UnitedHealthcare Medicare Advantage

UnitedHealthcare Medicare Advantage

Policy Guideline Update Bulletin: June 2023

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New		
Policy Title	**Approval Date**	**Policy Summary**
Intravitreal Corticosteroid Implants	May 10, 2023	**Overview** Intravitreal implants are specially designed to release drugs in a controlled manner over a longer duration. It helps to directly deliver the drug to the vitreous, thus overcoming systemic pathways and obtaining a high drug concentration in the vitreous chamber. **Guidelines** The U.S. Food and Drug Administration approved Iluvien® (fluocinolone acetonide intravitreal implant) 0.19 mg for the treatment of diabetic macular edema (DME) in patients who have been previously treated with a course of corticosteroids and did not have a clinically significant rise in intraocular pressure. Iluvien® is an intravitreal implant of fluocinolone acetonide and is the first DME treatment to deliver 36 months of continuous, low dose corticosteroid with a single injection. The Iluvien® intravitreal implant is designed to release fluocinolone acetonide/day at an initial rate of 0.25 µg/day.

Updated		
Policy Title	**Approval Date**	**Summary of Changes**
Blepharoplasty, Blepharoptosis, and Brow Lift	May 10, 2023	**Policy Summary** ***Guidelines*** • Removed language indicating coverage is based upon the existing Local Coverage Determination (LCD) for the jurisdiction in which the procedure is performed **Applicable Codes** ***Diagnosis Codes*** For CPT Codes 15820 and 15821 (Facility Only) • Added list of applicable codes: C44.1021, C44.1022, C44.1091, C44.1092, C44.1121, C44.1122, C44.1191, C44.1192, C44.1221, C44.1222, C44.1291, C44.1292, C44.131, C44.1321, C44.1322, C44.1391, C44.1392, C44.1921, C44.1922, C44.1991, C44.1992, C44.301, C44.309, C44.311, C44.319, C44.321, C44.329, C44.391, C44.399, C44.90, C44.91, C44.92, C44.99, C47.0, C49.0, D04.111, D04.112, D04.121, D04.122, D22.111, D22.112, D22.121, D22.122, D22.30, D22.39, D23.111, D23.112, D23.121, D23.122, D23.30, D23.39, G24.5, G51.0, G51.2, G51.31, G51.32, G51.33, G51.4, G51.8, G51.9, G70.00, G70.80, G70.81, G73.1, H01.001, H01.002, H01.004, H01.005, H01.00A, H01.00B, H01.01A, H01.01B, H01.02A, H01.02B, H02.001, H02.002, H02.004, H02.005, H02.011, H02.012, H02.014, H02.015, H02.021, H02.022, H02.024, H02.025, H02.031, H02.032, H02.034, H02.035, H02.041, H02.042, H02.044, H02.045, H02.051, H02.052, H02.054, H02.055, H02.101, H02.102, H02.104, H02.105, H02.111, H02.112, H02.114, H02.115, H02.121,

