United Healthcare Medicare Advantage

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Policy Guideline Update Bulletin: August 2022

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United Healthcare®

In This Issue

Policy Guideline Updates

Updated

Policy Title	Approval Date	Summary of Changes

Clinical Diagnostic Laboratory Services	Jul. 13, 2022	**Related Policies**
		• Removed reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled:
		  ○ *Diagnostic Pap Smears NCD 190.2)*
		  ○ *Home Prothrombin Time/International Normalized Ratio (PT/INR) Monitoring for Anticoagulation Management (NCD 190.11)*
		  ○ *Lymphocyte Mitogen Response Assays (NCD 190.8)*
		  ○ *Pharmacogenomic Testing for Warfarin Response (NCD 90.1)*
		  ○ *Qualitative Drug Testing for Indications Other Than Mental Health*
		  ○ *Screening Pap Smears and Pelvic Examinations for Early Detection of Cervical or Vaginal Cancer (NCD 210.2)*
		  ○ *Screening for the Human Immunodeficiency Virus (HIV) Infection (NCD 210.7)*
		Applicable Codes
		• Added CPT codes 0227U, 0323U, 0324U, 0325U, 0326U, 0327U, 0328U, 0329U, 0330U, 0331U, 86352, 86353, and 87913
		• Removed CPT codes 0124U, 0125U, 0126U, 0127U, and 0128U
		Supporting Information
		• Updated *References* section to reflect the most current information

Neuromuscular Electrical Stimulation (NMES) (NCD 160.12)	Jul. 13, 2022	**Applicable Codes** • Added HCPCS code E0770 **Supporting Information** • Updated *References* section to reflect the most current information
Ocular Telescope	Jul. 13, 2022	**Applicable Codes** • Removed ICD-10 diagnosis codes H35.3110, H35.3111, H35.3112, H35.3120, H35.3121, H35.3122, H35.3130, H35.3131, and H35.3132 **Supporting Information** • Updated *References* section to reflect the most current information

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Policy Title	Approval Date	Summary of Changes

Category III CPT Codes	Jul. 13, 2022	**Related Policies**
		• Removed reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled:
		  ○ *Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) for Essential Tremor*
		  ○ *Retinal Prosthesis*

Policy Guideline Updates

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Category III CPT Codes (continued)	Jul. 13, 2022	• Added reference link to the UnitedHealthcare Commercial Medical Policy titled *Discogenic Pain Treatment* Applicable Codes *Non-Covered* • Added CPT codes 0100T, 0627T, 0628T, 0629T, and 0630T *Provisional Coverage* • Reclassified/relocated 0100T (refer to the list of *Non-Covered* codes) Supporting Information • Updated *References* section to reflect the most current information
Delivery of IMRT/SRS/SBRT	Jul. 13, 2022	Policy Summary *Stereotactic Radiosurgery (SRS)* • Replaced language indicating "the delivery of a high dose of ionizing radiation that conforms to the shape of the lesion mandates an overall accuracy of approximately 1mm *to intracranial targets and selected tumors around the base of the skull*" with "the delivery of a high dose of ionizing radiation that conforms to the shape of the lesion mandates an overall accuracy of approximately 1mm" • Removed language indicating stereotactic body radiation therapy (SBRT) codes must be used if more than one session [of SRS] is required Guidelines *Indications for IMRT* • Replaced language indicating: ○ "Intensity modulated radiation therapy (IMRT) is not *a replacement therapy for* conventional *and* 3-D conformal radiation therapy *methods* that deliver good clinical outcomes and low toxicity" with "IMRT is not *considered reasonable and necessary when IMRT does not offer an advantage over* conventional *or* 3-D conformal radiation therapy *techniques* that deliver good clinical outcomes and low toxicity" ○ "IMRT *may be considered reasonable and necessary* when highly conformal dose planning is required *and the patient has at least* one of the [listed] conditions *met*" with "IMRT *is clinically indicated* when highly conformal dose planning is required; *IMRT planning may be clinically indicated when* one *or more* of the [listed] conditions *are present*" *Indications for SRS* • Replaced reference to "conditions" with "indications" • Updated list of conditions for which SRS is medically reasonable and necessary; replaced "as a boost treatment for larger cranial*, base of skull,* or spinal lesions that have been treated initially with external beam radiation therapy or

