UnitedHealthcare Medicare Advantage

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Coverage Summary Update Bulletin: September 2023

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Coverage Summary Updates

Updated		
Policy Title	**Approval Date**	**Summary of Changes**
Cosmetic and Reconstructive Procedures	Aug. 9, 2023	**Coverage Guidelines** ***Breast Reconstruction Following Mastectomy*** • Added reference link to the *Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage, §180 – Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare* • Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Non-Covered Services (Including Services/Complications Related to Non-Covered Services)*
Genetic Testing	Aug. 9, 2023	**Coverage Guidelines** ***Other Molecular Diagnostic Genetic Tests*** Pharmacogenomic Testing for Warfarin Response (CYP2C9 and VKORC1) (CPT Codes G9143, 81227, and 81355) • Added reference link to the *Medicare Managed Care Manual, Chapter 4, §10.7.3 – Payment for Clinical Studies Approved Under Coverage with Evidence Development (CED)* • Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Experimental Procedures and Items, Investigational Devices and Clinical Trials*
Laboratory Tests and Services	Aug. 9, 2023	**Coverage Guidelines** ***Non-Covered Laboratory Tests and Services*** • Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Preventive Health Services and Procedures*

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Cardiac Procedures: Pacemakers, Pulmonary Artery Pressure Measurements, Ventricular Assistive Devices, Valve Repair, and Valve Replacements	Aug. 9, 2023	**Coverage Guidelines** ***Leadless Pacemakers (CPT Codes 33274 and 33275)*** • Added reference link to the *Medicare Managed Care Manual, Chapter 4, §10.7.3 – Payment for Clinical Studies Approved Under Coverage with Evidence Development (CED)* • Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Experimental Procedures and Items, Investigational Devices, and Clinical Trials* **Valve Repairs and Replacements** ***Percutaneous Left Atrial Appendage (LAA) Closure Therapy (CPT Code 33340), Transcatheter Edge-to-Edge Repair (TEER) for Mitral Valve Regurgitation (CPT Codes 0345T, 33418, and 33419), and Transcatheter Aortic Valve Replacement (TAVR) (CPT Codes 33361, 33362, 33363, 33364, 33365, 33366,***

<table>
<tr><th colspan="3">Revised</th></tr>
<tr><th>Policy Title</th><th>Approval Date</th><th>Summary of Changes</th></tr>
<tr><td>Cardiac Procedures: Pacemakers, Pulmonary Artery Pressure Measurements, Ventricular Assistive Devices, Valve Repair, and Valve Replacements (continued)</td><td>Aug. 9, 2023</td><td>33367, 33368, and 33369)
Added reference link to the Medicare Managed Care Manual, Chapter 4, §10.7.3 – Payment for Clinical Studies Approved Under Coverage with Evidence Development (CED)
Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled Experimental Procedures and Items, Investigational Devices, and Clinical Trials</td></tr>
<tr><td>Complementary, Alternative Medicine, and Chiropractic Services</td><td>Aug. 9, 2023</td><td>Title Change
Previously titled Complementary and Alternative Medicine
Coverage Guidelines
Non-Covered Complementary and Alternative Therapies
Removed language indicating Medicare does not have a National Coverage Determination (NCD) for the examples of complementary and alternative medicine listed [in the policy] and there are no available Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) at this time
Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled Mental Health Services and Procedures
Chiropractic Services
Added language to indicate chiropractic services are covered when Medicare coverage criteria are met
Depending on the member's plan, members may have additional chiropractic benefit; refer to the member's Evidence of Coverage (EOC)/Summary of Benefits (SB) to determine coverage eligibility for additional chiropractic benefit
If member has the additional benefit (routine benefit, not Medicare-covered), contact Optum Health Physical Health (OHPH) at 866-785-1654; for California members, contact 800-428-6337 (depending on the member's plan and state, some Medicare covered chiropractic benefits are also handled by OHPH)
Manual Manipulation
Added language to indicate:
Coverage of chiropractic service is specifically limited to treatment of the spine to correct subluxation by means of manual manipulation, i.e., by use of the hands
Additionally, manual devices (i.e., those that are hand-held with the thrust of the force of the device being</td></tr>
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Complementary, Alternative Medicine, and Chiropractic Services (continued)	Aug. 9, 2023	controlled manually) may be used by chiropractors in performing manual manipulation of the spine; however, no additional payment is available for use of the device, nor does Medicare recognize an extra charge for the device itself ○ All other services furnished or ordered by chiropractors are not covered; examples include but are not limited to: ▪ X-rays ▪ Office physical and examination or other diagnostic tests furnished by or ordered by a chiropractor **Subluxation** • Added language to indicate: ○ Subluxation is defined as a motion segment in which alignment, movement integrity and/or physiological function of the spine are altered, although contact between joint surfaces remains intact ○ To demonstrate a subluxation based on physical examination, two of the four criteria mentioned [in the policy] under physical examination are required, one of which must be asymmetry/misalignment or range of motion abnormality **Maintenance Therapy** • Added language to indicate: ○ Maintenance therapy is a treatment plan that seeks to prevent disease, promote health, and prolong, and enhance the quality of life, or maintain, or prevent deterioration of a chronic condition; when further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy ○ Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulation treatment is considered maintenance therapy and is not covered **Dynamic Thrust** • Added language to indicate: ○ Dynamic thrust is the therapeutic force or maneuver delivered by the practitioner during manipulation in the anatomic region of involvement ○ Refer to the *Medicare Benefit Policy Manual*: ▪ *Chapter 15, §30.5 – Chiropractor's Services* ▪ *Chapter 15, §240 – Chiropractic Services – General* ○ LCDs/LCAs exist and compliance with these policies is required where applicable