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Updated		
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Blepharoplasty, Blepharoptosis, and Brow Lift (continued)	May 10, 2023	H02.122, H02.124, H02.125, H02.131, H02.132, H02.134, H02.135, H02.141, H02.142, H02.144, H02.145, H02.151, H02.152, H02.154, H02.155, H02.156, H02.159, H02.201, H02.202, H02.204, H02.205, H02.20A, H02.20B, H02.20C, H02.211, H02.212, H02.214, H02.215, H02.21A, H02.21B, H02.21C, H02.221, H02.222, H02.224, H02.225, H02.22A, H02.22B, H02.22C, H02.231, H02.232, H02.234, H02.235, H02.23A, H02.23B, H02.23C, H02.31, H02.32, H02.34, H02.35, H02.401, H02.402, H02.403, H02.411, H02.412, H02.413, H02.421, H02.422, H02.423, H02.431, H02.432, H02.433, H02.521, H02.522, H02.524, H02.525, H02.531, H02.532, H02.534, H02.535, H02.70, H02.831, H02.832, H02.834, H02.835, H02.881, H02.882, H02.884, H02.885, H02.88A, H02.88B, H02.89, H02.9, H04.521, H04.522, H04.523, H50.89, H57.811, H57.812, H57.813, L11.8, L11.9, L57.2, L57.4, L66.4, L85.8, L87.1, L87.8, L90.3, L90.4, L90.8, L91.8, L92.2, L94.8, L98.5, L98.6, L99, Q10.0, Q10.1, Q10.2, Q10.3, Q11.1, S04.51XA, S04.52XA, T85.21XA, T85.22XA, T85.29XA, Z44.21, Z44.22, and Z90.01 For CPT Codes 15822 and 15823 (Facility Only) • Added list of applicable codes: C43.111, C43.112, C43.121, C43.122, C44.1021, C44.1022, C44.1091, C44.1092, C44.1121, C44.1122, C44.1191, C44.1192, C44.1221, C44.1222, C44.1291, C44.1292, C44.131, C44.1321, C44.1322, C44.1391, C44.1392, C44.1921, C44.1922, C44.1991, C44.1992, C44.300, C44.301, C44.309, C44.311, C44.319, C44.321, C44.329, C44.391, C44.399, C44.90, C44.91, C44.92, C44.99, C47.0, C49.0, D03.111, D03.112, D03.121, D03.122, D04.111, D04.112, D04.121, D04.122, D04.39, D22.111, D22.112, D22.121, D22.122, D22.30, D22.39, D23.111, D23.112, D23.121, D23.122, D23.30, D23.39, G24.5, G51.0, G51.2, G51.31, G51.32, G51.33, G51.4, G51.8, G51.9, G70.00, G70.80, G70.81, G73.1, H01.001, H01.002, H01.004, H01.005, H01.00A, H01.00B, H01.01A, H01.01B, H01.02A, H01.02B, H02.001, H02.002, H02.004, H02.005, H02.011, H02.012, H02.014, H02.015, H02.021, H02.022, H02.024, H02.025, H02.031, H02.032, H02.034, H02.035, H02.041, H02.042, H02.044, H02.045, H02.051, H02.052, H02.054, H02.055, H02.101, H02.102, H02.104, H02.105, H02.111, H02.112, H02.114, H02.115, H02.121, H02.122, H02.124, H02.125, H02.131, H02.132, H02.134, H02.135, H02.141, H02.142, H02.144, H02.145, H02.151, H02.152, H02.154, H02.155, H02.156, H02.159, H02.201, H02.202, H02.204, H02.205, H02.20A, H02.20B, H02.20C, H02.211, H02.212, H02.214, H02.215, H02.21A, H02.21B, H02.21C, H02.221, H02.222, H02.224, H02.225, H02.22A, H02.22B, H02.22C, H02.231, H02.232, H02.234, H02.235, H02.23A, H02.23B, H02.23C, H02.31, H02.32, H02.34, H02.35, H02.401, H02.402, H02.403, H02.411, H02.412, H02.413, H02.421, H02.422, H02.423, H02.431, H02.432, H02.433, H02.521, H02.522, H02.524, H02.525, H02.531, H02.532, H02.534, H02.535, H02.70, H02.831, H02.832, H02.834, H02.835, H02.881, H02.882, H02.884, H02.885, H02.88A, H02.88B, H02.89, H02.9, H04.521, H04.522, H04.523, H50.89, H57.811, H57.812, H57.813, L11.8, L11.9, L57.2, L57.4, L66.4, L85.8, L87.1, L87.8, L90.3, L90.4, L90.8, Q10.0, Q10.1, Q10.2, Q10.3, Q11.1, Q15.9, Q18.8, S00.10XA, S00.10XD, S00.10XS, S00.11XA, S00.11XD, S00.11XS, S00.12XA, S00.12XD, S00.12XS, S01.101A, S01.101D, S01.101S, S01.102A, S01.102D, S01.102S, S01.111A, S01.111D, S01.111S, S01.112A, S01.112D, S01.112S, S01.119A, S01.119D, S01.119S, S01.121A, S01.121D, S01.121S, S01.122A, S01.122D, S01.122S, S01.129A, S01.129D, S01.129S, S01.131A, S01.131D, S01.131S,

