United Healthcare Medicare Advantage

UnitedHealthcare Medicare Advantage
Policy Guideline Update Bulletin: June 2022

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Replaced

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Policy Title	**Approval Date**	**Summary of Changes**
Computed Tomography	May 12, 2022	**Related Policies** • Added reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Colorectal Cancer Screening Tests (NCD 210.3)* **Applicable Codes** • Removed CPT code 74263 **Supporting Information** • Updated *References* section to reflect the most current information

Deep Brain Stimulation for Essential Tremor and Parkinson's Disease (NCD 160.24)	May 12, 2022	**Related Policies**
		• Updated list of related UnitedHealthcare Medicare Advantage Coverage Summaries:
		  ○ Added reference link to the policy titled *Electrical Stimulators*
		  ○ Removed reference link the policy titled *Deep Brain Stimulation for Essential Tremor and Parkinson's Disease*
		Supporting Information
		• Updated *References* section to reflect the most current information

Endothelial Cell Photography (NCD 80.8)	May 12, 2022	**Related Policies** • Added reference link to the UnitedHealthcare Medicare Advantage Reimbursement Policy titled *Multiple Procedure Payment Reduction (MPPR) on Diagnostic Cardiovascular and Ophthalmology Procedure Policy*
Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)	May 12, 2022	**Applicable Codes** *Other Ancillary Services* • Added instruction to refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Cosmetic and Reconstructive Services and Procedures* for CPT code 21270 *ICD-10 Procedure Codes* • Added 0UQJ0ZZ **Supporting Information** • Updated *References* section to reflect the most current information
Porcine Skin and Gradient Pressure Dressings (NCD 270.5)	May 12, 2022	**Applicable Codes** *Porcine Skin Substitutes* • Added HCPCS codes A2001, A2004, A2008, A2010, A2013, Q4130, and Q4142 **Supporting Information** • Updated *References* section to reflect the most current information

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Vaccination (Immunization)	May 12, 2022	**Applicable Codes** *Medicare Covered for Hepatitis B* • Added CPT code 90759 **Supporting Information** • Updated *References* section to reflect the most current information

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Acupuncture	May 12, 2022	**Title Change**
		• Previously titled *Acupuncture (NCD 30.3)*
		Related Policies
		• Removed reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled:
		  ○ *Acupuncture for Fibromyalgia (NCD 30.3.1)*
		  ○ *Acupuncture for Osteoarthritis (NCD 30.3.2)*
		  ○ *Acupuncture for Chronic Lower Back Pain (cLBP) (NCD 30.3.3)*
		Policy Summary
		Nationally Covered Indications
		• Added language [previously outlined in the UnitedHealthcare Medicare Advantage Policy Guideline titled *Acupuncture for Chronic Lower Back Pain (cLBP) (NCD 30.3.3)*] to indicate:
		  ○ Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances:
		  ▪ For the purpose of this decision, chronic lower back pain (cLBP) is defined as:
		  – Lasting 12 weeks or longer;
		  – Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease);
		  – Not associated with surgery; and
		  – Not associated with pregnancy
		  ▪ An additional 8 sessions will be covered for those patients demonstrating an improvement
		  ▪ No more than 20 acupuncture treatments may be administered annually
		  ▪ Treatment must be discontinued if the patient is not improving or is regressing
		  ○ Physicians (as defined in *1861(r)(1)) of the Social Security Act (the Act)* may furnish acupuncture in accordance with applicable state requirements
		  ○ Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in *1861(aa)(5) of the Act*), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:

