

UnitedHealthcare Medicare Advantage Policy Guideline Update Bulletin: December 2023

In This Issue

Policy Guideline Updates

Page

Updated

• Blepharoplasty, Blepharoptosis, and Brow Lift	2
• Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Programs.....	2
• Hemophilia Clotting Factors and Products.....	2
• Long-Term Wearable Electrocardiographic Monitoring	2
• Percutaneous Coronary Interventions.....	3
• Pneumatic Compression Devices (NCD 280.6)	3
• Porcine Skin and Gradient Pressure Dressings (NCD 270.5)	3
• Self-Administered Drug(s) (SAD).....	3
• Transcutaneous Electrical Nerve Stimulation (TENS).....	4
• Xofigo® Radioactive Therapeutic Agent	4

Revised

• Cosmetic and Reconstructive Services and Procedures	5
• Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)	6
• Transportation Services	7

Retired

• Human Tumor Stem Cell Drug Sensitivity Assays (NCD 190.7).....	8
--	---

Policy Guideline Updates

Updated		
Policy Title	Approval Date	Summary of Changes
Blepharoplasty, Blepharoptosis, and Brow Lift	Nov. 8, 2023	<p>Applicable Codes</p> <p>Diagnosis Codes</p> <p>For CPT Codes 15820, 15821, 67900, 67901, 67902, 67903, 67904, 67906, and 67908 (Facility Only)</p> <ul style="list-style-type: none"> Added H57.8A1, H57.8A2, and H57.8A3 <p>For CPT Codes 15822 and 15823 (Facility Only)</p> <ul style="list-style-type: none"> Added H57.8A1, H57.8A2, H57.8A3, L91.8, L92.2, L94.8, L98.5, L98.6, and L99 <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>References</i> section to reflect the most current information
Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Programs	Nov. 8, 2023	<p>Applicable Codes</p> <p>Diagnosis Codes</p> <p>For CPT Codes 93797 and 93798</p> <ul style="list-style-type: none"> Added I20.81, I20.89, I21.B, I24.81, I24.89, and I25.85 Added notation to indicate: <ul style="list-style-type: none"> I20.8 was “deleted Sep. 30, 2023” I25.111, I25.119, I25.5, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.760, I25.761, I25.768, I25.769, I25.790, I25.791, I25.798, I25.799, I25.810, I25.811, I25.812, I25.89, I25.9, I50.812, I50.814, I50.83, Z48.812, Z96.82, and Z96.89 were “deleted Oct. 31, 2023” Revised description for I25.112 Removed I21.9, I21.A1, I21.A9, I25.10, and I50.32 <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>References</i> section to reflect the most current information
Hemophilia Clotting Factors and Products	Nov. 8, 2023	<p>Applicable Codes</p> <ul style="list-style-type: none"> Added HCPCS codes J7213 and J7214 <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>References</i> section to reflect the most current information
Long-Term Wearable Electrocardiographic Monitoring	Nov. 8, 2023	<p>Applicable Codes</p> <p>Diagnosis Codes</p> <p>For CPT Codes 93224, 93225, 93226, 93227, 93228, 93229, 93241, 93242, 93243, 93244, 93245, 93246, 93247, 93248, 93268, 93270, 93271, and 93272</p>

