United Healthcare Medicare Advantage

UnitedHealthcare Medicare Advantage
Policy Guideline Update Bulletin: July 2022

In This Issue

Policy Guideline Updates — Page

Updated

Revised

Replaced

Retired

United Healthcare

In This Issue

Policy Guideline Updates

Updated

Policy Title	Approval Date	Summary of Changes
Facet Joint Interventions for Pain Management	Jun. 8, 2022	**Applicable Codes** • Added notation to indicate CPT codes 64492 and 64495 are "non-covered" **Supporting Information** • Updated *References* section to reflect the most current information
Knee Orthoses	Jun. 8, 2022	**Applicable Codes** • Removed modifier code EY and GZ **Supporting Information** • Updated *References* section to reflect the most current information

Revised

Policy Title	Approval Date	Summary of Changes
Avastin® (Bevacizumab)	Jun. 8, 2022	**Policy Summary** *Guidelines* • Replaced language indicating "the drug must be used according to the indication and protocol listed in the accepted compendia *listed* [in the policy]' with "the drug must be used according to the indication and protocol listed in *any of* the accepted compendia [in the policy]" • Revised list of accepted compendia; replaced: ○ "*Thomson* Micromedex DrugDex" with "Micromedex DrugDex" ○ "*Wolters Kluwer* Lexi-Drugs" with "Lexi-Drugs" **Cancer** • Replaced language indicating bevacizumab (Avastin®) is indicated for the treatment of metastatic colorectal cancer "in combination with fluoropyrimidine-irinotecan- or fluoropyrimidine-oxaliplatin-based chemotherapy for second-line treatment in patients *with metastatic colorectal cancer* who have progressed on a first-line Avastin®" with "in combination with fluoropyrimidine-irinotecan- or fluoropyrimidine-oxaliplatin-based chemotherapy for second-line treatment in patients who have progressed on a first-line Avastin®*-containing regime*" **Ophthalmology** *Limitations* • Replaced language indicating "bevacizumab is contraindicated in patients with ocular or periocular infections *or* known hypersensitivity to bevacizumab or any of *the* inactive ingredients *in bevacizumab*" with "bevacizumab is contraindicated in patients with ocular or periocular infections *and in patients with* known hypersensitivity to bevacizumab or any of *its* inactive ingredients" *Documentation Requirements*

Policy Guideline Updates

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Avastin® (Bevacizumab) (continued)	Jun. 8, 2022	• Replaced language indicating "medical record documentation [must be] maintained by the performing *ophthalmologist*" with "medical record documentation [must be] maintained by the performing *physician*" • Updated list of items to be documented in the medical record; replaced "indication that the patient has been provided appropriate informed consent regarding the benefits and risks of *this therapy and* off-label use of *this drug*" with "indication that the patient has been provided appropriate informed consent regarding the benefits and risks of *the* off-label use of *bevacizumab*" **Applicable Codes** • Added ICD-10 diagnosis codes C45.2, C45.7, C45.9, and C56.3 • Removed ICD-10 diagnosis code Z80.49 **Supporting Information** • Updated *References* section to reflect the most current information

Continuous Glucose Monitoring	Jun. 8, 2022	**Policy Summary**
		Overview
		• Revised language to indicate:
		  ○ The general term "Continuous Glucose Monitor (CGM)" refers to both therapeutic/non-adjunctive and non-therapeutic/adjunctive CGMs
		  ○ A therapeutic or non-adjunctive CGM can be used to make treatment decisions without the need for a stand-alone blood glucose monitor (BGM) to confirm testing results
		  ▪ A non-therapeutic or adjunctive CGM requires the user verify their glucose levels or trends displayed on a CGM with a BGM prior to making treatment decisions
		  ▪ On Feb. 28, 2022, the Centers for Medicare & Medicaid Services (CMS) determined that both therapeutic/non-adjunctive and non-therapeutic/adjunctive CGMs may be classified as Durable Medical Equipment (DME)
		Patient Coverage Criteria for Nonimplantable (DME) CGMs
		• Updated instruction to clarify both the *Non-Medical Necessity Coverage and Payment Rules* and *Coding Guidelines* sections in the Local Coverage Determination (LCD)-related Policy Article should be referenced for additional information *regarding classification of CGMs as DME*
		• Replaced language indicating "therapeutic CGMs and related supplies are covered by Medicare when all of the [listed] coverage criteria are met" with "to be eligible for coverage of a CGM and related supplies, the beneficiary must meet all of the [listed] coverage criteria"
		• Added language to indicate:
		  ○ When a CGM (HCPCS codes K0554 or E2102) is covered, the related supply allowance (HCPCS codes K0553 or A4238) is also covered