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Updated		
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Blepharoplasty, Blepharoptosis, and Brow Lift (continued)	May 10, 2023	S01.132A, S01.132D, S01.132S, S01.139A, S01.139D, S01.139S, S01.141A, S01.141D, S01.141S, S01.142A, S01.142D, S01.142S, S01.149A, S01.149D, S01.149S, S01.151A, S01.151D, S01.151S, S01.152A, S01.152D, S01.152S, S01.159A, S01.159D, S01.159S, S04.51XA, S04.52XA, S05.20XA, S05.20XD, S05.20XS, S05.21XA, S05.21XD, S05.21XS, S05.22XA, S05.22XD, S05.22XS, S09.92XA, S09.92XD, S09.92XS, S09.93XA, S09.93XD, S09.93XS, S16.8XXA, S16.8XXD, S16.8XXS, S16.9XXA, S16.9XXD, S16.9XXS, S19.80XA, S19.80XD, S19.80XS, S19.81XA, S19.81XD, S19.81XS, S19.82XA, S19.82XD, S19.82XS, S19.83XA, S19.83XD, S19.83XS, S19.84XA, S19.84XD, S19.84XS, S19.85XA, S19.85XD, S19.85XS, S19.89XA, S19.89XD, S19.89XS, S19.9XXA, S19.9XXD, S19.9XXS, T26.00XA, T26.00XD, T26.00XS, T26.01XA, T26.01XD, T26.01XS, T26.02XA, T26.02XD, T26.02XS, T26.20XA, T26.20XD, T26.20XS, T26.21XA, T26.21XD, T26.21XS, T26.22XA, T26.22XD, T26.22XS, T26.40XA, T26.40XD, T26.40XS, T26.41XA, T26.41XD, T26.41XS, T26.42XA, T26.42XD, T26.42XS, T26.50XA, T26.50XD, T26.50XS, T26.51XA, T26.51XD, T26.51XS, T26.52XA, T26.52XD, T26.52XS, T85.21XA, T85.22XA, T85.29XA, Z44.21, Z44.22, and Z90.01 For CPT Codes 67900, 67901, 67902, 67903, 67904, 67906, and 67908 (Facility Only) • Added list of applicable codes: C43.111, C43.112, C43.121, C43.122, C44.1021, C44.1022, C44.1091, C44.1092, C44.1121, C44.1122, C44.1191, C44.1192, C44.1221, C44.1222, C44.1291, C44.1292, C44.1921, C44.1922, C44.1991, C44.1992, C44.300, C44.301, C44.309, C44.311, C44.319, C44.321, C44.329, C44.391, C44.399, C47.0, C49.0, D03.111, D03.112, D03.121, D03.122, D04.111, D04.112, D04.121, D04.122, D04.39, D22.111, D22.112, D22.121, D22.122, D23.111, D23.112, D23.121, D23.122, G24.5, G51.2, G51.31, G51.32, G51.4, G70.00, G70.80, G70.81, G73.1, H02.001, H02.002, H02.004, H02.005, H02.011, H02.012, H02.014, H02.015, H02.021, H02.022, H02.024, H02.025, H02.031, H02.032, H02.034, H02.035, H02.041, H02.042, H02.044, H02.045, H02.051, H02.052, H02.054, H02.055, H02.101, H02.102, H02.104, H02.105, H02.111, H02.112, H02.114, H02.115, H02.121, H02.122, H02.124, H02.125, H02.131, H02.132, H02.134, H02.135, H02.141, H02.142, H02.144, H02.145, H02.151, H02.152, H02.154, H02.155, H02.201, H02.202, H02.204, H02.205, H02.20A, H02.20B, H02.20C, H02.211, H02.212, H02.214, H02.215, H02.21A, H02.21B, H02.21C, H02.221, H02.222, H02.224, H02.225, H02.22A, H02.22B, H02.22C, H02.231, H02.232, H02.234, H02.235, H02.23A, H02.23B, H02.23C, H02.31, H02.32, H02.34, H02.35, H02.401, H02.402, H02.403, H02.411, H02.412, H02.413, H02.421, H02.422, H02.423, H02.431, H02.432, H02.433, H02.521, H02.522, H02.524, H02.525, H02.531, H02.532, H02.534, H02.535, H02.70, H02.831, H02.832, H02.834, H02.835, H57.811, H57.812, H57.813, L57.4, L85.8, Q10.0, Q10.1, Q10.2, Q10.3, Q11.1, Q15.9, Q18.8, S00.10XA, S00.10XD, S00.10XS, S00.11XA, S00.11XD, S00.11XS, S00.12XA, S00.12XD, S00.12XS, S01.101A, S01.101D, S01.101S, S01.102A, S01.102D, S01.102S, S01.111A, S01.111D, S01.111S, S01.112A, S01.112D, S01.112S, S01.119A, S01.119D, S01.119S, S01.121A, S01.121D, S01.121S, S01.122A, S01.122D, S01.122S, S01.129A, S01.129D, S01.129S, S01.131A, S01.131D, S01.131S, S01.132A, S01.132D, S01.132S, S01.139A, S01.139D, S01.139S, S01.141A, S01.141D, S01.141S, S01.142A, S01.142D, S01.142S, S01.149A, S01.149D, S01.149S, S01.151A, S01.151D,