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Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), Nutritional Therapy, and Medical Supplies Grid	Aug. 9, 2023	**Coverage Guidelines** • Removed reference link to the UnitedHealthcare Medicare Advantage Coverage summary titled *Durable Medical Equipment, Prosthetics, Corrective Appliances/Orthotics, and Medical Supplies* • Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), and Medical Supplies*) to indicate: ***DME Rental or Purchase*** ○ DME may be rented or purchased and must meet all of the following criteria: ▪ The equipment meets the definition of DME (refer to the *Definitions* section of the policy) ▪ The equipment is necessary and reasonable for the treatment of the member's illness or injury or to improve the functioning of his/her malformed body member ▪ The equipment is used in the Member's Home (refer to the *Definitions* section of the policy) ○ For payment rules for capped-rental DME, refer to the *42 CFR Title 42, Chapter IV, §414.229 Other Durable Medical Equipment – Capped Rental* ○ Refer to the *Medicare Benefit Policy Manual, Chapter 15, §110 – Durable Medical Equipment – General* ***Prosthetic and Corrective Appliances/Orthotics*** ○ Prosthetic Devices and corrective appliances/orthotics must meet all of the following criteria: ▪ The item meets the definition of prosthetic or corrective appliances/orthotics (refer to the *Definitions* section of the policy) ▪ The item is furnished on a physician's order ○ Refer to the *Medicare Benefit Policy Manual, Chapter 15, §120 – Prosthetic Devices* ***Supplies for DME Items, Prosthetic Devices, and Corrective Appliances*** ○ Supplies for DME items, Prosthetic Devices, and corrective appliances (e.g., oxygen, batteries for an artificial larynx) are covered only when they are necessary for the effective use of the item/device; for specific coverage guidelines; refer to the *Medicare Benefit Policy Manual, Chapter 15, §110.3 – Coverage of Supplies and Accessories* ***Repairs, Maintenance, and Replacement*** Durable Medical Equipment ○ Repairs, maintenance, and replacement of medically required DME are covered when criteria are met; for coverage guidelines, refer to the *Medicare Benefit Policy Manual, Chapter 15, §110.2 – Repairs, Replacement, and Maintenance and Delivery* Prosthetic Devices