Policy Guideline Updates

Updated		
Policy Title	Approval Date	Summary of Changes
Long-Term Wearable Electrocardiographic Monitoring (continued)	Nov. 8, 2023	<ul style="list-style-type: none"> Added I20.81, I20.89, I24.81, I24.89, I47.10, I47.11, I47.19, Q20.3, Q20.5, Q20.8, Q20.9, Q21.11, Q21.12, Q21.13, Q21.21, Q21.22, Q21.23, Q21.3, and Q24.6 Added notation to indicate I20.8, I24.8, and I47.1 were “deleted Sep. 30, 2023” Revised description for I25.112
Percutaneous Coronary Interventions	Nov. 8, 2023	<p>Applicable Codes</p> <p>Diagnosis Codes</p> <p>For CPT/HCPCS Codes 92920, 92924, 92928, 92933, 92937, 92941, 92943, C9600, C9601, C9602, C9603, C9604, C9605, C9606, C9607, and C9608</p> <ul style="list-style-type: none"> Added I20.81, I20.89, I21.B, I24.81, I24.89, and I25.85 Added notation to indicate I20.8 and I24.8 were “deleted Sep. 30, 2023” Revised description for I25.112 <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>References</i> section to reflect the most current information
Pneumatic Compression Devices (NCD 280.6)	Nov. 8, 2023	<p>Related Policies</p> <ul style="list-style-type: none"> Removed reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled <i>Durable Medical Equipment, Prosthetics, Corrective Appliances/Orthotics, and Medical Supplies</i> <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>References</i> section to reflect the most current information
Porcine Skin and Gradient Pressure Dressings (NCD 270.5)	Nov. 8, 2023	<p>Policy Summary</p> <ul style="list-style-type: none"> Removed instruction to refer to the appropriate Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) for individual state coverage guidelines <p>Applicable Codes</p> <ul style="list-style-type: none"> Removed HCPCS codes A2010, A2013, Q4130, and Q4142 <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>References</i> section to reflect the most current information
Self-Administered Drug(s) (SAD)	Nov. 8, 2023	<p>Applicable Codes</p> <ul style="list-style-type: none"> Updated list of applicable drug names: <ul style="list-style-type: none"> For HCPCS code C9399; added: <ul style="list-style-type: none"> Adalimumab-Aacf (Idacio®) Adalimumab-Adaz (Hyrimoz) Adalimumab-Afzb (Abrilada)

Policy Guideline Updates

Updated		
Policy Title	Approval Date	Summary of Changes
Self-Administered Drug(s) (SAD) (continued)	Nov. 8, 2023	<ul style="list-style-type: none"> ▪ Adalimumab-Aqvh (Yusimry) ▪ Adalimumab-Bwwd (Hadlima) ▪ Adalimumab-Fkjp (Hulio[®]) ○ For HCPCS code J0801; added: <ul style="list-style-type: none"> ▪ Acthar Gel ○ For HCPCS code J0802; added: <ul style="list-style-type: none"> ▪ ANI, Cortrophin[®] Gel ○ For HCPCS code J1941; added: <ul style="list-style-type: none"> ▪ Furoscix ○ For HCPCS codes J3490, J3590, and J9999; added: <ul style="list-style-type: none"> ▪ Adalimumab-Aacf (Idacio[®]) ▪ Adalimumab-Afzb (Abrilada) ▪ Adalimumab-Aqvh (Yusimry) ▪ Adalimumab-Fkjp (Hulio[®]) ○ For HCPCS code Q5131; added: <ul style="list-style-type: none"> ▪ Idacio <p>Supporting Information</p> <ul style="list-style-type: none"> ● Updated <i>References</i> section to reflect the most current information
Transcutaneous Electrical Nerve Stimulation (TENS)	Nov. 8, 2023	<p>Applicable Codes</p> <ul style="list-style-type: none"> ● Removed M54.5 from the list of non-covered diagnosis codes <p>Supporting Information</p> <ul style="list-style-type: none"> ● Updated <i>References</i> section to reflect the most current information
Xofigo [®] Radioactive Therapeutic Agent	Nov. 8, 2023	<p>Policy Summary</p> <p>Overview</p> <ul style="list-style-type: none"> ● Removed and relocated language pertaining to the U.S. Food and Drug Administration (FDA) approval of radium Ra 223 dichloride (Xofigo[®] Injection, Bayer HealthCare Pharmaceuticals Inc.) usage (refer to the <i>Guidelines</i> section) <p>Guidelines</p> <ul style="list-style-type: none"> ● Revised language to indicate: <ul style="list-style-type: none"> ○ The U.S. Food and Drug Administration (FDA) approved radium Ra 223 dichloride (Xofigo[®] Injection, Bayer HealthCare Pharmaceuticals Inc.) for the treatment of patients with castration-resistant prostate cancer (CRPC), symptomatic bone metastases and no known visceral metastatic disease ○ The recommended dose and schedule for Xofigo[®] is 55 kBq/kg (1.49 microcuries/kg) administered by slow