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Updated		
Policy Title	**Approval Date**	**Summary of Changes**
Blepharoplasty, Blepharoptosis, and Brow Lift (continued)	May 10, 2023	S01.151S, S01.152A, S01.152D, S01.152S, S01.159A, S01.159D, S01.159S, S05.20XA, S05.20XD, S05.20XS, S05.21XA, S05.21XD, S05.21XS, S05.22XA, S05.22XD, S05.22XS, S09.92XA, S09.92XD, S09.92XS, S09.93XA, S09.93XD, S09.93XS, S16.8XXA, S16.8XXD, S16.8XXS, S16.9XXA, S16.9XXD, S16.9XXS, S19.80XA, S19.80XD, S19.80XS, S19.81XA, S19.81XD, S19.81XS, S19.82XA, S19.82XD, S19.82XS, S19.83XA, S19.83XD, S19.83XS, S19.84XA, S19.84XD, S19.84XS, S19.85XA, S19.85XD, S19.85XS, S19.89XA, S19.89XD, S19.89XS, S19.9XXA, S19.9XXD, S19.9XXS, T26.00XA, T26.00XD, T26.00XS, T26.01XA, T26.01XD, T26.01XS, T26.02XA, T26.02XD, T26.02XS, T26.20XA, T26.20XD, T26.20XS, T26.21XA, T26.21XD, T26.21XS, T26.22XA, T26.22XD, T26.22XS, T26.40XA, T26.40XD, T26.40XS, T26.41XA, T26.41XD, T26.41XS, T26.42XA, T26.42XD, T26.42XS, T26.50XA, T26.50XD, T26.50XS, T26.51XA, T26.51XD, T26.51XS, T26.52XA, T26.52XD, T26.52XS, Z44.21 and Z44.22 **Supporting Information** • Updated *References* section to reflect the most current information
Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Programs	May 10, 2023	**Applicable Codes** ***Diagnosis Codes*** • Added notation to indicate I21.9, I21.A1, I21.A9, I25.10, and I50.32 were “deleted Sep. 30, 2021” for CPT codes 93797 and 93798 **Supporting Information** • Updated *References* section to reflect the most current information
Clinical Diagnostic Laboratory Services	May 10, 2023	**Applicable Codes** • Added CPT codes 0289U, 0290U, 0291U, 0292U, 0293U, and 0294U • Added notation to indicate HCPCS codes U0003, U0004, and U0005 were “deleted May 12, 2023” **Supporting Information** • Updated *References* section to reflect the most current information
Cosmetic and Reconstructive Services and Procedures	May 10, 2023	**Policy Summary** ***Coding Clarifications*** • Relocated notations pertaining to skin/deep tissue flaps and graft procedures (refer to the *Applicable Codes* section) **Applicable Codes** ***CPT Codes*** Autologous Soft Tissue and Fat Grafting • Added 15773 and 15774 Cosmetic (Always Considered Cosmetic and Non-Covered) • Removed and reclassified/relocated 15773 and 15774 (refer to the list of applicable codes for *Autologous Soft Tissue*

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Policy Title	Approval Date	Summary of Changes

Cosmetic and Reconstructive Services and Procedures (continued)	May 10, 2023	*and Fat Grafting*)
		Flaps (Skin and/or Deep Tissue) Procedures
		• Added notation (relocated from the *Guidelines* section) to indicate:
		  ○ CPT codes 15733-15738 are described by donor site of the muscle, myocutaneous or fasciocutaneous flap
		  ○ A repair of a donor site requiring a skin graft or local flaps is considered an additional separate procedure
		    ▪ CPT codes 15756-15758 represent microvascular flaps
		    ▪ CPT codes 15570-15576 represent flaps without inclusion of a vascular pedicle
		    ▪ CPT codes 14000-14302 represent flaps for adjacent tissue transfer
		  ○ The regions listed refer to recipient area (not the donor site) when a flap is being attached in a transfer or to a final site
		  ○ CPT codes 15570-15738 do not include extensive immobilization (e.g., large plaster casts and other immobilizing devices are considered additional separate procedures)
		Other Flaps and Grafts Procedures
		• Added notation (relocated from the *Guidelines* section) to indicate:
		  ○ CPT code 15740 describes a cutaneous flap, transposed into a nearby but not immediately adjacent defect, with a pedicle that incorporates an anatomically named axial vessel into its design
		    ▪ The flap is typically transferred through a tunnel underneath the skin and sutured into its new position
		    ▪ The donor site is closed directly
		  ○ Neurovascular pedicle procedures are reported with CPT code 15750
		    ▪ This code includes not only skin but also a functional motor or sensory nerve(s)
		    ▪ The flap serves to re-innervate a damaged portion of the body dependent on touch or movement (e.g., thumb)
		    ▪ Repair of donor site requiring skin graft or local flaps should be reported as an additional procedure
		  ○ For random island flaps, V-Y subcutaneous flaps, advancement flaps and other flaps from adjacent areas without clearly defined anatomically named axial vessels; see CPT codes 14000-14302
		Diagnosis Codes
		For CPT Codes 15830 and 15847
		• Removed E65
		For CPT Codes 19325, 19355, and 19316
		• Removed D24.9, D48.60, and D49.3
		For CPT Codes 15780, 15781, 15782, and 15783
		• Removed L71.9