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Acupuncture (continued)	May 12, 2022	▪ A masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and ▪ A current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia ○ Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, physician assistant (PA), or nurse practitioner (NP)/clinical nurse specialist (CNS) required by our regulations at *42 CFR §§ 410.26 and 410.27* *Nationally Non-Covered Indications* ● Added language [previously outlined in the UnitedHealthcare Medicare Advantage Policy Guidelines titled *Acupuncture for Fibromyalgia (NCD 30.3.1)* and *Acupuncture for Osteoarthritis (NCD 30.3.2)*] to indicate: ○ After careful reconsideration of its initial non-coverage determination for acupuncture, the Centers for Medicare & Medicaid Services (CMS) concludes that there is no convincing evidence for the use of acupuncture for pain relief in patients with fibromyalgia or osteoarthritis ○ Study design flaws presently prohibit assessing acupuncture's utility for improving health outcomes; accordingly, CMS determines that acupuncture is not considered reasonable and necessary for the treatment of fibromyalgia or osteoarthritis within the meaning of *§1862(a)(1) of the Social Security Act*, and the national non-coverage determination for acupuncture for fibromyalgia and osteoarthritis continues ○ All types of acupuncture including dry needling for any condition other than cLBP are non-covered by Medicare Applicable Codes ● Added modifier code KX ● Added ICD-10 diagnosis codes M40.36, M40.37, M40.46, M40.47, M40.56, M40.57, M41.26, M41.27, M41.56, M41.57, M42.16, M42.17, M43.06, M43.07, M43.16, M43.17, M43.26, M43.27, M43.5X6, M43.5X7, M43.8X6, M43.8X7, M47.16, M47.26, M47.27, M47.816, M47.817, M47.896, M47.897, M48.061, M48.062, M48.07, M48.16, M48.17, M48.26, M48.27, M48.36, M48.37, M48.8X6, M48.8X7, M51.06, M51.16, M51.17, M51.26, M51.27, M51.36, M51.37, M51.46, M51.47, M51.86, M51.87, M53.2X6, M53.2X7, M53.86, M53.87, M54.16, M54.17, M54.31, M54.32, M54.41, M54.42, M54.5, M54.51, M54.59, S32.000A, S32.000B, S32.000D, S32.000G, S32.000K, S32.000S, S32.001A, S32.001B, S32.001D, S32.001G, S32.001K, S32.001S, S32.002A, S32.002B, S32.002D, S32.002G, S32.002K, S32.002S, S32.008A, S32.008B, S32.008D, S32.008G, S32.008K, S32.008S, S32.009A, S32.009B, S32.009D, S32.009G, S32.009K, S32.009S, S32.010A, S32.010B, S32.010D, S32.010G, S32.010K, S32.010S, S32.011A, S32.011B, S32.011D, S32.011G, S32.011K, S32.011S, S32.012A, S32.012B, S32.012D, S32.012G, S32.012K, S32.012S, S32.018A, S32.018B, S32.018D, S32.018G, S32.018K, S32.018S, S32.019A, S32.019B, S32.019D, S32.019G, S32.019K, S32.019S, S32.020A, S32.020B, S32.020D, S32.020G, S32.020K, S32.020S, S32.021A, S32.021B, S32.021D, S32.021G, S32.021K, S32.021S, S32.022A, S32.022B, S32.022D, S32.022G, S32.022K, S32.022S,

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Acupuncture (continued)	May 12, 2022	S32.028A, S32.028B, S32.028D, S32.028G, S32.028K, S32.028S, S32.029A, S32.029B, S32.029D, S32.029G, S32.029K, S32.029S, S32.030A, S32.030B, S32.030D, S32.030G, S32.030K, S32.030S, S32.031A, S32.031B, S32.031D, S32.031G, S32.031K, S32.031S, S32.032A, S32.032B, S32.032D, S32.032G, S32.032K, S32.032S, S32.038A, S32.038B, S32.038D, S32.038G, S32.038K, S32.038S, S32.039A, S32.039B, S32.039D, S32.039G, S32.039K, S32.039S, S32.040A, S32.040B, S32.040D, S32.040G, S32.040K, S32.040S, S32.041A, S32.041B, S32.041D, S32.041G, S32.041K, S32.041S, S32.042A, S32.042B, S32.042D, S32.042G, S32.042K, S32.042S, S32.048A, S32.048B, S32.048D, S32.048G, S32.048K, S32.048S, S32.049A, S32.049B, S32.049D, S32.049G, S32.049K, S32.049S, S32.050A, S32.050B, S32.050D, S32.050G, S32.050K, S32.050S, S32.051A, S32.051B, S32.051D, S32.051G, S32.051K, S32.051S, S32.052A, S32.052B, S32.052D, S32.052G, S32.052K, S32.052S, S32.058A, S32.058B, S32.058D, S32.058G, S32.058K, S32.058S, S32.059A, S32.059B, S32.059D, S32.059G, S32.059K, S32.059S, S33.0XXA, S33.0XXD, S33.0XXS, S33.100A, S33.100D, S33.100S, S33.101A, S33.101D, S33.101S, S33.110A, S33.110D, S33.110S, S33.111A, S33.111D, S33.111S, S33.120A, S33.120D, S33.120S, S33.121A, S33.121D, S33.121S, S33.130A, S33.130D, S33.130S, S33.131A, S33.131D, S33.131S, S33.140A, S33.140D, S33.140S, S33.141A, S33.141D, S33.141S, S33.5XXA, S33.5XXD, S33.5XXS, S33.6XXA, S33.6XXD, S33.6XXS, S34.21XA, S34.21XD, S34.21XS, S34.22XA, S34.22XD, S34.22XS, S39.002A, S39.002D, S39.002S, S39.012A, S39.012D, S39.012S, S39.022A, S39.022D, S39.022S, S39.092A, S39.092D, and S39.092S **Questions and Answers (Q&A)** • Updated Q&A #1 pertaining to limited coverage of acupuncture • Added Q&A #4 addressing the use modifier KX **Supporting Information** • Updated *References* section to reflect the most current information
Blepharoplasty, Blepharoptosis, and Brow Lift	May 12, 2022	**Related Policies** • Added reference link to the Medicare Advantage Policy Guideline titled *Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)* **Policy Summary** ***Guidelines*** • Updated list of clinical information/items to be documented in the medical notes, when applicable: ○ Removed language indicating photographs and medical record documentation must demonstrate at least one of the following (digital or film photographs are acceptable): – For Blepharoplasty Repair • Frontal photos are needed to demonstrate redundant skin on the upper eyelids • Upper eyelid skin resting on the eyelashes or over eyelid margin