Policy Guideline Updates

Updated		
Policy Title	Approval Date	Summary of Changes
Xofigo® Radioactive Therapeutic Agent (continued)	Nov. 8, 2023	<p>intravenous injection over 1 minute every 4 weeks for 6 doses</p> <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>References</i> section to reflect the most current information
Revised		
Policy Title	Approval Date	Summary of Changes
Cosmetic and Reconstructive Services and Procedures	Nov. 8, 2023	<p>Template Update</p> <ul style="list-style-type: none"> Updated <i>Purposes</i> section <p>Policy Summary Guidelines</p> <p>Cosmetic Clinical Indications</p> <ul style="list-style-type: none"> Added language to indicate Medicare does not have a National Coverage Determination (NCD) and Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist for the following services; refer to the UnitedHealthcare Commercial Medical Policy titled <i>Cosmetic and Reconstructive Procedures</i> for applicable coverage guidelines for: <ul style="list-style-type: none"> Abrasion; single lesion (e.g., keratosis, scar) (CPT code 15786) Abrasion; each additional 4 lesions or less (list separately in addition to code for primary procedure) (CPT code 15757) Ear piercing (CPT code 69090) Injection, deoxycholic acid, 1 mg (CPT code J0591) <p>Reconstructive Clinical Indications</p> <ul style="list-style-type: none"> Added language to indicate Medicare does not have a National Coverage Determination (NCD) and Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist for the following services: <ul style="list-style-type: none"> Refer to the UnitedHealthcare Commercial Medical Policy titled <i>Cosmetic and Reconstructive Procedures</i> for applicable coverage guidelines for: <ul style="list-style-type: none"> Adjacent tissue transfer (CPT codes 14000, 14001, 14020, 14021, 14040, 14041, 14060, 14061, 14301, and 14302) Autologous soft tissue and fat grafting (CPT codes 15769, 15771, 15772, 15773, and 15774) Myocutaneous flaps (CPT codes 15570, 15572, 15574, 15731, 15734, 15736, 15738, 15740, and 15756) Refer to the UnitedHealthcare Commercial Medical Policy titled <i>Rhinoplasty and Other Nasal Procedures</i> for applicable coverage guidelines for: <ul style="list-style-type: none"> Surgery for rhinophyma (CPT code 30120)

Policy Guideline Updates

Revised		
Policy Title	Approval Date	Summary of Changes
Cosmetic and Reconstructive Services and Procedures (continued)	Nov. 8, 2023	<p>Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare</p> <ul style="list-style-type: none"> Removed language indicating: <ul style="list-style-type: none"> All submitted non-covered or no payment claims using condition code 21 will be processed to completion, and all services on those claims, since they are submitted as non-covered, will be denied The default liability for payment of these claims is assigned to the beneficiary, who may then submit the denial from Medicare, as the primary payer, to subsequent payer(s) for consideration <p>Applicable Codes</p> <p>CPT Codes</p> <p>Biologic Implant</p> <ul style="list-style-type: none"> Added notation to indicate 15777 was “deleted Aug. 1, 2023” <p>Myocutaneous Flaps</p> <ul style="list-style-type: none"> Added notation to indicate CPT codes 15776, 15750, 15757, and 15758 were “deleted Aug. 1, 2023” <p>Coding Clarifications</p> <ul style="list-style-type: none"> Removed notations pertaining to skin/deep tissue flaps and graft procedures <p>Diagnosis Codes</p> <p>For Abdominal Lipectomy/Panniculectomy (CPT Codes 15830 and 15847) and Other Lipectomy (CPT Codes 15832, 15833, 15834, 15835, 15836, 15837, 15838, and 15839)</p> <ul style="list-style-type: none"> Added B96.83 <p>For Breast Surgery (CPT Codes 19325 and 19355) and Mastopexy (CPT Code 19316 and ICD-10 Procedure Codes 0HST0ZZ, 0HSU0ZZ, and 0HSV0ZZ)</p> <ul style="list-style-type: none"> Added D22.5, D23.5, N64.1, T21.31XA, T21.31XD, T21.31XS, T21.71XA, T21.71XD, and T21.71XS <p>Definitions</p> <ul style="list-style-type: none"> Removed definition of: <ul style="list-style-type: none"> Adjacent Tissue Transfer Cervicoplasty <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>References</i> section to reflect the most current information
Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)	Nov. 8, 2023	<p>Template Update</p> <ul style="list-style-type: none"> Updated <i>Purposes</i> section <p>Policy Summary</p>