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Cosmetic and Reconstructive Services and Procedures (continued)	May 10, 2023	For CPT Codes 21120, 21121, 21122, 21123, 21125, 21127, 21137, 21138, 21139, 21172, 21175, 21179, 21180, 21181, 21182, 21183, 21184, 21208, 21209, 21230, 21255, 21256, 21260, 21261, 21263, 21267, 21268, 21270, 21275, 21295, and 21296 • Added C4A.21 and C4A.22 • Revised description for C84.41 For CPT Code 19318 • Removed 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, M25.519, M40.00, M40.03, M40.04, M40.05, M40.202, M40.203, M40.204, M40.205, M40.209, M43.6, 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, R29.5, Z42.1, and Z42.8 For CPT Codes 30400, 30410, 30420, 30430, 30435, 30450, 30460, 30462, and 30468 • Removed Q37.8 and Q37.9 **Supporting Information** • Updated *References* section to reflect the most current information
Gender Dysphoria and Gender Reassignment Surgery (NCD 140.9)	May 10, 2023	**Applicable Codes** ***Other Ancillary Services*** • Removed CPT code 19324 **Supporting Information** • Updated *References* section to reflect the most current information
Intraocular Photography (NCD 80.6)	May 10, 2023	**Applicable Codes** ***Remote Imaging of Retina*** • Revised description for CPT code 92229
Pharmacogenomics Testing	May 10, 2023	**Applicable Codes** ***Non-Covered Diagnosis Codes*** • Removed CPT codes 0289U, 0290U, 0291U, 0292U, 0293U, and 0294U
Transcatheter Edge-to-Edge Repair (TEER) for Mitral Valve Regurgitation (NCD 20.33)	May 10, 2023	**Applicable Codes** • Removed ICD-10 procedure codes 02QG3ZE, 02QG4ZE, 02UG37E, 02UG38E, 02UG3JE, 02UG3KZ, 02UG47E, 02UG48E, 02UG4JE, 02UG4KE, 02WG37Z, 02WG38Z, 02WG3JZ, and 02WG3KZ **Questions and Answers (Q&A)**

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Policy Title	Approval Date	Summary of Changes
Transcatheter Edge-to-Edge Repair (TEER) for Mitral Valve Regurgitation (NCD 20.33) (continued)	May 10, 2023	• Updated Q&A pertaining to verification of CPT/HCPCS codes with limited coverage under CED (Coverage with Evidence Development) prior to claim submission **Supporting Information** • Updated *References* section to reflect the most current information
Transcutaneous Electrical Nerve Stimulation (TENS)	May 10, 2023	**Applicable Codes** • Added M51.A1, M51.A2, M51.A4, and M51.A5 to the list of non-covered diagnosis codes

Revised

Policy Title	Approval Date	Summary of Changes

Incontinence Control Devices (NCD 230.10)	May 10, 2023	**Policy Summary**
		Continued Coverage for the inFlow Device Beyond the First Three Months of Therapy
		• Removed language pertaining to claims with dates of service prior to Apr. 1, 2021
		• Added language pertaining to claims with dates of service on or after Apr. 1, 2023 to indicate:
		  ○ The inFlow Intraurethral Valve-Pump system (Vesiflo, Inc.) must be billed using HCPCS code A4341 (indwelling intraurethral drainage device with valve, patient inserted, replacement only, each)
		  ○ If a replacement of the indwelling intraurethral drainage device with valve is performed by the treating practitioner, claims for this service must be billed to the Part B MAC
		• Replaced language indicating:
		  ○ "Claims for [the initial sizing and insertion of the inFlow device] billed to the *DME* MAC, *will be denied as wrong jurisdiction*" with "claims for these services *must be* billed to the *Part B* MAC"
		  ○ "Replacement of the indwelling intraurethral drainage device with valve is *typically* done by a trained caregiver at home and may be billed on a monthly basis" with "replacement of the indwelling intraurethral drainage device with valve is done by a trained caregiver *or the beneficiary* at home and may be billed on a monthly basis"
		  ○ "Since the activator and charging base are provided at the time of initial issue to the beneficiary, these may only be billed to the DME MAC as a replacement" with "since the activator and charging base are provided at the time of initial issue *in the treating practitioner's office* to the beneficiary, these may only be billed to the DME MAC as a replacement *using HCPCS code A4342 (accessories for patient inserted indwelling intraurethral drainage device with valve, replacement only, each)*"
		Applicable Codes