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Delivery of IMRT/SRS/SBRT (continued)	Jul. 13, 2022	surgery (e.g., sarcomas, chondrosarcomas, chordomas, and nasopharyngeal or paranasal sinus malignancies)" with "as a boost treatment for larger cranial or spinal lesions that have been treated initially with external beam radiation therapy or surgery (e.g., sarcomas, chondrosarcomas, chordomas, and nasopharyngeal or paranasal sinus malignancies)" *Other Neoplasms* • Revised language to indicate primary treatment of lesions of bone, breast, uterus, ovary and other internal organs not listed [in the policy] as covered are not considered medically necessary Supporting Information • Updated *References* section to reflect the most current information
Wrong Surgical or Other Invasive Procedure	Jul. 13, 2022	Title Change • Previously titled *Wrong Surgical or Other Invasive Procedure Performed on a Patient (NCD 140.6)* Related Policies • Removed reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled: ○ *Surgical or Other Invasive Procedure Performed on the Wrong Body Part (NCD 140.7)* ○ *Surgical or Other Invasive Procedure Performed on the Wrong Patient (NCD 140.8)* Policy Summary *Overview* • Revised list of surgical "never events"; added: ○ Surgery performed on the wrong body part ○ Surgical procedure performed on the wrong patient *Nationally Non-Covered Indications* • Added language [previously included in the UnitedHealthcare Medicare Advantage Policy Guideline titled *Surgical or Other Invasive Procedure Performed on the Wrong Body Part (NCD 140.7)*] to indicate: ○ As stated in the NCD for *Surgical or Other Invasive Procedure Performed on the Wrong Body Part (NCD 140.7)*, CMS does not cover a particular surgical or other invasive procedure to treat a particular medical condition when a practitioner erroneously performs the procedure on the wrong body part because that particular surgical or other invasive procedure is not a reasonable and necessary treatment for the Medicare beneficiary's particular medical condition ○ A surgical or other invasive procedure is considered to have been performed on the wrong body part if it is not consistent with the correctly documented informed consent for that patient including surgery on the right body part, but on the wrong location of the body; for example, left versus right (appendages and/or organs), or at the wrong level (spine)

Policy Guideline Updates

Revised

Policy Title	Approval Date	Summary of Changes
Wrong Surgical or Other Invasive Procedure (continued)	Jul. 13, 2022	• Added language [previously included in the UnitedHealthcare Medicare Advantage Policy Guideline titled *Surgical or Other Invasive Procedure Performed on the Wrong Patient (NCD 140.8)*] to indicate: ○ As stated in the NCD for *Surgical or Other Invasive Procedure Performed on the Wrong Patient (NCD 140.8)*, CMS does not cover a particular surgical or other invasive procedure to treat a particular medical condition when a practitioner erroneously performs a procedure that was intended for a different patient on a Medicare beneficiary who does not need that procedure because it is not a reasonable and necessary treatment for the Medicare beneficiary's particular medical condition ○ A surgical or other invasive procedure is considered to have been performed on the wrong patient if that procedure is not consistent with the correctly documented informed consent for that patient **Applicable Codes** • Added modifier codes PA and PB • Added ICD-10 diagnosis codes Y65.52 and Y65.53 **Supporting Information** • Updated *References* section to reflect the most current information

Replaced

Policy Title	Approval Date	Summary of Changes
Lymphocyte Mitogen Response Assays (NCD 190.8)	Jul. 13, 2022	Policy replaced; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Clinical Laboratory Services*
Retinal Prosthesis	Jul. 13, 2022	Policy replaced; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Category III CPT Codes*
Surgical or Other Invasive Procedure Performed on the Wrong Body Part (NCD 140.7)	Jul. 13, 2022	Policy replaced; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Wrong Surgical or Other Invasive Procedure*
Surgical or Other Invasive Procedure Performed on the Wrong Patient (NCD 140.8)	Jul. 13, 2022	Policy replaced; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Wrong Surgical or Other Invasive Procedure*

Policy Guideline Updates

Retired

The following Policy Guidelines have been retired effective Jul. 13, 2022:

- Adult Liver Transplantation (NCD 260.1)
- Ambulatory Blood Pressure Monitoring (NCD 20.19)
- Antigens Prepared for Sublingual Administration (NCD 110.9)
- Apheresis (Therapeutic Pheresis) (NCD 110.14)
- Arthroscopic Lavage and Arthroscopic Debridement for the Osteoarthritic Knee (NCD 150.9)
- Autologous Cellular Immunotherapy Treatment (NCD 110.22)
- Cavernous Nerves by Electrical Stimulation with Penile Plethysmography (NCD 160.26)
- Cryosurgery of Prostate (NCD 230.9)
- Diathermy Treatment (NCD 150.5)
- Evoked Response Tests (NCD 160.10)
- Intensive Behavioral Therapy for Obesity (NCD 210.12)
- Intestinal and Multi-Visceral Transplantation (NCD 260.5)
- Intrapulmonary Percussive Ventilator (IPV) (NCD 240.5)
- Intravenous Histamine Therapy (NCD 30.6)
- L-Dopa (NCD 160.17)
- Lower Limb Prostheses
- Lung Cancer Screening with Low Dose Computed Tomography (LDCT) (NCD 210.14)
- Noninvasive Tests of Carotid Function (NCD 20.17)
- Pediatric Liver Transplantation (NCD 260.2)
- Phaco-Emulsification Procedure – Cataract Extraction (NCD 80.10)
- Pharmacogenomic Testing for Warfarin Response (NCD 90.1)
- Prostate Cancer Screening Tests (NCD 210.1)
- Qualitative Drug Testing for Indications Other Than Mental Health
- Refractive Keratoplasty (NCD 80.7)
- Scleral Shell (NCD 80.5)
- Screening Pap Smears and Pelvic Examinations for Early Detection of Cervical or Vaginal Cancer (NCD 210.2)
- Services Provided for the Diagnosis and Treatment of Diabetic Sensory Neuropathy with Loss of Protective Sensation (aka Diabetic Peripheral Neuropathy) (NCD 70.2.1)
- Thermogenic Therapy (NCD 30.2)
- Treatment of Psoriasis (NCD 250.1)

Policy Guideline Updates

Retired
• Ultrasonic Surgery (NCD 50.8) • Vitamin B12 Injections to Strengthen Tendons, Ligaments, etc., of the Foot (NCD 150.6)

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.