Policy Guideline Updates

Revised		
Policy Title	Approval Date	Summary of Changes
Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9) (continued)	Nov. 8, 2023	<p>Guidelines</p> <ul style="list-style-type: none"> Replaced language indicating “the Centers for Medicare & Medicaid <i>Coverage</i> (CMS) conducted a National Coverage Analysis that focused on the topic of gender reassignment surgery” with “<i>National Coverage Determination (NCD) 140.9 Gender Dysphoria and Gender Reassignment Surgery states</i>, the Centers for Medicare & Medicaid <i>Services</i> (CMS) conducted a National Coverage Analysis that focused on the topic of gender reassignment surgery” Added language to indicate: <ul style="list-style-type: none"> Local Coverage Determination (LCD)/Local Coverage Articles (LCAs) exist and compliance with this policy is required where applicable For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled <i>Gender Dysphoria Treatment (for Commercial Only)</i> <p>Applicable Codes</p> <p>Other Ancillary Services</p> <ul style="list-style-type: none"> Added notation to indicate CPT codes 19340 and 19342 were “deleted Jul 1, 2023” Removed instruction to refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled <i>Cosmetic and Reconstructive Services and Procedures</i> for CPT codes 15750, 15757, and 15758 <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>References</i> section to reflect the most current information
Transportation Services	Nov. 8, 2023	<p>Policy Summary</p> <p>Guidelines</p> <ul style="list-style-type: none"> Removed content/language addressing physician certification and written orders <p>Emergency Ambulance Services (Ground)</p> <ul style="list-style-type: none"> Removed language indicating an immediate response is one in which the ambulance provider or supplier begins as quickly as possible to take the steps necessary to respond to the call <p>Medical Reasonableness for Non-Emergency (Scheduled) Ambulance Service (Ground)</p> <ul style="list-style-type: none"> Removed language indicating: <ul style="list-style-type: none"> If the condition contraindicating other means of transportation is “bed confined”, the beneficiary must meet the following criteria of “bed confined”; the beneficiary is: <ul style="list-style-type: none"> Unable to get up from bed without assistance Unable to ambulate; and Unable to sit in a chair or wheelchair Revised description of “bed confined” <p>Medical Reasonableness for Emergency Air Ambulance Transportation</p>

Policy Guideline Updates

Revised		
Policy Title	Approval Date	Summary of Changes
Transportation Services (continued)	Nov. 8, 2023	<ul style="list-style-type: none"> Revised language to indicate if the air transport was medically appropriate (that is, ground transportation was contraindicated, and the member required air transport to a hospital), but the member could have been treated at a hospital nearer than the one to which they were transported, the air transport payment is limited to the rate for the distance from the point of pickup to that nearer hospital <p>Destination for Emergency Air Ambulance Transportation</p> <ul style="list-style-type: none"> Revised language to indicate air ambulance services may be paid only for ambulance services to a hospital. Other destinations e.g., skilled nursing facility, a physician’s office, or a patient’s home may not be paid air ambulance <p>Appropriate Facilities for Emergency Air Ambulance Transportation</p> <ul style="list-style-type: none"> Removed language indicating it is the institution, its equipment, its personnel, and its capability to provide the services necessary to support the required medical care that determine whether it has appropriate facilities <p>Utilization Guidelines</p> <ul style="list-style-type: none"> Removed language indicating: <ul style="list-style-type: none"> A single payment allowance for mileage will be prorated by the number of beneficiaries onboard for multiple patient transport Down coding from air to ground is a <i>Social Security Act §1862 (a)(1)(A)</i> denial When multiple units respond to a call for services, the entity that provides the transport for the beneficiary should be the only provider billing the service <p>Billing for Ground Ambulance Services when the Beneficiary is Pronounced Deceased</p> <ul style="list-style-type: none"> Revised language pertaining to reimbursement of ambulance services provided to a deceased Medicare member to indicate: <ul style="list-style-type: none"> According to <i>Pub. 100-02, Chapter 10, Section 10.2.6</i>, because the Medicare ambulance benefit is a transport benefit, if no transport of a Medicare member occurs, then there is no Medicare-covered service In general, if the member dies before being transported, then no Medicare payment may be made, thus, in a situation where the member dies, whether any payment under the Medicare ambulance benefit may be made depends on the time at which the member is pronounced dead by an individual authorized by the State to make such pronouncements <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>References</i> section to reflect the most current information
Retired		
<p>The following Policy Guideline has been retired effective Nov. 8, 2023:</p> <ul style="list-style-type: none"> Human Tumor Stem Cell Drug Sensitivity Assays (NCD 190.7) 		

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.

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 Policy Guidelines is available at [UHCprovider.com](https://www.uhcprovider.com) > Policies and Protocols > Medicare Advantage Policies > [Policy Guidelines](#).