Policy Guideline Updates

Revised

Policy Title	Approval Date	Summary of Changes
Continuous Glucose Monitoring (continued)	Jun. 8, 2022	○ Supplies (HCPCS code A4238) for an adjunctive CGM integrated into an external insulin infusion pump are covered when the beneficiary meets both the CGM coverage criteria and the coverage criteria for an external insulin infusion pump; refer to the *External Infusion Pumps Local Coverage Determination (LCD) (L33794)* for additional information regarding billing a CGM receiver incorporated into an insulin infusion pump ○ If any coverage criteria [in the policy] are not met, the CGM and related supply allowance will be denied as not reasonable and necessary **Non-Adjunctive CGM Devices and Supplies** ● Revised language to indicate: ○ Non-adjunctive CGM devices replace standard home BGMs (HCPCS codes E0607, E2100, and E2101) and related supplies (HCPCS codes A4233, A4234, A4235, A4236, A4244, A4245, A4246, A4247, A4250, A4253, A4255, A4256, A4257, A4258, and A4259); claims for a BGM and related supplies, billed in addition to a non-adjunctive CGM device (HCPCS code K0554) and associated supply allowance (HCPCS code K0553), will be denied ○ For non-adjunctive CGMs, the supply allowance (HCPCS code K0553) also includes a home BGM and related supplies (test strips, lancets, lancing device, calibration solution, and batteries), if necessary; supplies used with a non-covered CGM are considered non-covered (no Medicare benefit) and must not be billed using HCPCS codes K0553 or A4238 **Adjunctive CGM Devices and Supplies** ● Reformatted and revised language pertaining to adjunctive CDM devices, supplies, and accessories to indicate: ○ Adjunctive CGM devices do not replace a standard home BGM ▪ The supply allowance for an adjunctive CGM (HCPCS code A4238) encompasses all items necessary for the use of the device and includes, but is not limited to, CGM sensors and transmitters ▪ HCPCS code A4238 does not include a home BGM and related BGM testing supplies; these items may be billed separately, in addition to HCPCS code A4238 ▪ Refer to the *Coding Guidelines* section in the LCD-related Policy Article for additional information ○ For claims with dates of service on or before Mar. 31, 2022, adjunctive CGMs which meet the definition of DME must be billed with HCPCS code E1399 ▪ For claims with dates of service on or after Apr. 1, 2022, adjunctive CGMs which meet the definition of DME must be billed with HCPCS code E2102 ▪ There are currently no stand-alone adjunctive CGMs on the United States (US) market which meet the definition of DME (as described under the *Non-Medical Necessity Coverage and Payment Rules* section); however, there are adjunctive CGMs incorporated into an insulin infusion pump on the US market which may meet the definition of DME ○ For claims with dates of service on or before Mar. 31, 2022, adjunctive CGM disposable supplies which fall under