<table>
<tr><th colspan="3">Revised</th></tr>
<tr><th>Policy Title</th><th>Approval Date</th><th>Summary of Changes</th></tr>
<tr><td>Incontinence Control Devices (NCD 230.10) (continued)</td><td>May 10, 2023</td><td>Added HCPCS codes A4341 and A4342
Removed HCPCS codes K1010, K1011, and K1012</td></tr>
<tr><td>Mobility Devices (Non-Ambulatory) and Accessories</td><td>May 10, 2023</td><td>Policy Summary
Consolidated/reformatted content
Overview
Guidelines
Removed content/language addressing:
Face-to-face encounters
Home assessments
Footrests/legrests
Wheels/tires for manual wheelchairs
Equipment retained from a prior payer
Revised language to indicate:
Power mobility devices, power wheelchairs, power operated vehicles, and manual wheelchairs are covered under the Durable Medical Equipment benefit (Social Security Act §1861(s)(6))
In order for a beneficiary's equipment to be eligible for reimbursement, the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination (LCD) must be met
In addition, there are specific statutory payment policy requirements that also must be met
If the power mobility device, power wheelchair, power operated vehicle, and/or manual wheelchair is only for use outside the home, it will be denied as "non-covered, no benefit" as the DME benefit requires use within the home for coverage eligibility
Documentation Requirements – General
Removed notation indicating references to the term power mobility device (PMD) includes power operated vehicles (POVs) and power wheelchairs (PWCs)
Miscellaneous
Removed language indicating:
A POV with captain's chair is not appropriate for a beneficiary who needs a separate wheelchair seat and/or back cushion
A POV or PWC which has not been reviewed or which has been reviewed and found not to meet the definition of a specific POV/PWC will be denied as not reasonable and necessary and should be coded as K0899
Power Operated Vehicle/Power Mobility Device/Power Wheelchair</td></tr>
</table>

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Mobility Devices (Non-Ambulatory) and Accessories (continued)	May 10, 2023	Basic Coverage Criteria • Revised language to indicate: ○ All of the following basic criteria below must be met for a power mobility device (HCPCS codes K0800, K0801, K0802, K0806, K0807, K0808, K0812, K0813, K0814, K0815, K0816, K0820, K0821, K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843, K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855, K0856, K0857, K0858, K0859, K0860, K0861, K0862, K0863, K0864, K0868, K0869, K0870, K0871, K0877, K0878, K0879, K0880, K0884, K0885, K0886, K0890, K0891, and K0898) or a push-rim activated power assist device (E0986) to be covered; additional coverage criteria for specific devices are listed below: ▪ The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home; a mobility limitation is one that: – Prevents the beneficiary from accomplishing an MRADL entirely, or – Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or – Prevents the beneficiary from completing an MRADL within a reasonable time frame ▪ The beneficiary's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker ▪ The beneficiary does not have sufficient upper extremity function to self-propel an optimally configured manual wheelchair in the home to perform MRADLs during a typical day – Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function – An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories ○ Additionally, a POV (HCPCS codes K0800, K0801, K0802, K0806, K0807, K0808, and K0812) is covered if all of the basic coverage criteria above has been met and if criteria below are also met: ▪ The beneficiary is able to: – Safely transfer to and from a POV; and – Operate the tiller steering system; and – Maintain postural stability and position while operating the POV in the home ▪ The beneficiary's mental capabilities (e.g., cognition, judgment) and physical capabilities (e.g., vision) are sufficient for safe mobility using a POV in the home ▪ The beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for the

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Policy Guideline Updates

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Policy Title	**Approval Date**	**Summary of Changes**
Mobility Devices (Non-Ambulatory) and Accessories (continued)	May 10, 2023	operation of the POV that is provided ▪ The beneficiary's weight is less than or equal to the weight capacity of the POV that is provided and greater than or equal to 95% of the weight capacity of the next lower weight class POV (i.e., a heavy duty POV is covered for a beneficiary weighing 285 – 450 pounds; a very heavy duty POV is covered for a beneficiary weighing 428 – 600 pounds) ▪ Use of a POV will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it in the home ▪ The beneficiary has not expressed an unwillingness to use a POV in the home ○ Additionally, a power wheelchair (HCPCS codes K0013, K0814, K0815, K0816, K0820, K0821, K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843, K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855, K0856, K0857, K0858, K0859, K0860, K0861, K0862, K0863, K0864, K0868, K0869, K0870, K0871, K0877, K0878, K0879, K0880, K0884, K0885, K0886, K0890, K0891, and K0898) is covered if all of the basic coverage criteria above has been met and if criteria below are also met: ▪ The beneficiary does not meet additional coverage criterion for a POV; and ▪ Either criterion of the following is met: – The beneficiary has the mental and physical capabilities to safely operate the power wheelchair that is provided; or – If the beneficiary is unable to safely operate the power wheelchair, the beneficiary has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the power wheelchair that is provided; and ▪ All the following criteria are met: – If the beneficiary is unable to safely operate the power wheelchair, the beneficiary has a caregiver who is unable to adequately propel an optimally configured manual wheelchair, but is available, willing, and able to safely operate the power wheelchair that is provided; and – The beneficiary's weight is less than or equal to the weight capacity of the power wheelchair that is provided and greater than or equal to 95% of the weight capacity of the next lower weight class PWC (i.e., a heavy duty PWC is covered for a beneficiary weighing 285 – 450 pounds; a very heavy duty PWC is covered for a beneficiary weighing 428 – 600 pounds; an extra heavy duty PWC is covered for a beneficiary weighing 570 pounds or more) – The beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of the power wheelchair that is provided – Use of a power wheelchair will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it in the home; for beneficiaries with severe cognitive and/or physical impairments,