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<tr><td>Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), Nutritional Therapy, and Medical Supplies Grid
(continued)</td><td>Aug. 9, 2023</td><td>
Payment may be made for the replacement of a Prosthetic Device that is an artificial limb, or replacement part of a device, if the ordering physician determines that the replacement device or part is necessary because of any of the following:
A change in the physiological condition of the patient;
An irreparable change in the condition of the device, or in a part of the device; or
The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced
Refer to the Medicare Benefit Policy Manual, Chapter 15, §120 – Prosthetic Devices
Corrective Appliances
Adjustment of corrective appliances are covered when required by wear or a change in the patient's condition and ordered by a physician; refer to the Medicare Benefit Policy Manual, Chapter 15, §130 – Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes
Medical Supplies
Medical supplies are covered only when they are incident to a physician's professional services or authorized home health services and are furnished as an integral, although incidental, part of those services in the course of diagnosis or treatment of an injury or illness; refer to the Medicare Benefit Policy, Manual, Chapter 15, §60.1 – Incident to Physician's Professional Services
Medical supplies are expendable items required for care related to a medical illness or dysfunction; refer to the Medicare Benefit Policy Manual, Chapter 15, §110.1 – Definition of Durable Medical Equipment
Medical supplies may not be billed as Implantable Devices (refer to Definitions section of the policy)
For additional coverage guidelines, refer to the Medicare Benefit Policy Manual, Chapter 15, §110 – §130
For general instructions on billing and claims processing, refer to the Medicare Claims Processing Manual, Chapter 20 – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
DME, Prosthetic, Corrective Appliance/Orthotic and Medical Supplies Grid
Face Masks – Oxygen
Added instruction to refer to the:
National Coverage Determination (NCD) for Home Use of Oxygen (NCD 240.2) for coverage criteria
Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Local Coverage Determination (LCD) for Oxygen and Oxygen Equipment (L33797)
Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled Oxygen for Home Use
Humidifiers – For Use with Oxygen System
Added instruction to refer to the:
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Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), Nutritional Therapy, and Medical Supplies Grid (continued)	Aug. 9, 2023	○ NCD for *Home Use of Oxygen (NCD 240.2)* for coverage criteria ○ DME MAC LCD for *Oxygen and Oxygen Equipment (L33797)* • Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Oxygen for Home Use* ***Mobility Assistive Equipment (MAE)*** Power Mobility Device (PMDs) • Removed language indicating: ○ A seat elevator is a statutorily non-covered option on a Group 2 power wheelchair ○ If a power wheelchair (PWC) with a seat elevator (K0830, K0831) is provided, it will be denied as non-covered • Removed reference link to the DME MAC LCD for *Power Mobility Devices (L33789)* ***Orthopedic Shoes*** • Added language to indicate: ○ Coverage criteria apply ○ LCDs/LCAs exist and compliance with these policies is required where applicable ○ Refer to the: ▪ *Medicare Benefit Policy Manual, Chapter 15, §140 - Therapeutic Shoes for Individuals with Diabetes* ▪ *Medicare Benefit Policy Manual, Chapter 15, § 290 – Foot Care* ▪ DME MAC LCD for *Therapeutic Shoes for Persons with Diabetes (L33369)* • Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Foot Care Services and Supportive Devices* ***Oxygen and Oxygen Equipment*** • Added instruction to refer to the: ○ NCD for *Home Use of Oxygen (NCD 240.2)* for coverage criteria ○ DME MAC Local Coverage Determination (LCD) for *Oxygen and Oxygen Equipment (L33797)* • Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Oxygen for Home Use* ***Pumps – Infusion*** • Added language to indicate: ○ Coverage criteria apply ○ LCDs/LCAs exist and compliance with these policies is required where applicable ○ Refer to the: ▪ NCD for *Infusion Pumps (NCD 280.14)* ▪ DME MAC LCD for *External Infusion Pumps (L33794)* • Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Infusion Pump*

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

Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), Nutritional Therapy, and Medical Supplies Grid
(continued)
	Aug. 9, 2023	*Therapy*
		Insulin – Implantable
		• Added language to indicate:
		  ○ LCDs/LCAs exist and compliance with these policies is required where applicable
		  ○ Refer to the NCD for *Infusion Pumps (NCD 280.14)*
		• Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Infusion Pump Therapy*
		Shoes
		• Added language to indicate:
		  ○ Coverage criteria apply
		  ○ LCDs/LCAs exist and compliance with these policies is required where applicable
		  ○ Refer to the:
		    ▪ *Medicare Benefit Policy Manual, Chapter 15, §140 – Therapeutic Shoes for Individuals with Diabetes*
		    ▪ *Medicare Benefit Policy Manual, Chapter 15, § 290 – Foot Care*
		    ▪ DME MAC LCD for *Therapeutic Shoes for Persons with Diabetes (L33369)*
		• Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Foot Care Services and Supportive Devices*
		Toe Filler
		• Added language to indicate:
		  ○ LCDs/LCAs exist and compliance with these policies is required where applicable
		  ○ Refer to the *Medicare Benefit Policy Manual, Chapter 15, § 290 – Foot Care*
		• Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Foot Care Services and Supportive Devices*
		Traction Equipment
		Power Traction Equipment/Devices
		• Added instruction to refer to the:
		  ○ NCD for *Vertebral Axial Decompression (VAX-D)*
		  ○ *Medicare Benefit Policy Manual:*
		    ▪ *Chapter 16, §10 – General Exclusions from Coverage*
		    ▪ *Chapter 16, §20 – Services Not Reasonable and Necessary*
		Wheelchairs
		Seat Elevator for Power Wheelchair (PWC)