Policy Guideline Updates

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Continuous Glucose Monitoring (continued)	Jun. 8, 2022	the DME benefit must be billed with HCPCS code A9999 (miscellaneous DME supply or accessory, not otherwise specified) for the supply allowance ○ For claims with dates of service on or after Apr. 1, 2022, adjunctive CGM disposable supplies which fall under the DME benefit must be billed with HCPCS code A4238 for the supply allowance ○ The CGM supply allowance includes all items necessary for the use of the device and includes, but is not limited to, CGM sensors and transmitters *Patient Coverage Criteria for Implantable CGMs* • Removed language indicating the FDA approved indication must include use as a therapeutic CGM in order to be considered reasonable and necessary *Miscellaneous Coding Information* • Added language to indicate: ○ Only one (1) Unit of Service (UOS) of HCPCS code A4238 may be billed at a time; billing more than 1 UOS per 30 days will be denied as not reasonable and necessary ○ Refer to the *Coding Guidelines* section in the LCD-related Policy Article for additional billing instructions • Removed language indicating HCPCS codes A9276 and A9277 are not used to bill for supplies used with code K0554 [receiver (monitor)] Supporting Information • Updated *References* section to reflect the most current information
Erythropoiesis Stimulating Agents (ESA)	Jun. 8, 2022	Title Change • Previously titled *Erythropoietin Stimulating Agent (ESA)* Related Policies • Removed reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions (NCD 110.21)* Policy Summary *Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions* • Added language [previously included in the UnitedHealthcare Medicare Advantage Policy Guideline titled *Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions (NCD 110.21)*] to indicate: ○ Erythropoiesis stimulating agents (ESAs) stimulate the bone marrow to make more red blood cells and are United States Food and Drug Administration (FDA) approved for use in reducing the need for blood transfusion in patients with specific clinical indications ○ The FDA has issued alerts and warnings for ESAs administered for a number of clinical conditions, including cancer

Policy Guideline Updates

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Erythropoiesis Stimulating Agents (ESA) (continued)	Jun. 8, 2022	○ Published studies report a higher risk of serious and life-threatening events associated with oncologic uses of ESAs **Nationally Covered Indications** ● Added language [previously included in the UnitedHealthcare Medicare Advantage Policy Guideline titled *Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions (NCD 110.21)*] to indicate: ○ ESA treatment for the anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia is only reasonable and necessary under the following specified conditions: ▪ The hemoglobin level immediately prior to initiation or maintenance of ESA treatment is < 10 g/dL (or the hematocrit is < 30%) ▪ The starting dose for ESA treatment is the recommended FDA label starting dose, no more than 150 U/kg/3 times weekly for epoetin and 2.25 mcg/kg/1 time weekly for darbepoetin alpha; equivalent doses may be given over other approved time periods ▪ Maintenance of ESA therapy is the starting dose if the hemoglobin level remains below 10g/dL (or hematocrit is < 30%) 4 weeks after initiation of therapy and the rise in hemoglobin is ≥ 1g/dL (hematocrit ≥ 3%) ▪ For patients whose hemoglobin rises < 1g/dl (hematocrit rise < 3%) compared to pretreatment baseline over 4 weeks of treatment and whose hemoglobin level remains < 10g/dL after the 4 weeks of treatment (or the hematocrit is < 30%), the recommended FDA label starting dose may be increased once by 25%; continued use of the drug is not reasonable and necessary if the hemoglobin rises < 1g/dl (hematocrit rise < 3%) compared to pretreatment baseline by 8 weeks of treatment ▪ Continued administration of the drug is not reasonable and necessary if there is a rapid rise in hemoglobin > 1g/dl (hematocrit > 3%) over 2 weeks of treatment unless the hemoglobin remains below or subsequently falls to < 10g/dL (or the hematocrit is < 30%); continuation and reinstitution of ESA therapy must include a dose reduction of 25% from the previously administered dose ▪ ESA treatment duration for each course of chemotherapy includes the 8 weeks following the final dose of myelosuppressive chemotherapy in a chemotherapy regimen **Nationally Non-Covered Indications** ● Added language [previously included in the UnitedHealthcare Medicare Advantage Policy Guideline titled *Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions (NCD 110.21)*] to indicate: ○ ESA treatment is not reasonable and necessary for beneficiaries with certain clinical conditions, either because of a deleterious effect of the ESA on their underlying disease or because the underlying disease increases their risk of adverse effects related to ESA use ○ These conditions include:

Policy Guideline Updates

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Erythropoiesis Stimulating Agents (ESA) (continued)	Jun. 8, 2022	▪ Any anemia in cancer or cancer treatment patients due to folate deficiency, B-12 deficiency, iron deficiency, hemolysis, bleeding, or bone marrow fibrosis; ▪ The anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML), or erythroid cancers; ▪ The anemia of cancer not related to cancer treatment; ▪ Any anemia associated only with radiotherapy; ▪ Prophylactic use to prevent chemotherapy-induced anemia; ▪ Prophylactic use to reduce tumor hypoxia; ▪ Patients with erythropoietin-type resistance due to neutralizing antibodies; and ▪ Anemia due to cancer treatment if patients have uncontrolled hypertension **Other** • Added language [previously included in the UnitedHealthcare Medicare Advantage Policy Guideline titled *Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions (NCD 110.21)*] to indicate: ○ Local Medicare Administrative Contractors may continue to make reasonable and necessary determinations on all other uses of ESAs not specified in the National Coverage Determination ***End Stage Renal Disease*** • Replaced reference to the "*Medicare Claims Processing Manual, Publication 100-02, Chapter 8*" with the "*Medicare Claims Processing Manual, Publication 100-04, Chapter 8*" **Applicable Codes** • Removed instruction to refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions (NCD 110.21)* for HCPCS codes J0881, J0885, and Q5106 • Removed modifier codes JA, JB, and JE **Supporting Information** • Updated *References* section to reflect the most current information
Lucentis® (Ranibizumab)	Jun. 8, 2022	**Related Policies** • Added reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Medications/Drugs (Outpatient/Part B)* **Policy Summary** ***Guidelines*** • Replaced language indicating "the drug must be used according to the indication and protocol listed in the accepted compendia *ratings* listed [in the policy]" with "the drug must be used according to the indication and protocol listed in

Policy Guideline Updates

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Lucentis® (Ranibizumab) (continued)	Jun. 8, 2022	*any of* the accepted compendia listed [in the policy]" ● Revised list of accepted compendia: ○ Added "Lexi-Drugs" ○ Replaced "*Thomson* Micromedex DrugDex" with "Micromedex DrugDex" **Applicable Codes** ● Added HCPCS codes C9093 and Q5124 **Supporting Information** ● Updated *References* section to reflect the most current information
Nebulizers	Jun. 8, 2022	**Related Policies** ● Added reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled: ○ *Home Use of Oxygen (NCD 240.2)* ○ *Home Use of Oxygen in Approved Clinical Trials (NCD 240.2.1)* ○ *KX Modifier* **Policy Summary** *Guidelines* ● Added language to indicate a diagnosis code describing the condition which necessitates nebulizer therapy must be included on each claim for equipment, accessories, and/or drugs ● Simplified language indicating a face-to-face encounter and a Written Order Prior to Delivery (WOPD) are required for nebulizers **Documentation Requirements - General** ● Revised language to indicate there are numerous Centers for Medicare & Medicaid (CMS) manual requirements, reasonable and necessary requirements, benefit category, and other statutory and regulatory requirements that must be met in order for payment to be justified ○ In the event of a claim review, a DMEPOS supplier must provide sufficient information to demonstrate that the applicable criteria have been met thus justifying payment ○ Refer to the Local Coverage Determination (LCD), National Coverage Determination (NCD) or other CMS Manuals for more information on what documents may be required ○ See the LCA titled *Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426)* **Applicable Codes** ● Removed HCPCS code E0580 ● Removed modifier codes EY, GA, and GZ **Supporting Information**

Policy Guideline Updates

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Nebulizers (continued)	Jun. 8, 2022	• Updated *References* section to reflect the most current information