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Blepharoplasty, Blepharoptosis, and Brow Lift (continued)	May 12, 2022	● Upper eyelid dermatitis secondary to redundant skin ● Dermatochalasis – For Brow Ptosis Repair ● Photographs should document medical necessity for brow ptosis repair (drooping of brows) ● Frontal photographs are necessary – For a combination of any of the above procedures (blepharoptosis repair, blepharoplasty repair and brow ptosis repair) ● The medical necessity criteria for each procedure must be met and the additional criteria of lateral and full-face photographs with attempts at brow elevation and upward gaze (i.e., with the brow relaxed) must also be met ○ Replaced "visual fields" with "*photographs and/or* visual fields" **Applicable Codes** ● Removed CPT code 67961 **Supporting Information** ● Updated *References* section to reflect the most current information
Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Programs	May 12, 2022	**Title Change** ● Previously titled *Cardiac Rehabilitation Programs for Chronic Heart Failure (NCD 20.10.1)* **Related Policies** ● Removed reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled: ○ *Benson-Henry Institute Cardiac Wellness Program (NCD 20.31.3)* ○ *Intensive Cardiac Rehabilitation (ICR) Programs (NCD 20.31)* ○ *Ornish Program for Reversing Heart Disease (NCD 20.31.2*) ○ *The Pritikin Program (NCD 20.31.1)* **Policy Summary** *Overview* ● Added language [previously outlined in the UnitedHealthcare Medicare Advantage Policy Guideline titled *Intensive Cardiac Rehabilitation (ICR) Programs (NCD 20.31)*] to indicate: ○ Intensive cardiac rehabilitation (ICR) refers to a physician-supervised program that furnishes cardiac rehabilitation services more frequently and often in a more rigorous manner ○ As required by *§1861(eee)(4)(A) of the Social Security Act (the Act)*, an ICR program must show, in peer-reviewed published research, that it accomplished one or more of the following for its patients: ▪ Positively affected the progression of coronary heart disease;

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Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Programs (continued)	May 12, 2022	▪ Reduced the need for coronary bypass surgery; or ▪ Reduced the need for percutaneous coronary interventions ○ The ICR program must also demonstrate through peer-reviewed published research that it accomplished a statistically significant reduction in five or more of the following measures for patients from their levels before cardiac rehabilitation services to after cardiac rehabilitation services: ▪ Low density lipoprotein; ▪ Triglycerides; ▪ Body mass index; ▪ Systolic blood pressure; ▪ Diastolic blood pressure; and ▪ The need for cholesterol, blood pressure, and diabetes medications ○ Individual ICR programs must be approved through the national coverage determination process to ensure that they demonstrate these accomplishments **The Pritikin Program (NCD 20.31.1) (new to policy)** ● Added language [previously outlined in UnitedHealthcare Medicare Advantage Policy Guideline titled *The Pritikin Program (NCD 20.31.1)*] to indicate: ○ The Pritikin diet was designed and adopted by Nathan Pritikin in 1955; the diet was modeled after the diet of the Tarahumara Indians in Mexico, which consisted of 10% fat, 13% protein, 75-80% carbohydrates and provided 15-20 grams per day of crude fiber with only 75 mg/day of cholesterol ○ The Pritikin Program (also known as the Pritikin Longevity Program) evolved into a comprehensive program that is provided in a physician's office and incorporates a specific diet (10%-15% of calories from fat, 15%-20% from protein, 65%-75% from complex carbohydrates), exercise and counseling lasting 21-26 days; an optional residential component is also available for participants **Ornish Program for Reversing Heart Disease (NCD 20.31.2) (new to policy)** ● Added language [previously outlined in the UnitedHealthcare Medicare Advantage Policy Guideline titled *Ornish Program for Reversing Heart Disease (NCD 20.31.2)*] to indicate: ○ The Ornish Program for Reversing Heart Disease (also known as the Multisite Cardiac Lifestyle Intervention Program, the Multicenter Cardiac Lifestyle Intervention Program, and the Lifestyle Heart Trial Program) was initially described in the 1970s and incorporates comprehensive lifestyle modifications including exercise, a low-fat diet, smoking cessation, stress management training, and group support sessions; over the years, the Ornish Program has been refined but continues to focus on these specific risk factors