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<tr><td>Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), Nutritional Therapy, and Medical Supplies Grid
(continued)</td><td>Aug. 9, 2023</td><td>• Revised language to indicate:
  ○ Seat elevators for power wheelchairs are now covered as DME and covered
  ○ Coverage criteria apply for Group 2 power wheelchair with power options that can accommodate rehabilitative features (for example, tilt in space) or Group 3 power wheelchair
• Added reference link to the NCD for Seat Elevation Equipment (Power Operated) on Power Wheelchairs (NCD 280.16)
Definitions
• Added definition of (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), and Medical Supplies):
  ○ Corrective Appliances/Orthotic
  ○ Durable Medical Equipment (DME)
  ○ Implantable Devices
  ○ Member's Home
  ○ Prosthetic Device</td></tr>
<tr><td>Home Health Services, Home Health Visits, Respite Care, and Hospice Care</td><td>Aug. 9, 2023</td><td>Title Change
• Previously titled Home Health Services, Home Health Visits, and Respite Care
Coverage Guidelines
• Removed language pertaining to COVID-19 Public Health Emergency (PHE) Waivers and Flexibilities
Home Health Services
Respite Care
• Removed link to the UnitedHealthcare Medicare Advantage Coverage Summary titled Hospice Services
Hospice Services
• Added language to indicate:
  ○ Hospice is covered by Original Medicare under Part A for members who elect to receive hospice care; refer to the:
    ▪ Medicare Claims Processing Manual, Chapter 11– Processing Hospice Claims
    ▪ Medicare Managed Care Manual, Chapter 4, §10.2 – Basic Rule and §10.4 – Hospice Coverage
  ○ For Medicare detailed coverage guidelines for hospice services, refer to the Medicare Benefit Policy Manual, Chapter 9 – Coverage of Hospice Services under Hospital Insurance</td></tr>
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<tr><td>Medications/Drugs (Outpatient/Part B)</td><td>Aug. 9, 2023</td><td>
Coverage Guidelines
Unlabeled Use of a Part B Drug

Added instruction (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled Chemotherapy, and Associated Drugs and Treatments) to refer to the Medicare Benefit Policy Manual, Chapter 15, §50.4.5 – Off-Label Use of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen
Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled Chemotherapy and Associated Drugs and Treatments

Medications/Drugs Covered Under Part B
Oral Anti-Cancer Drugs and Oral Anti-Emetics

Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled Chemotherapy, and Associated Drugs and Treatments) to indicate:

For detailed coverage requirements, refer to the Medicare Benefit Policy Manual, Chapter 15, §50.5.3 Oral Anti-Cancer Drugs
For claims payment and coding information, refer to the Medicare Claims Processing Manual, Chapter 17, §80.1 Oral Cancer Drugs
Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable
Members may have additional coverage for oral anti-cancer under the Part D Prescription Drug Plan, which are not covered in this Coverage Summary; refer to the member's pharmacy booklet or contact the Prescription Solutions customer service department to determine coverage eligibility for prescription drug plan benefit

Immunizations

Added instruction (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled Preventive Health Services and Procedures) to refer to the Medicare Benefit Policy Manual, Chapter 15, §50.4.4.2 – Immunizations
Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled Preventive Health Services and Procedures

Antigens/Antihistamines

Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled Allergy Testing and Allergy Immunotherapy) to indicate:

Refer to the Medicare Benefit Policy Manual:

Chapter 12, §200 – Allergy Testing and Immunotherapy
Chapter 15, §20.2 – Physician Expense for Allergy Treatment

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Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Medications/Drugs (Outpatient/Part B) (continued)	Aug. 9, 2023	▪ *Chapter 15, §50.2 – Determining Self-Administration of Drug or Biological* ▪ *Chapter 15, §50.4.4.1 – Antigens* ○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable ***Medications/Drugs Not Covered*** Investigational or Experimental Drugs • Added instruction (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Experimental Procedures and Items, Investigational Devices and Clinical Trials*) to refer to the *Medical Benefit Policy Manual, Chapter 15, §50.4.3 – Examples of Not Reasonable and Necessary* • Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Experimental Procedures and Items, Investigational Devices and Clinical Trials* ***Other Specific Medications (Not Listed in the Policy)*** • Removed instruction to refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Chemotherapy and Associated Drugs and Treatments* for information on chemotherapy drugs ***Other Examples of Specific Drugs/Medications*** • Revised coverage guidelines for **Aduhelm™ (Aducanumab-Avwa) and Leqembi™ (Lecanemab)**; added instruction to refer to the *Medicare Managed Care Manual, Chapter 4, §10.7.3 – Payment for Clinical Studies Approved Under Coverage with Evidence Development (CED)*
Neurologic Services and Procedures	Aug. 9, 2023	**Coverage Guidelines** ***Neurologic Services and Procedures*** Vagus Nerve Stimulation for Treatment of Seizures • Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Mental Health Services and Procedures*) to indicate: ○ The Centers for Medicare and Medicaid Services (CMS) covers FDA approved vagus nerve stimulation (VNS) devices for treatment resistant depression (TRD) through Coverage with Evidence Development (CED) ○ Approved CED studies are posted on the CMS Coverage with Evidence Development webpage at http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/index.html ○ For payment rules for National Coverage Determinations (NCDs) requiring CED, refer to the *Medicare Managed Care Manual, Chapter 4, §10.7.3 – Payment for Clinical Studies Approved Under Coverage with Evidence Development (CED)* • Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Mental Health Services and Procedures*