Photodynamic Therapy	Jun. 8, 2022	**Related Policies**
		• Removed reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled:
		  ○ *Ocular Photodynamic Therapy (OPT) (NCD 80.2.1)*
		  ○ *Photosensitive Drugs (NCD 80.3)*
		  ○ *Verteporfin (NCD 80.3.1)*
		Policy Summary
		Overview
		• Added language [previously included in the UnitedHealthcare Medicare Advantage Policy Guideline titled *Verteporfin (NCD 80.3.1)* and *Photosensitive Drugs (NCD 80.3)*] to indicate:
		  ○ Verteporfin, a benzoporphyrin derivative, is an intravenous lipophilic photosensitive drug with an absorption peak of 690 nm
		  ○ This drug was first approved by the Food and Drug Administration (FDA) on Apr. 12, 2000, and subsequently, approved for inclusion in the United States Pharmacopoeia on Jul. 18, 2000, meeting Medicare's definition of a drug when used in conjunction with ocular photodynamic therapy (OPT) when furnished intravenously incident to a physician's service
		Guidelines
		Nationally Covered Indications
		• Replaced language indicating "*Classic Subfoveal Choroidal Neovascular (CNV) Lesions*-OPT *is covered* with a diagnosis of neovascular age-related macular degeneration (AMD) with [the listed indications]" with "OPT with *verteporfin continues to be approved for* a diagnosis of neovascular age-related macular degeneration (AMD) with [the listed indications]"
		• Added language [previously included in the UnitedHealthcare Medicare Advantage Policy Guidelines titled *Ocular Photodynamic Therapy (OPT) (NCD 80.2.1)* and *Verteporfin (NCD 80.3.1)*] to indicate:
		  ○ OPT with verteporfin continues to be approved for a diagnosis of neovascular age-related macular degeneration (AMD) with:
		  ▪ Subfoveal occult with no classic CNV associated with AMD
		  ▪ Subfoveal minimally classic CNV (where the area of classic CNV occupies < 50% of the area of the entire lesion) associated with AMD
		  ▪ The above 2 indications are considered reasonable and necessary only when:
		  – The lesions are small (4 disk areas or less in size) at the time of initial treatment or within the 3 months

Policy Guideline Updates

Revised

Policy Title	Approval Date	Summary of Changes
Photodynamic Therapy (continued)	Jun. 8, 2022	prior to initial treatment; and – The lesions have shown evidence of progression within the 3 months prior to initial treatment; evidence of progression must be documented by deterioration of visual acuity (at least 5 letters on a standard eye examination chart), lesion growth (an increase in at least 1 disk area), or the appearance of blood associated with the lesion • Removed language indicating Occult Subfoveal CNV Lesions-OPT is non-covered for patients with a diagnosis of AMD with occult and no classic CNV lesions **Nationally Noncovered Indications** • Added language [previously included in the UnitedHealthcare Medicare Advantage Policy Guidelines titled *Ocular Photodynamic Therapy (OPT) (NCD 80.2.1)* and *Verteporfin (NCD 80.3.1)*] to indicate: ○ Other uses of OPT with verteporfin to treat AMD not already addressed by the Centers for Medicare & Medicaid Services will continue to be non-covered. These include, but are not limited to, the following AMD indications: ▪ Juxtafoveal or extrafoveal CNV lesions (lesions outside the fovea), ▪ Inability to obtain a fluorescein angiogram, ▪ Atrophic, or dry AMD **Applicable Codes** • Added HCPCS code J3396 • Removed modifier code 50 **Supporting Information** • Updated *References* section to reflect the most current information
Testosterone Pellets (Testopel®)	Jun. 8, 2022	**Policy Summary** ***Guidelines*** • Revised language to indicate: ○ Injectable testosterone pellets (brand name Testopel®) may be covered, by Medicare, for the FDA-approved indication, if the service meets all Medicare coverage requirements in the Centers for Medicare & Medicaid (CMS) *Internet-Only Manual (IOM) Medicare Benefit Policy Manual Chapter 15, Section 50.4.3.2 for Injection Method Not Indicated*; medication given by injection (parenterally) is not covered if standard medical practice indicates that the administration of the medication by mouth (orally) is effective and is an accepted or preferred method of administration ○ Pellet implantation is much less flexible for dosage adjustment and more invasive than oral medication, nasal administration, transdermal administration or intramuscular injection; Medicare coverage determinations indicate that the use of this product (Testopel®) should be rare since the "accepted method of medical practice" is to