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Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Programs (continued)	May 12, 2022	**Benson-Henry Institute Cardiac Wellness Program (NCD 20.31.3) (new to policy)**
		• Added language [previously outlined in the UnitedHealthcare Medicare Advantage Policy Guideline titled *Benson-Henry Institute Cardiac Wellness Program (NCD 20.31.3)*] to indicate:
		  ○ The fundamental concepts of the Benson-Henry Institute Cardiac Wellness Program were developed by Herbert Benson, MD, over 40 years ago; Benson states that "in the middle 1960s, when I noticed that people's blood pressures were higher during visits to my office than at other times and wondered whether stress wasn't causing that rise. Stress wasn't on the radar then, so I began investigating a connection between stress and hypertension." (http://www.ideafit.com/fitness-library/mind-body-medicine-balanced-approach)
		  ○ The Cardiac Wellness Program is a multi-component intervention program that includes supervised exercise, behavioral interventions, and counseling, and is designed to reduce cardiovascular risk and improve health outcomes
		Guidelines
		Nationally Covered Indications
		• Replaced language indicating "stable patients are defined as patients who have not had recent (<6 weeks) or planned (<6 months) major cardiovascular hospitalizations or procedures" with "stable patients are defined as patients who have not had recent (≤6 weeks) or planned (≤6 months) major cardiovascular hospitalizations or procedures"
		• Added language to indicate:
		  ○ The Pritikin Program, the Ornish Program for Reversing Heart Disease, and the Benson-Henry Institute Cardiac Wellness Program meet the intensive cardiac rehabilitation (ICR) program requirements set forth by Congress in *§1861(eee) (4) (A) of the Social Security Act* and in regulations at *42 C.F.R. §410.49(c)* and, as such, have been included on the list of approved ICR programs available at https://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/ICR
		Nationally Non-Covered Indications
		• Added language to indicate an ICR program is not covered if it is not included on the list of Medicare-approved ICR programs
		Program Setting
		• Revised language to indicate cardiac rehabilitation and *intensive cardiac rehabilitation* services must be furnished in a physician's office or a hospital outpatient setting
		Applicable Codes
		HCPCS Codes
		• Added G0422 and G0423

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Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Programs (continued)	May 12, 2022	*Diagnosis Codes* For CPT codes 93797 and 93798 ● Added I50.812, I50.814, and I5A ● Removed I50.812 and I50.814 For HCPCS codes G0422 and G0423 ● Added instruction to refer to the National Coverage Determination (NCD) for *Intensive Cardiac Rehabilitation (ICR) Programs (NCD 20.31)* for applicable ICD-10 diagnosis codes Questions and Answers (Q&A) ● Added Q&A #2 addressing the use modifier KX for intensive cardiac rehabilitation (ICR) Supporting Information ● Updated *References* section to reflect the most current information
Cosmetic and Reconstructive Services and Procedures	May 12, 2022	Policy Summary *Guidelines* ● Revised language to indicate: ○ According to the American Society of Plastic Surgeons, the specialty of plastic surgery includes [both] cosmetic and reconstructive procedures: ▪ Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem ▪ Surgery performed purely for the purpose of enhancing one's appearance is not covered ▪ Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, involutional defects, or disease ▪ It is generally performed to improve function but may also be done to approximate a normal appearance *Cosmetic Clinical Indications* ● Removed: ○ Eye surgery that does not correct a functional impairment ○ Nasal surgery performed solely to improve the patient's appearance in the absence of any signs and/or symptoms of functional abnormalities ○ Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen (abdominoplasty) when performed to improve the patient's appearance ○ Abdominal lipectomy/panniculectomy for treatment of: ▪ Neck or back pain ▪ Psychological symptomatology or psychosocial complaints

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Cosmetic and Reconstructive Services and Procedures (continued)	May 12, 2022	• Replaced: ○ "A mastopexy *performed primarily to lift or reshape the breast and* unrelated to breast reconstruction following a medically necessary mastectomy" with "a mastopexy unrelated to breast reconstruction following a medically necessary mastectomy" ○ "Mastectomy for gynecomastia when *the tissue removed is primarily fatty tissue*" with "mastectomy for gynecomastia when *performed solely to improve appearance of the male breast or to alter contours of the chest wall*" ○ "Dermabrasion *when* performed for *a cosmetic reason (i.e.,* post-acne scarring)" with "dermabrasion performed for post-acne scarring *is classified as cosmetic and is not covered*" ○ "Rhytidectomy *when performed for a cosmetic reason*" with "rhytidectomy *is generally considered a cosmetic procedure*" ○ "*Abdominoplasty* and panniculectomy *are not covered* when performed primarily for any of the [listed] indications because it is considered not medically necessary" with "*abdominal lipectomy/* panniculectomy when performed primarily for any of the [listed] indications because it is considered not medically necessary" ○ "Rhinoplasty *solely for the purpose of changing* appearance" with "rhinoplasty/nasal surgery solely *to improve the patient's* appearance *in the absence of any signs and/or symptoms of functional abnormalities*" *Reconstructive Clinical Indications* • Removed: ○ Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen (abdominoplasty) will be considered reasonable and medically necessary when these procedures are performed due to another surgery being done at the same time and would affect the healing of the surgical incision ○ Obstructed nasal breathing due to septal deformity or deviation that has proved unresponsive to medical management and is interfering with the effective use of medically necessary Continuous Positive Airway Pressure (CPAP) for the treatment of an obstructive sleep disorder • Replaced: ○ "Reduction mammoplasty to reduce the size of a normal breast to bring it in symmetry with a breast reconstructed after cancer surgery" with "reduction mammoplasty to improve symmetry following cancer surgery on one breast" ○ "Removal *or revision* of breast implant is considered medically necessary when it is removed for one of the following reasons" with "removal of *a* breast *implant(s)* is considered medically necessary when it is removed for one of the following reasons" ○ "Mastectomy *if it is documented that the tissue is primarily breast tissue and not just adipose (fatty tissue)*" with "mastectomy *with nipple preservation or reduction mammoplasty is considered reconstructive for males with gynecomastia Grade III and IV or abnormal breast development with redundancy"*

