Coverage Determination (NCD) for chelation therapy for lead poisoning
		  ○ 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 *Chelation Therapy for Non-Overload Conditions*
		Medications/Drugs Not Covered
		Medications for the Treatment of Sexual Dysfunction
		• Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Impotence Treatment*) to indicate:

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Medications/Drugs (Outpatient/Part B) (continued)	Aug. 3, 2022	○ Erectile dysfunction (ED) drugs will meet the definition of a Part D drug when prescribed for medically accepted indications approved by the Federal Drug Administration (FDA) other than sexual or erectile dysfunction (such as pulmonary hypertension) ○ ED drugs will not meet the definition of a Part D drug when used off-label, even when the off-label use is listed in one of the compendia found in section *1927(g)(1)(B)(i) of the Act: American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information* (or its successor publications), and *DRUGDEX® Information System* ○ Refer to the *Medicare Prescription Drug Benefit Manual, Chapter 6, Section 20.1 – Excluded Categories* *Other Examples of Specific Drugs/Medication* Antiemetics (Oral) for Oncology ● Updated list of applicable drugs/medications: ○ Added: ▪ Kytril® (granisetron) tablet ▪ Varubi® (rolapitant) tablet ○ Removed/relocated: ▪ Aloxi® (palonosetron hydrochloride) ▪ Cinvanti® (aprepitant) ▪ Sustol® (granisetron) ○ Replaced: ▪ "Akynzeo® (netupitant and palonosetron)" with Akynzeo® (netupitant and palonosetron) *capsule*" ▪ "Emend® (aprepitant)" with Emend® (aprepitant) *capsule*" ▪ "Zofran® (ondansetron)" with "Zofran® (ondansetron) *tablet*" ● Revised language to indicate Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable ● Removed default guidelines for states with no LCDs/LCAs ● Removed step therapy requirement Antiemetics (Injectable) for Oncology ● Added list of applicable drugs/medications: ○ Neurokinin 1 Receptor Antagonist (NK1 RA) ○ 5-hydroxytryptamine Receptor Antagonist (5HT3 RA), NK1 RA/5HT3 RA combination ○ Akynzeo® (netupitant and palonosetron) injection ○ Aloxi® (palonosetron hydrochloride) injection ○ Cinvanti® (aprepitant) injectable emulsion

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Medications/Drugs (Outpatient/Part B) (continued)	Aug. 3, 2022	○ Emend® (aprepitant) injection ○ Kytril® (granisetron) injection ○ Sustol® (granisetron) injection ○ Zuplenz ○ Zofran ODT® ○ Zofran® (ondansetron) injection ● Added instruction to refer to the UnitedHealthcare Commercial Medical Benefit Drug policy titled *Antiemetics for Oncology* for states with no LCDs/LCAs ● Added step therapy requirement; refer to the UnitedHealthcare Medicare Advantage Medical Benefit Drug Policy titled *Medicare Part B Step Therapy Programs* **Skyrizi® (Risankizumab-Rzaa)** ● Added language to indicate Review at Launch (RAL) guidelines apply **Supporting Information** ● Updated list of available LCDs/LCAs to reflect the most current reference links
Neurologic Services and Procedures	Aug. 3, 2022	**Related Policies** ● Added reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Evoked Response Tests (NCD160.10)* **Coverage Guidelines** ● Added language to indicate: ○ Neurophysiological studies and neuropsychological testing are covered when Medicare coverage criteria are met ○ The guidelines in this Coverage Summary are for specific procedures only; for procedures not addressed in this Coverage Summary, refer to the following websites to search for applicable coverage policies: ▪ Medicare Coverage Database ▪ National Coverage NCD Report ▪ Local Coverage Final LCDs Report ● Removed content/language addressing: ○ Surgically induced nerve track ○ Multiple-seizure electroconvulsive therapy ○ Invasive intracranial pressure monitoring ○ Stereotaxic depth electrode implantation ○ Electroencephalographic (EEG) monitoring ○ Sensory nerve conduction threshold tests (sNCTs) ○ Electromyography (EMG) and nerve conduction studies

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Neurologic Services and Procedures (continued)	Aug. 3, 2022	○ Evoked response tests *Neurophysiological Studies* Intraoperative Neurophysiology Monitoring • Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Neurophysiological Studies*) to indicate: ○ Medicare does not have a National Coverage Determination (NCD) for intraoperative neurophysiology monitoring ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable; refer to the list of available *LCDs/LCAs for Intraoperative Neurophysiology Monitoring* in the *Supporting Information* section of the policy ○ For coverage guidelines for states/territories with no LCDs/LCAs, refer to the Wisconsin Physicians LCD for *Intraoperative Neurophysiological Testing (L34623)* *Neuropsychological Testing* • Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Neuropsychological Testing*) to indicate: ○ Medicare does not have a NCD for neuropsychological testing ○ LCDs/LCAs exist and compliance with these policies is required where applicable; refer to the list of available *LCDs/LCAs for Neuropsychological Testing* in the *Supporting Information* section of the policy
Obesity: Treatment of Obesity, Non-Surgical and Surgical (Bariatric Surgery)	Aug. 3, 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 following websites to search for applicable coverage policies: ○ Medicare Coverage Database ○ National Coverage NCD Report ○ Local Coverage Final LCDs Report *Non-Surgical Services* • Removed language addressing supplemental fasting (refer to the section titled *Non-Covered Services*) *Non-Covered Services* • Revised list of examples of non-covered services; added “supplemental fasting as a general treatment for obesity”
Oxygen for Home Use	Aug. 3, 2022	Coverage Guidelines *Coverage Criteria for Oxygen and Oxygen Equipment* • Added language to indicate: ○ Effective Jul. 8, 2022, the Medicare Administrative Contractor (MAC) may determine reasonable and necessary coverage of oxygen therapy and oxygen equipment in the home for patients who are not described in section B or