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Mobility Devices (Non-Ambulatory) and Accessories (continued)	May 10, 2023	participation in MRADLs may require the assistance of a caregiver – The beneficiary has not expressed an unwillingness to use a power wheelchair in the home; and ▪ Any coverage criteria pertaining to the specific wheelchair type [listed in the policy] are met **Power Seating System** ● Revised language to indicate: ○ A power seating system (tilt only, recline only, or combination tilt and recline) with or without power elevating leg rests will be covered if criteria 1, 2, and 3 are met and if criterion 4, 5, or 6 is met 1. The beneficiary meets all the coverage criteria for a power wheelchair described in the Power Mobility Devices LCD; and 2. A specialty evaluation that was performed by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT) or practitioner who has specific training and experience in rehabilitation wheelchair evaluations of the beneficiary's seating and positioning needs; the PT, OT, or practitioner may have no financial relationship with the supplier; and 3. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the beneficiary 4. The beneficiary is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or 5. The beneficiary utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed; or 6. The power seating system is needed to manage increased tone or spasticity ○ If these criteria are not met, the power seating component(s) will be denied as not reasonable and necessary **Non-Medical Necessity Coverage and Payment Rules** ● Revised language to indicate: ○ A power mobility device may not be ordered by a podiatrist; if it is, it will be denied as statutorily non-covered ○ For power wheelchairs, there is no separate billing for non-standard seat frame dimensions (width, depth, or height) with the following exceptions: ▪ For Group 3 and 4 power wheelchairs, with a sling/solid seat/back, the following items may be billed separately using HCPCS code K0108: – For standard duty, seat width and/or depth greater than 20 inches – For heavy duty, seat width and/or depth greater than 22 inches – For very heavy duty, seat width and/or depth greater than 24 inches – For extra heavy duty, no separate billing

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Mobility Devices (Non-Ambulatory) and Accessories (continued)	May 10, 2023	▪ For Group 3 and 4 PWCs with a sling/solid seat/back, the following items may be billed separately using HCPCS code K0108: – For standard duty, back width greater than 20 inches – For heavy duty, back width greater than 22 inches – For very heavy duty, back width greater than 24 inches – For extra heavy duty, no separate billing ○ HCPCS code K0108 may not be billed for non-standard dimensions of a power tilt and/or recline seating system (HCPCS codes E1002, E1003, E1004, E1005, E1006, E1007, and E1008); the definition of those codes includes any frame width and depth ○ Group 2 POVs (HCPCS codes K0806, K0807, and K0808) have added capabilities that are not needed for use in the home; therefore, if a Group 2 POV is provided, it will be denied as not reasonable and necessary ○ Group 4 PWCs (HCPCS codes K0868, K0869, K0870, K0871, K0877, K0878, K0879, K0880, K0884, K0885, and K0886) have added capabilities that are not needed for use in the home; therefore, if these wheelchairs are provided, they will be denied as not reasonable and necessary ○ If a POV/PWC will be used inside the home and coverage criteria are not met, it will be denied as not reasonable and necessary ○ If the PWC base is not covered, then related accessories will be denied ○ If a heavy duty, very heavy duty, or extra heavy duty PWC or POV is provided and if the beneficiary's weight is outside the range listed in criterion above (i.e., for heavy duty 285–450 pounds, for very heavy duty 428–600 pounds, for extra heavy duty 570 pounds or more), it will be denied as not reasonable and necessary ○ An add-on to convert a manual wheelchair to a joystick-controlled power mobility device (HCPCS code E0983) or to a tiller-controlled power mobility device (E0984) will be denied as not reasonable and necessary ○ Payment is made for only one wheelchair at a time; backup chairs are denied as not reasonable and necessary ○ A power mobility device will be denied as not reasonable and necessary if the underlying condition is reversible and the length of need is less than 3 months (e.g., following lower extremity surgery which limits ambulation) ○ A seat elevator is a statutorily non-covered option on a power wheelchair; if a PWC with a seat elevator (HCPCS codes K0830 and K0831) is provided, it will be denied as non-covered ○ A power seat elevation feature (HCPCS codes E2300) and power standing feature (HCPCS codeE2301) are non-covered because they are not primarily medical in nature ▪ If a wheelchair has an electrical connection device described by HCPCS code E2310 or E2311 and if the sole function of the connection is for a power seat elevation or power standing feature, it will be denied as non-covered ○ An option/accessory that is beneficial primarily in allowing the beneficiary to perform leisure or recreational