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Cosmetic and Reconstructive Services and Procedures (continued)	May 12, 2022	○ "Punch graft hair transplant may be considered reconstructive when it is performed for eyebrow(s) or symmetric hairline replacement following a burn injury or tumor removal" with "punch graft hair transplant may be considered reconstructive when it is performed for eyebrow(s) or symmetric hairline replacement following a burn injury, *trauma,* or tumor removal" ○ "Dermabrasion coverage *may* be provided when correcting defects resulting from traumatic injury, surgery or disease" with "dermabrasion coverage *will* be provided when correcting defects resulting from traumatic injury, surgery or disease" ○ "Abdominal lipectomy/panniculectomy *may be* considered reconstructive when performed to alleviate complicating factors" with "abdominal lipectomy/panniculectomy *is* considered reconstructive when performed to alleviate complicating factors" ○ "Inability to walk normally" with "inability to walk normally *due to pannus size*" ○ "Rhinoplasty, *when there is photographic documentation (all of the following: frontal, lateral, and worm's eye view) of the individual's condition and* the procedure is performed for correction or repair of any of the following" with "rhinoplasty *is considered medically reasonable and necessary when* the procedure is performed for correction or repair of any of the [listed indications]" ○ "Rhinoplasty performed secondary to trauma, disease, congenital defect with nasal airway obstruction *unresponsive to a recent trial of conservative medical management lasting at least six weeks* that has *either* not resolved after previous septoplasty/turbinectomy" with "rhinoplasty performed secondary to trauma, disease, congenital defect with nasal airway obstruction that has not resolved after previous septoplasty/turbinectomy" ○ "Septal deviation causing nasal airway obstruction that has proved unresponsive to a recent trial of conservative medical management *lasting at least six weeks*" with "septal *deformity/*deviation causing nasal airway obstruction that has proved unresponsive to a recent trial of conservative medical management *(e.g., topical nasal corticosteroids, nasal decongestants, nasal dilators); this includes nasal airway obstructions that interfere with the effective use of medically necessary Continuous Positive Airway Pressure (CPAP) for the treatment of an obstructive sleep disorder* " *Documentation Requirements* ● Updated list of clinical information/items to be documented in the medical notes, when applicable: Reduction Mammoplasty ○ Removed: ▪ The evaluation and management note for the date of service and the note for the day the decision to perform surgery was made ○ Replaced:

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Cosmetic and Reconstructive Services and Procedures (continued)	May 12, 2022	▪ "The pathology report *with the weight* of the tissue removed from each breast" with "the pathology report of the tissue removed from each breast" Abdominal Lipectomy/Panniculectomy ○ Removed: ▪ The evaluation and management note in which the decision to perform surgery was made, surgical note and any notes indicating medical complications necessitating the surgery Applicable Codes *CPT Codes* Breast Surgery ● Removed 19324 ● Updated notation: ○ Added reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Breast Reconstruction Following Mastectomy (NCD 140.2)* ○ Removed reference link to the UnitedHealthcare Advantage Policy Guideline titled *Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)* Dermabrasion ● Revised description for 15780, 15782, and 15783 Rhinoplasty/Nasal Reconstructive Surgery ● Added 30520 *Diagnosis Codes* For CPT codes 15830 and 15847 ● Added notation to indicate E65 was "deleted Jul. 10, 2021" For CPT codes 19325 and 19355 ● Added C84.7A, T85.818A, T85.818D, T85.818S, T85.828A, T85.828D, T85.828S, T85.838A, T85.838D, T85.838S, T85.848A, T85.848D, T85.848S, T85.858A, T85.858D, T85.858S, T85.868A, T85.868D, T85.868S, T85.898A, T85.898D, and T85.898S ● Added notation to indicate D24.9, D48.60, and D49.3 were "deleted Jul. 10, 2021" For CPT codes 15780, 15781, 15782, and 15783 ● Added notation to indicate L71.9 was "deleted Jul. 10, 2021" For CPT code 19316 ● Added C84.7A, T85.818A, T85.818D, T85.818S, T85.828A, T85.828D, T85.828S, T85.838A, T85.838D, T85.838S,