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Policy Title	**Approval Date**	**Summary of Changes**
Obesity: Treatment of Obesity, Non-Surgical, and Surgical (Bariatric Surgery)	Aug. 9, 2023	**Coverage Guidelines** ***Non-Surgical Services*** Intensive Behavioral Therapy • Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Preventive Health Services and Procedures*) to indicate Intensive Behavioral Therapy for Obesity is covered when criteria are met; refer to the *Medicare Preventive Services-Medicare Learning Network (MLN) Educational Tool* at https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html
Organ and Tissue Transplants	Aug. 9, 2023	**Coverage Guidelines** ***Stem Cell Transplantation and Bone Marrow Transplantation*** • Added instruction (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Experimental Procedures and Items, Investigational Devices, and Clinical Trials*) to refer to the *Medicare Managed Care Manual, Chapter 4, §10.7.3 – Payment for Clinical Studies Approved Under Coverage with Evidence Development (CED)* • Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Experimental Procedures and Items, Investigational Devices, and Clinical Trials*
Pain Management and Pain Rehabilitation	Aug. 9, 2023	**Coverage Guidelines** ***Infusion Pumps for Treatment of Intractable Cancer Pain*** • Added reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), Nutritional Therapy, and Medical Supplies Grid* • Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Infusion Pump Therapy* **Supporting Information** • Updated list of available Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) to reflect the most current information
Prostate Services and Procedures and Impotence Treatment	Aug. 9, 2023	**Coverage Guidelines** ***Prostate Cancer Screening*** • Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Preventive Health Services and Procedures*) to indicate prostate cancer screening is covered when coverage criteria is met; refer to the Medicare Preventive Services-MLN Educational Tool

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Radiologic Diagnostic Procedures	Aug. 9, 2023	**Coverage Guidelines** ***Bone (Mineral) Density Studies/Mass Measurements*** • Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Preventive Health Services and Procedures*) to indicate bone (mineral) density studies/mass measurements are covered when Medicare coverage criteria are met ○ Refer to the: ▪ National Coverage Determination (NCD) for *Bone (Mineral) Density Studies (NCD 150.3)* ▪ *Medicare Benefit Policy Manual, Chapter 15, §80.5 – Bone Mass Measurements (BMMs)* ▪ *Medicare Preventive Services-Medicare Learning Network (MLN) Educational Tool* at https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html ○ Local Coverage Determinations (LCDs/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable ***Magnetic Resonance Imaging (MRI)*** • Added instruction (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Experimental Procedures and Items, Investigational Devices, and Clinical Trials*) to refer to the *Medicare Managed Care Manual, Chapter 4, §10.7.3 – Payment for Clinical Studies Approved Under Coverage with Evidence Development (CED)* for payment rules for NCDs requiring CED • Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Experimental Procedures and Items, Investigational Devices and Clinical Trials* ***Proton Emission Tomography*** • Added language [previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Positron Emission Tomography (PET)/Combined PET-CT (Computed Tomography)*] to indicate: ○ Positron emission tomography (PET) (FDG) for oncologic conditions may be covered when criteria are met; refer to the NCD for *Positron Emission Tomography (FDG) for Oncologic Conditions (NCD 220.6.17)* ○ PET for other specific conditions may be covered when criteria are met; refer to the following NCDs: ▪ *PET for Perfusion of the Heart (NCD 220.6.1)* ▪ *FDG PET for Dementia and Neurodegenerative Diseases (NCD 220.6.13)* – The list of Medicare approved clinical trials is available at http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/FDG-PET-and-Other-Neuroimaging-Devices-for-Dementia.html – For payment rules for NCDs requiring CED, refer to the *Medicare Managed Care Manual, Chapter 4,*