Policy Guideline Updates

Revised

Policy Title	Approval Date	Summary of Changes
Testosterone Pellets (Testopel®) (continued)	Jun. 8, 2022	administer testosterone transdermally, but there may be reasons that require this injectable medication ○ The number of pellets to be implanted depends upon the minimal daily requirements of testosterone propionate titrated to a serum testosterone level in the low normal range for a healthy adult male ▪ The usual dosage is 150 mg to 450 mg subcutaneously every 3 to 6 months, which translates to 2 to 6 pellets every 3 to 6 months; insertion of more than 6 pellets every 3 months will not be considered reasonable and necessary ▪ Medicare may only cover the number of pellets actually implanted in the patient (maximum of 6 pellets); wastage is not covered ○ Refer to the list of available Local Coverage Determination (LCD) references for Medicare expectations on the establishment of a diagnosis of primary hypogonadism in the *Supporting Information* section of the policy *Contraindications* • Removed language indicating the clinical records shall reflect that these issues were discussed with the patient before initiating therapy • Added instruction to refer to the list of available LCD references for limitations of coverage, as these may vary by jurisdiction, in the *Supporting Information* section of the policy Supporting Information • Updated *References* section to reflect the most current information

Replaced

Policy Title	Approval Date	Summary of Changes
Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions (NCD 110.21)	Jun. 8, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled Erythropoiesis Stimulating Agents (ESA)
Ocular Photodynamic Therapy (OPT) (NCD 80.2.1)	Jun. 8, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled Photodynamic Therapy
Photosensitive Drugs (NCD 80.3)	Jun. 8, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled Photodynamic Therapy

Policy Guideline Updates

Replaced

Policy Title	Approval Date	Summary of Changes
Verteporfin (NCD 80.3.1)	Jun. 8, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled Photodynamic Therapy

Retired

The following Policy Guidelines have been retired effective Jun. 8, 2022:

- Assessing Patient's Suitability for Electrical Nerve Stimulation Therapy (NCD 160.7.1)
- Cardiac Output Monitoring by Thoracic Electrical Bioimpedance (TEB) (NCD 20.16)
- Cardiac Pacemaker Evaluation Services (NCD 20.8.1)
- Challenge Ingestion Food Testing (NCD 110.12)
- Cochleostomy with Neurovascular Transplant for Meniere's Disease (NCD 50.7)
- Collagen Meniscus Implant (NCD 150.12)
- Colonic Irrigation (NCD 100.7)
- Counseling to Prevent Tobacco Use (NCD 210.4.1)
- Dental Examination Prior to Kidney Transplantation (NCD 260.6)
- Dermal Injections for the Treatment of Facial Lipodystrophy Syndrome (LDS) (NCD 250.5)
- Diabetes Outpatient Self-Management Training (NCD 40.1)
- Diagnostic Pap Smears (NCD 190.2)
- Displacement Cardiography (NCD 20.24)
- Electrical Continence Aid (NCD 230.15)
- Electrical Nerve Stimulators (NCD 160.7)
- Electrocardiographic Services (NCD 20.15)
- Home Prothrombin Time/International Normalized Ratio (PT/INR) Monitoring for Anticoagulation Management (NCD 190.11)
- Insulin Syringe (NCD 40.4)
- Intensive Behavioral Therapy for Cardiovascular Disease (NCD 210.11)
- Islet Cell Transplantation in the Context of a Clinical Trial (NCD 260.3.1)
- Low Frequency, Non-Contact, Non-Thermal Ultrasound
- Lung Volume Reduction Surgery (NCD 240.1)
- Mammograms (NCD 220.4)
- Manipulation (NCD 150.1)
- Microvolt T-Wave Alternans (MTWA) (NCD 20.30)

United Healthcare Medicare Advantage

Policy Guideline Updates

Retired
• Outpatient Intravenous Insulin Treatment (NCD 40.7) • Pancreas Transplants (NCD 260.3) • Plethysmography (NCD 20.14) • Prolotherapy, Joint Sclerotherapy, and Ligamentous Injections with Sclerosing Agents (NCD 150.7) • Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse (NCD 210.8) • Screening for the Human Immunodeficiency Virus (HIV) Infection (NCD 210.7) • Sykes Hernia Control (NCD 280.12) • Transcendental Meditation (NCD 30.5) • Transfer Factor for Treatment of Multiple Sclerosis (NCD 160.20) • Transtelephonic Monitoring of Cardiac Pacemakers (NCD 20.8.1.1) • Vertebral Axial Decompression (VAX-D) (NCD 160.16) • Vitrectomy (NCD 80.11)

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.