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Cosmetic and Reconstructive Services and Procedures (continued)	May 12, 2022	T85.848A, T85.848D, T85.848S, T85.858A, T85.858D, T85.858S, T85.868A, T85.868D, T85.868S, T85.898A, T85.898D, and T85.898S • Added notation to indicate D24.9, D48.60, and D49.3 were "deleted Jul. 10, 2021" For CPT code 19318 • Added notation to indicate: ○ C44.501, C44.511, C44.521, C44.591, C50.021, C50.022, C50.121, C50.122, C50.221, C50.222, C50.321, C50.322, C50.421, C50.521, C50.522, C50.621, C50.622, C50.821, C50.822, C50.921, C50.922, C79.2, C79.81, D04.5, D05.01, D05.02, D05.11, D05.12, D05.81, D05.82, D24.1, D24.2, N60.01, N60.02, N60.11, N60.12, N60.21, N60.22, N60.31, N60.32, N60.41, N60.42, N60.81, N60.82, N60.91, N60.92, and Z42.1 were "deleted Nov. 13, 2021" ○ M25.519, M40.00, M40.03, M40.04, M40.05, M40.202, M40.203, M40.204, M40.205, M40.209, M43.6, N64.2, R29.5, and Z42.8 were "deleted Jul. 11, 2021" For CPT codes 30400, 30410, 30420, 30430, 30435, 30450, 30460, 30462, and 30468 • Added notation to indicate Q37.8 and Q37.9 were "deleted Jul. 10, 2021" Definitions • Added definition of: ○ American Society of Plastic Surgeons' Gynecomastia Scale • Updated definition of: ○ Abdominoplasty ○ Macromastia (Breast Hypertrophy) Supporting Information • Updated *References* section to reflect the most current information
Pressure Reducing Support Surfaces	May 12, 2022	Policy Summary *Overview* • Replaced references to "UnitedHealthcare" with "Medicare" Documentation Requirements • Removed content/language pertaining to documentation requirements Applicable Codes • Removed Modifier code EY Supporting Information • Updated *References* section to reflect the most current information

Policy Guideline Updates

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Transcutaneous Electrical Nerve Stimulation (TENS)	May 12, 2022	**Title Change** ● Previously titled *Transcutaneous Electrical Nerve Stimulation (TENS) for Acute Post-Operative Pain (NCD 10.2)* **Related Policies** ● Removed reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP) (NCD 160.27)* **Policy Summary** *Overview* ● Added language (previously located in the *Guidelines* section) to indicate: ○ A transcutaneous electrical nerve stimulator (TENS) is a device that utilizes electrical current delivered through electrodes placed on the surface of the skin to decrease the patient's perception of pain by inhibiting the transmission of afferent pain nerve impulses and/or stimulating the release of endorphins ○ A TENS unit must be distinguished from other electrical stimulators (e.g., neuromuscular stimulators), which are used to directly stimulate muscles and/or motor nerves ○ TENS is a type of electrical nerve stimulator that is employed to treat chronic intractable pain; this stimulator is attached to the surface of the patient's skin over the peripheral nerve to be stimulated *Guidelines* ● Added language to indicate: ○ A TENS is covered for the treatment of beneficiaries with chronic, intractable pain (other than chronic low back pain), or acute post-operative pain **Acute Post-Operative Pain (new to policy)** ● Added language to indicate: ○ TENS is covered for acute post-operative pain ○ Coverage is limited to 30 days (one month's rental) from the day of surgery; payment will be made only as a rental ○ A TENS unit will be denied as not reasonable and necessary for acute pain (less than three months duration) other than for post-operative pain **Chronic Pain Other than Low Back Pain (new to policy)** ● Added language to indicate: ○ TENS is covered for chronic, intractable pain other than chronic low back pain when all of the following criteria must be met: ▪ The presumed etiology of the pain must be a type that is accepted as responding to TENS therapy; examples of conditions for which TENS therapy is not considered to be reasonable and necessary are (not all-inclusive): – Headache

Policy Guideline Updates

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Transcutaneous Electrical Nerve Stimulation (TENS) (continued)	May 12, 2022	– Visceral abdominal pain – Pelvic pain – Temporomandibular joint (TMJ) pain ▪ The pain must have been present for at least three months ▪ Other appropriate treatment modalities must have been tried and failed ○ TENS therapy for chronic pain that does not meet these criteria will be denied as not reasonable and necessary ○ When used for the treatment of chronic, intractable pain, the TENS unit must be used by the beneficiary on a trial basis for a minimum of one month (30 days), but not to exceed two months ○ The trial period will be paid as a rental; the trial period must be monitored by the treating practitioner to determine the effectiveness of the TENS unit in modulating the pain ○ For coverage of a purchase, the treating practitioner must determine that the beneficiary is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time ○ A 4-lead TENS unit may be used with either 2 leads or 4 leads, depending on the characteristics of the beneficiary's pain; if it is ordered for use with 4 leads, the medical record must document why 2 leads are insufficient to meet the beneficiary's needs **Chronic Low Back Pain (CLBP) (new to policy)** ● Added language [previously outlined in the UnitedHealthcare Medicare Advantage Policy Guideline titled [*Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP) (NCD 160.27)*] to indicate: ○ TENS therapy for Chronic Low Back Pain will be denied as not reasonable and necessary ○ Chronic low back pain (CLBP) is defined as: ▪ An episode of low back pain that has persisted for three months or longer; and ▪ Not a manifestation of a clearly defined and generally recognizable primary disease entity; for example, there are cancers that, through metastatic spread to the spine or pelvis, may elicit pain in the lower back as a symptom; and certain systemic diseases such as rheumatoid arthritis and multiple sclerosis manifest many debilitating symptoms of which low back pain is not the primary focus **Supplies** ● Added language to indicate: ○ HCPCS code A4595 (TENS supply allowance) is an all-inclusive code ○ HCPCS codes A4556 (electrodes, [e.g., apnea monitor], per pair), A4558 (conductive paste or gel), and A4630 (replacement batteries, medically necessary TENS owned by patient) are not valid for claim submission to the DME MAC; HCPCS code A4595 should be used instead ○ For code A4557, one unit of service is for lead wires going to two electrodes; if all the lead wires of a 4 lead TENS unit needed to be replaced, billing would be for two units of service