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Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Radiologic Diagnostic Procedures (continued)	Aug. 9, 2023	*§10.7.3 – Payment for Clinical Studies Approved Under Coverage with Evidence Development (CED)* ▪ *FDG PET for Myocardial Viability (NCD 220.6.8)* ▪ *FDG PET for Refractory Seizures (NCD 220.6.9)* ▪ *Positron Emission Tomography (NaF-18) to Identify Bone Metastasis of Cancer (NCD 220.6.19)* ***Beta Amyloid Positron Emission Tomography in Dementia and Neurodegenerative Disease*** • Added language [previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Positron Emission Tomography (PET)/Combined PET-CT (Computed Tomography)*] to indicate: ○ One PET Aβ scan per patient will be covered through coverage with evidence development (CED), under *§1862(a)(1)(E) of the Act*, in clinical studies that meet the criteria as outlined in the NCD for *Beta Amyloid Positron Tomography in Dementia and Neurodegenerative Disease (NCD 220.6.20)* ○ The list of Medicare approved clinical trials is available at https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Amyloid-PET.html ○ For payment rules for NCDs requiring CED, refer to the *Medicare Managed Care Manual, Chapter 4, §10.7.3 – Payment for Clinical Studies Approved Under Coverage with Evidence Development (CED)* **Supporting Information** • Updated list of available Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) to reflect the most current information
Rehabilitation: Cardiac and Medical	Aug. 9, 2023	**Coverage Guidelines** • Removed language pertaining to COVID-19 Public Health Emergency (PHE) Waivers and Flexibilities ***Skilled Nursing Facility*** • Added language to indicate inpatient skilled nursing facility care (up to 100 days per benefit period) including room and board, skilled nursing care, and other customarily provided services in a Medicare certified skilled nursing facility bed are covered when coverage factors are met; refer to the Medicare Benefit Policy Manual, Chapter 8, §30 - Skilled Nursing Facility Level of Care – General for more detailed guideline and examples • Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Skilled Nursing Facility (SNF) Care and Exhaustion of SNF Benefits*
Reproductive Services: Infertility, Family Planning, and Maternity Care	Aug. 9, 2023	**Coverage Guidelines** ***Maternity Care*** • Removed reference link to the: ○ *Medicare Benefit Policy Manual, Chapter 15, §20.1-Physician Expense for Surgery, Childbirth, and Treatment for Infertility* ○ UnitedHealthcare Medicare Advantage Coverage Summary titled *Abortion*

Coverage Summary Updates

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

Reproductive Services: Infertility, Family Planning, and Maternity Care (continued)	Aug. 9, 2023	***Abortion***
		• Added language to indicate:
		  ○ Abortion is covered only under the following circumstances:
		    ▪ If the pregnancy is the result of an act of rape or incest; or
		    ▪ In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the woman in danger of death unless an abortion is performed
		    ▪ Refer to the National Coverage Determination (NCD) for *Abortion (NCD 140.1)*
		  ○ Health care associated with pregnancy termination, whether spontaneously or for therapeutic reasons (i.e., where the life of the mother would be endangered if the fetus were brought to term), is also covered; refer to the:
		    ▪ *Medicare Benefit Policy Manual, Chapter 1, §80 – Health Care Associated with Pregnancy and §90 – Termination of Pregnancy*
		    ▪ *Medicare Benefit Policy Manual, Chapter 15, §20.1 – Physician Expense, Surgery, Childbirth, and Treatment for Infertility*

Respiratory Services and Equipment	Aug. 9, 2023	**Title Change**
		• Previously titled *Respiratory Therapy, Pulmonary Rehabilitation and Pulmonary Services*
		Coverage Guidelines
		• Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Oxygen for Home Use*) to indicate home use of oxygen is covered when Medicare coverage criteria are met
		  Coverage Criteria for Oxygen and Oxygen Equipment
		  ○ Medicare coverage of home oxygen and oxygen equipment, under the durable medical equipment (DME) benefit, is considered reasonable and necessary only for patients with significant hypoxemia who meet the Medicare coverage criteria; for coverage criteria, refer to the:
		    ▪ National Coverage Determination (NCD) for *Home Use of Oxygen (NCD 240.2)*
		    ▪ Durable Medical Equipment (DME) Medicare administrative Contractor (MAC) Local Coverage Determination (LCD) for *Oxygen and Oxygen Equipment (L33797)*
		  ○ For other oxygen related equipment and supplies, 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*
		  Overnight Oximetry Studies
		  ○ Overnight sleep oximetry are covered when coverage criteria are met; refer to the DME MAC LCD for *Oxygen and Oxygen Equipment (L33797)*