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Oxygen for Home Use (continued)	Aug. 3, 2022	precluded by section C of the National Coverage Determination (NCD) for *Home Use of Oxygen (NCD 240.2)* ○ Initial coverage for patients with other conditions may be limited to the shorter of 90 days or the number of days included in the practitioner prescription at MAC discretion ○ Oxygen coverage may be renewed if deemed medically necessary by the MAC ○ The final NCD and decision memo can be accessed at https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=n&NCAId=307 *Portable Oxygen System* ● Removed language pertaining to the Centers for Medicare & Medicaid (CMS) final decision memo modifying the NCD for *Home Use of Oxygen (240.2)* *Home Oxygen Use to Treat Cluster Headaches (CH)* ● Removed language pertaining to dates of service prior to Sep. 26, 2021
Prostate Services and Procedures and Impotence Treatment	Aug. 3, 2022	Title Change ● Previously titled *Prostate Services and Procedures* Coverage Guidelines ● Added language to indicate treatment of impotency may be covered when Medicare criteria are met *Impotence Related Prosthetics and Devices* ● Added instruction to refer to the Coverage Summary titled *Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), Nutritional Therapy and Medical Supplies Grid* *Nerve Graft to Restore Erectile Function During Radical Prostatectomy* ● Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Impotence Treatment*) to indicate: ○ Medicare does not have a National Coverage Determination (NCD) for nerve graft to restore erectile function during radical prostatectomy ○ 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 *Nerve Graft to Restore Erectile Function During Radical Prostatectomy*
Respiratory Therapy, Pulmonary Rehabilitation and Pulmonary Services	Aug. 3, 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 following websites to search for applicable coverage policies: ○ Medicare Coverage Database ○ National Coverage NCD Report ○ Local Coverage Final LCDs Report

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Respiratory Therapy, Pulmonary Rehabilitation and Pulmonary Services (continued)	Aug. 3, 2022	• Removed content/language addressing:
		  ○ Postural drainage and pulmonary exercises
		  ○ Heat treatment including the use of diathermy and ultrasound for pulmonary conditions

Vision Services, Therapy and Rehabilitation	Aug. 3, 2022	**Related Policies**
		• Removed reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled:
		  ○ *Phaco-Emulsification Procedure – Cataract Extraction (NCD 80.10)*
		  ○ *Refractive Keratoplasty (NCD 80.7)*
		  ○ *Retinal Prosthesis*
		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 following websites to search for applicable coverage policies:
		  ○ Medicare Coverage Database
		  ○ National Coverage NCD Report
		  ○ Local Coverage Final LCDs Report
		• Removed content/language addressing:
		  ○ Verteporfin
		  ○ Keratoplasty/LASIK procedure
		  ○ Endothelial cell photography
		  ○ Phaco-emulsification procedure
		Retinal Prosthesis (CPT code 0100T)
		• Revised language to indicate Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist; for coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes*

Replaced

Policy Title	Approval Date	Summary of Changes
Breast Reconstruction Following Mastectomy	Aug. 3, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Cosmetic and Reconstructive Procedures*
Chelation Therapy	Aug. 3, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Medications/Drugs (Outpatient/Part B)*

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Impotence Treatment	Aug. 3, 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* ○ *Medications/Drugs (Outpatient/Part B)* ○ *Prostate Services and Procedures and Impotence Treatment*
Neurophysiological Studies	Aug. 3, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Neurologic Services and Procedures*
Neuropsychological Testing	Aug. 3, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Neurologic Services and Procedures*
Shoes and Foot Orthotics	Aug. 3, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Foot Care Services and Supportive Devices*
Ventricular Assist Device (VAD) and Artificial Heart	Aug. 3, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Cardiac Procedures: Pacemakers, Pulmonary Artery Pressure Measurements and Ventricular Assistive Devices*

General Information

This bulletin provides a list of new, updated, revised, replaced and/or retired UnitedHealthcare Medicare Advantage Policy Guidelines to reflect the most current clinical coverage rules and guidelines developed by the Centers for Medicare & Medicaid Services (CMS). The inclusion of a health service (e.g., test, drug, device or procedure) in this bulletin indicates only that UnitedHealthcare has recently adopted a new policy and/or updated, revised, replaced or retired an existing policy; it does not imply that UnitedHealthcare provides coverage for the health service. In the event of an inconsistency or conflict between the information provided in this bulletin and the posted policy, the provisions of the posted policy will prevail. Note that most benefit plan documents exclude from benefit coverage health services identified as investigational or unproven/not medically necessary. Physicians and other health care professionals may not seek or collect payment from a member for services not covered by the applicable benefit plan unless first obtaining the member's written consent, acknowledging that the service is not covered by the benefit plan and that they will be billed directly for the service.

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 Policy Guideline updates. When information in this bulletin conflicts with applicable state and/or federal law, UnitedHealthcare follows such applicable federal and/or state law.

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

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.

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