Policy Guideline Updates

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Transcutaneous Electrical Nerve Stimulation (TENS) (continued)	May 12, 2022	○ Separate allowance will be made for replacement supplies when they are reasonable and necessary and are used with a covered TENS; usual maximum utilization is: ▪ 2 TENS leads - a maximum of one unit of A4595 per month ▪ 4 TENS leads - a maximum of two units of A4595 per month ○ If the use of the TENS unit is less than daily, the frequency of billing for the TENS supply code should be reduced proportionally ○ Replacement of lead wires (HCPCS code A4557) more often than every 12 months would rarely be reasonable and necessary ○ A conductive garment (HCPCS code E0731) used with a TENS unit is rarely reasonable and necessary, but is covered only if all of the following conditions are met: ▪ It has been prescribed by the treating practitioner for use in delivering covered TENS treatment ▪ One of the medical indications outlined below is met: – The beneficiary cannot manage without the conductive garment because: ● There is such a large area or so many sites to be stimulated, and ● The stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires – The beneficiary cannot manage without the conductive garment for the treatment of chronic intractable pain because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires – The beneficiary has a documented medical condition, such as skin problems, that preclude the application of conventional electrodes, adhesive tapes, and lead wires – The beneficiary requires electrical stimulation beneath a cast to treat chronic intractable pain ○ A conductive garment is not covered for use with a TENS device during the trial period unless: ▪ The beneficiary has a documented skin problem prior to the start of the trial period, and ▪ The TENS is reasonable and necessary for the beneficiary ○ If the criteria above are not met for HCPCS code E0731, it will be denied as not reasonable and necessary ○ Reimbursement for supplies is contingent upon use with a covered TENS unit; claims for TENS supplies provided when there is no covered TENS unit will be denied as not reasonable and necessary Applicable Codes *Non-Covered Diagnosis Codes* ● Added list of applicable non-covered ICD-10 diagnosis codes: M40.36, M40.37, M40.46, M40.47, M40.56, M40.57, M41.26, M41.27, M41.56, M41.57, M42.16, M42.17, M43.06, M43.07, M43.16, M43.17, M43.26, M43.27, M43.5X6, M43.5X7, M43.8X6, M43.8X7, M47.16, M47.26, M47.27, M47.816, M47.817, M47.896, M47.897, M48.061, M48.062,