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Respiratory Services and Equipment (continued)	Aug. 9, 2023	○ For oximetry studies related to sleep apnea, refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Sleep Apnea Diagnosis and Treatment* ***Portable Oxygen System*** ○ Portable oxygen system may be purchased for chronic use when patient is mobile within the home and the qualifying blood gas study was performed while rest (awake) or during exercise ▪ If the only qualifying blood gas study was performed during sleep, portable oxygen will be denied as not reasonable and necessary ▪ If a patient meets the above requirement, the portable oxygen system is usually paid for separately in addition to the stationary system – If a patient qualifies for additional payment for greater than 4 LPM of oxygen and also meets the requirements for portable oxygen, payment will be made for either the stationary system of oxygen (at higher allowance) or the portable system (at the standard fee schedule allowance for portable system), but not both – When a portable system is added to a stationary system or vice versa a need for blood gas study is not required – If a portable oxygen system is covered, the supplier must provide whatever quantity of oxygen the patient uses; Medicare's reimbursement is the same, regardless of the quantity of oxygen dispensed ▪ Refer to the DME MAC LCD for Oxygen and Oxygen Equipment (L33797) ○ Portable (preset) oxygen system is not covered; considered precautionary equipment; essentially not therapeutic in nature; refer to the National Coverage Determination (NCD) for *Durable Medical Equipment Reference List (NCD 280.1)* ***Emergency or Stand-by Oxygen*** ○ Emergency or stand-by oxygen tanks, concentrators and other oxygen systems for patients who are not regularly using oxygen are not covered and will be denied as not reasonable and necessary since they are precautionary and not therapeutic in nature; refer to the: ▪ DME MAC LCD for *Oxygen and Oxygen Equipment (L33797)* ▪ NCD for *Durable Medical Equipment Reference List (NCD 280.1)* ***Home Oxygen for Chronic Obstructive Pulmonary Disease (COPD)*** ○ The home use of oxygen is covered for those members with arterial oxygen partial pressure measurements from 56 to 65 mmHg or oxygen saturation at or above 89% who are enrolled subjects in clinical trials approved by CMS and sponsored by the National Heart, Lung, and Blood Institute [(NHLBI); CMS, 2006)]; the additional Group II criteria do not apply to these patients ▪ Refer to the NCD for *Home Use of Oxygen in Approved Clinical Trials (NCD 240.2.1)*

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Respiratory Services and Equipment (continued)	Aug. 9, 2023	▪ The list of Medicare approved clinical trials is available at http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Home-Oxygen-for-COPD.html ▪ For payment rules for NCDs requiring Coverage with Evidence (CED), refer to the *Medicare Managed Care Manual, Chapter 4, §10.7.3 – Payment for Clinical Studies Approved Under Coverage with Evidence Development (CED)* ***Home Oxygen Use to Treat Cluster Headaches (CH)*** ○ Home Oxygen Use to Treat Cluster Headaches is covered when coverage criteria are met; refer to the DME MAC LCD for *Oxygen and Oxygen Equipment (L33797)* ***Oxygen Services Furnished by an Airline*** ○ Oxygen services furnished by an airline to a member are non-covered; refer to the DME MAC LCA for *Oxygen and Oxygen Equipment – Policy Article (A52514)*
Sleep Apnea Diagnosis and Treatment	Aug. 9, 2023	**Coverage Guidelines** ***Coverage with Evidence Development (CED)*** • Added instruction (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Experimental Procedures and Items, Investigational Devices and Clinical Trials*) to refer to the *Medicare Managed Care Manual, Chapter 4, §10.7.3 – Payment for Clinical Studies Approved Under Coverage with Evidence Development (CED)* • Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Experimental Procedures and Items, Investigational Devices and Clinical Trials* **Supporting Information** • Updated list of available Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) to reflect the most current information
Spine Procedures	Aug. 9, 2023	**Coverage Guidelines** ***Interlaminar Lumbar Instrumented Fusion (ILIF) Utilizing an interspinous Process Fusion Device (e.g., coflex-F® Implant System) (CPT Code 22899)*** • Revised default guidelines for interlaminar lumbar instrumented fusion (ILIF), e.g., Coflex-F® implant system: ○ Added reference link to the UnitedHealthcare Commercial Medical Policy titled *Interspinous Fusion and Decompression Devices* ○ Removed reference link to the UnitedHealthcare Commercial Medical Policy titled *Spinal Fusion and Decompression* ***Decompression Procedure, Percutaneous, of Nucleus Pulposus (CPT Code 62287)***

Coverage Summary Updates

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

Spine Procedures (continued)	Aug. 9, 2023	• Revised default guidelines for decompression procedure, percutaneous, of nucleus pulposus:
		  ○ Added reference link to the UnitedHealthcare Commercial Medical Policy titled *Minimally Invasive Spine Surgery Procedures*
		  ○ Removed reference link to the UnitedHealthcare Commercial Medical Policy titled *Discogenic Pain Treatment*
		Percutaneous Image-Guided Lumbar Decompression (PILD)
		Non-Covered Indications
		• Added reference link to the *Medical Benefit Policy Manual, Chapter 15, §50.4.3 – Examples of Not Reasonable and Necessary*
		• Removed reference link to the Medicare Advantage Coverage Summary titled *Experimental Procedures and Items, Investigational Devices and Clinical Trials*
		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 pertaining to applicable Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) to indicate LCDs/LCAs exist [for some states/territories] and compliance with these policies is required where applicable
		• Added instruction to refer to the UnitedHealthcare Commercial Medical Policy titled *Percutaneous Vertebroplasty and Kyphoplasty* for coverage guidelines for states/territories with no Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs)
		Percutaneous Sacral Augmentation (Sacroplasty) (CPT Codes 0200T and 0201T)
		• Revised default guidelines for sacroplasty:
		  ○ Added reference link to the UnitedHealthcare Commercial Medical Policy titled *Minimally Invasive Spine Surgery Procedures*
		  ○ Removed reference link to the UnitedHealthcare Commercial Medical Policy titled *Spinal Fusion and Decompression*
		Percutaneous Minimally Invasive Fusion/Stabilization of the Sacroiliac Joint for the Treatment of Back Pain (CPT Code 27279)
		• Revised default guidelines for percutaneous minimally invasive fusion/stabilization of the sacroiliac joint for the treatment of back pain:
		  ○ Added reference link to the UnitedHealthcare Commercial Medical Policy titled *Sacroiliac Joint Interventions*
		  ○ Removed reference link to the Wisconsin Physicians Service Insurance Corporation (WPS) LCD for *Percutaneous Minimally Invasive Fusion/Stabilization of the Sacroiliac Joint for the Treatment of Back Pain (L36000)*

UnitedHealthcare Medicare Advantage

Coverage Summary Updates

Revised

Policy Title	Approval Date	Summary of Changes
Vision Services, Therapy, and Rehabilitation	Aug. 9, 2023	**Coverage Guidelines** ***Eye Examination*** • Added instruction (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Preventive Health Services and Procedures*) to refer to the *Medicare Claims Processing Manual, Chapter 18, §80 – Initial Preventive Physical Examination (IPPE)* • Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Preventive Health Services and Procedures* ***Glaucoma Screening*** • Added language (previously included in the UnitedHealthcare Medicare Advantage Coverage Summary titled *Preventive Health Services and Procedures*) to indicate: ○ Screening for glaucoma is defined to include (1) a dilated eye examination with an intraocular pressure measurement; and (2) a direct ophthalmoscopy examination, or a slit lamp biomicroscopic examination ○ Annual (once every 12 months) glaucoma screening is covered for members with diabetes mellitus or a family history of glaucoma, or African Americans age 50 and over, or Hispanic-Americans age 65 and older ○ Optometrist may perform a Medicare covered glaucoma screening if the service is within the scope of practice permitted by state licensure ○ Refer to the *Medicare Benefit Policy Manual, Chapter 15, §280.1 – Glaucoma Screening* **Supporting Information** • Updated list of available Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) to reflect the most current information

Replaced

Policy Title	Approval Date	Summary of Changes
Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), and Medical Supplies	Aug. 9, 2023	• Replaced policy; 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
Oxygen for Home Use	Aug. 9, 2023	• Replaced policy; refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled Respiratory Services and Equipment

Coverage Summary Updates

Retired

The following Coverage Summaries have been retired effective Aug. 9, 2023:

- Abortion
- Alcohol, Chemical and/or Substance Abuse: Detoxification and Rehabilitation
- Allergy Testing and Allergy Immunotherapy
- Change in Membership Status while Hospitalized (Acute, LTC and SNF) or Receiving Home Health
- Chemotherapy, and Associated Drugs and Treatments
- Chiropractic Services
- Court, Attorney or Agency Requested Services
- Dialysis Services
- Experimental Procedures and Items, Investigational Devices, and Clinical Trials
- Foot Care Services and Supportive Devices
- Hospice Services
- Infusion Pump Therapy
- Mental Health Services and Procedures
- Non-Covered Services (Including Services/Complications Related to Non-Covered Services)
- Physician Services
- Positron Emission Tomography (PET)/Combined PET-CT (Computed Tomography)
- Preventive Health Services and Procedures
- Services While Confined/Incarcerated
- Skilled Nursing Facility (SNF) Care and Exhaustion of SNF Benefits
- Telemedicine/Telehealth Services
- Veteran Administration (VA) and Indian Health Services (IHS)

General Information

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

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

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

Policy Update Classifications

New

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

Updated

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

Revised

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

Replaced

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

Retired

An existing policy has been retired

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