Policy Guideline Updates

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Transcutaneous Electrical Nerve Stimulation (TENS) (continued)	May 12, 2022	M48.07, M48.16, M48.17, M48.26, M48.27, M48.36, M48.37, M48.8X6, M48.8X7, M51.06, M51.16, M51.17, M51.26, M51.27, M51.36, M51.37, M51.46, M51.47, M51.86, M51.87, M53.2X6, M53.2X7, M53.86, M53.87, M54.16, M54.17, M54.31, M54.32, M54.41, M54.42, M54.5, M54.50, M54.51, M54.59, S32.000A, S32.000B, S32.000D, S32.000G, S32.000K, S32.000S, S32.001A, S32.001B, S32.001D, S32.001G, S32.001K, S32.001S, S32.002A, S32.002B, S32.002D, S32.002G, S32.002K, S32.002S, S32.008A, S32.008B, S32.008D, S32.008G, S32.008K, S32.008S, S32.009A, S32.009B, S32.009D, S32.009G, S32.009K, S32.009S, S32.010A, S32.010B, S32.010D, S32.010G, S32.010K, S32.010S, S32.011A, S32.011B, S32.011D, S32.011G, S32.011K, S32.011S, S32.012A, S32.012B, S32.012D, S32.012G, S32.012K, S32.012S, S32.018A, S32.018B, S32.018D, S32.018G, S32.018K, S32.018S, S32.019A, S32.019B, S32.019D, S32.019G, S32.019K, S32.019S, S32.020A, S32.020B, S32.020D, S32.020G, S32.020K, S32.020S, S32.021A, S32.021B, S32.021D, S32.021G, S32.021K, S32.021S, S32.022A, S32.022B, S32.022D, S32.022G, S32.022K, S32.022S, S32.028A, S32.028B, S32.028D, S32.028G, S32.028K, S32.028S, S32.029A, S32.029B, S32.029D, S32.029G, S32.029K, S32.029S, S32.030A, S32.030B, S32.030D, S32.030G, S32.030K, S32.030S, S32.031A, S32.031B, S32.031D, S32.031G, S32.031K, S32.031S, S32.032A, S32.032B, S32.032D, S32.032G, S32.032K, S32.032S, S32.038A, S32.038B, S32.038D, S32.038G, S32.038K, S32.038S, S32.039A, S32.039B, S32.039D, S32.039G, S32.039K, S32.039S, S32.040A, S32.040B, S32.040D, S32.040G, S32.040K, S32.040S, S32.041A, S32.041B, S32.041D, S32.041G, S32.041K, S32.041S, S32.042A, S32.042B, S32.042D, S32.042G, S32.042K, S32.042S, S32.048A, S32.048B, S32.048D, S32.048G, S32.048K, S32.048S, S32.049A, S32.049B, S32.049D, S32.049G, S32.049K, S32.049S, S32.050A, S32.050B, S32.050D, S32.050G, S32.050K, S32.050S, S32.051A, S32.051B, S32.051D, S32.051G, S32.051K, S32.051S, S32.052A, S32.052B, S32.052D, S32.052G, S32.052K, S32.052S, S32.058A, S32.058B, S32.058D, S32.058G, S32.058K, S32.058S, S32.059A, S32.059B, S32.059D, S32.059G, S32.059K, S32.059S, S33.0XXA, S33.0XXD, S33.0XXS, S33.100A, S33.100D, S33.100S, S33.101A, S33.101D, S33.101S, S33.110A, S33.110D, S33.110S, S33.111A, S33.111D, S33.111S, S33.120A, S33.120D, S33.120S, S33.121A, S33.121D, S33.121S, S33.130A, S33.130D, S33.130S, S33.131A, S33.131D, S33.131S, S33.140A, S33.140D, S33.140S, S33.141A, S33.141D, S33.141S, S33.5XXA, S33.5XXD, S33.5XXS, S33.6XXA, S33.6XXD, S33.6XXS, S34.21XA, S34.21XD, S34.21XS, S34.22XA, S34.22XD, S34.22XS, S39.002A, S39.002D, S39.002S, S39.012A, S39.012D, S39.012S, S39.022A, S39.022D, S39.022S, S39.092A, S39.092D, and S39.092S **Supporting Information** • Updated *References* section to reflect the most current information
Urological Supplies	May 12, 2022	**Policy Summary** *Catheter Insertion Tray* • Removed instruction to refer to the Centers for Medicare & Medicaid Services (CMS) Local Coverage Determinations (LCDs) and Local Coverage Articles (LCAs) for coverage indications, limitations, and/or medical necessity guidelines

Policy Guideline Updates

Revised

Policy Title	Approval Date	Summary of Changes

Urological Supplies (continued)	May 12, 2022	*PureWick™ Urine Collection System (HCPCS code K1006) (new to policy)*
		• Added language to indicate the PureWick™ Female External Catheter and PureWick™ Urine Collection System are unproven and not medically necessary for managing urinary incontinence due to insufficient evidence of efficacy
		Documentation Requirements – General (new to policy)
		• Added language to indicate:
		  ○ There are numerous 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 LCD, 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
		• Added HCPCS code K1006
		Supporting Information
		• Updated *References* section to reflect the most current information

Replaced

Policy Title	Approval Date	Summary of Changes
Acupuncture for Chronic Lower Back Pain (cLBP) (NCD 30.3.3)	May 12, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled Acupuncture
Acupuncture for Fibromyalgia (NCD 30.3.1)	May 12, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled Acupuncture
Acupuncture for Osteoarthritis (NCD 30.3.2)	May 12, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled Acupuncture
Benson-Henry Institute Cardiac Wellness Program (NCD 20.31.3)	May 12, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Programs

Policy Guideline Updates

Replaced

Policy Title	Approval Date	Summary of Changes
Intensive Cardiac Rehabilitation (ICR) Programs (NCD 20.31)	May 12, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Programs
Intravenous Immune Globulin for the Treatment of Autoimmune Mucocutaneous Blistering Diseases (NCD 250.3)	May 12, 2022	• Policy replaced, refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled Intravenous Immune Globulin (IVIG)
Ornish Program for Reversing Heart Disease (NCD 20.31.2)	May 12, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Programs
The Pritikin Program (NCD 20.31.1)	May 12, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Programs
Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP) (NCD 160.27)	May 12, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled Transcutaneous Electrical Nerve Stimulation (TENS)

Retired

The following Policy Guidelines have been retired effective May 12, 2022:

- Computer Enhanced Perimetry (NCD 80.9)
- Extracranial-Intracranial (EC-IC) Arterial Bypass Surgery (NCD 20.2)
- Hydrophilic Contact Lenses (NCD 80.4)
- Hydrophilic Contact Lenses for Corneal Bandage (NCD 80.1)
- Intraocular Lenses (IOLs) (NCD 80.12)
- Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) for Essential Tremor
- Self-Contained Pacemaker Monitors (NCD 20.8.2)
- Transcranial Magnetic Stimulation

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.