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Mobility Devices (Non-Ambulatory) and Accessories (continued)	May 10, 2023	activities is non-covered ○ If an option or accessory that is included in another code is billed separately, the claim line will be denied as not separately payable ○ If an attendant control (HCPCS code E2331) is provided in addition to a beneficiary-operated drive control system, it will be denied as non-covered; refer to the related LCD for situations in which it is provided in place of a beneficiary-operated system ○ An electronic interface used to control lights or other electrical devices is non-covered because it is not primarily medical in nature ○ The following features of a power wheelchair will be denied as non-covered: ▪ Stair climbing (HCPCS code A9270) ▪ Electronic balance (HCPCS code A9270) ▪ Ability to elevate the seat by balancing on two wheels (HCPCS code A9270) ▪ Remote operation (HCPCS code A9270) ○ Swingaway, retractable, or removable hardware (HCPCS code E1028) is non-covered if the primary indication for its use is to allow the beneficiary to move close to desks or other surfaces; if it is ordered for this indication, a GY modifier must be added to the code ○ If the beneficiary has a POV or a power wheelchair with a captain's chair seat, a separate seat and/or back cushion will be denied as not reasonable and necessary ○ Accessories provided at the time of initial issue of a rollabout chair are not separately billable ▪ Accessories provided with the initial issue of a transport chair are not separately billable with the exception of elevating leg rests (HCPCS codes E0990 and K0195) ▪ A replacement accessory for a rollabout or transport chair is billed using code HCPCS code E1399 **Warranty, Maintenance, Repairs, and Replacements** ● Revised language to indicate: ○ One month's rental of a PWC or POV (HCPCS code K0462) is covered if a beneficiary-owned wheelchair is being repaired; payment is based on the type of replacement device that is provided but will not exceed the rental allowance for the power mobility device that is being repaired Reimbursement for the wheelchair codes includes all labor charges involved in the assembly of the wheelchair; reimbursement also includes support services, such as delivery, set-up, and education about the use of the PMD ○ The RB modifier is used when an option or accessory is provided as a replacement for the same part which has been worn or damaged (e.g., replacing a tire of the same type); the RB modifier must not be used: ▪ For an upgrade subsequent to providing the wheelchair base (e.g., replacing a standard seat of a power wheelchair with a power seating system)

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Mobility Devices (Non-Ambulatory) and Accessories (continued)	May 10, 2023	▪ If the accessory is provided at the same time as the wheelchair base, even if the option/accessory is the same as one that the beneficiary had on a prior wheelchair ○ The KC modifier would never be used at the time of initial issue of a wheelchair ▪ The KC modifier specifically states replacement, therefore, the RB modifier is not required ▪ The KC modifier (replacement of special power wheelchair interface) is used in the following situations: – Due to a change in the beneficiary's condition an integrated joystick and controller is being replaced by another drive control interface (e.g., remote joystick, head control, sip and puff, etc.); or – The beneficiary had a drive control interface described by HCPCS codes E2321, E2322, E2325, E2327, E2328, E2329, E2330, or E2373 and both the interface (e.g., joystick, head control, sip, and puff) and the controller electronics are being replaced due to irreparable damage Customization Options ● Revised language to indicate: ○ A custom motorized/power wheelchair base (HCPCS code K0013) must be uniquely constructed or substantially modified for a specific beneficiary according to the description and orders of the beneficiary's treating practitioner ▪ The beneficiary's needs must not be able to be accommodated by any other existing PMD and accessories, including customized seating arrangements ▪ Refer to *42 Code of Federal Regulations (CFR) Section 414.224(a)* ○ A custom motorized/power wheelchair base (HCPCS code K0013) will be covered if: ▪ The beneficiary meets the general coverage criteria for a power wheelchair; and ▪ The specific configurational needs of the beneficiary are not able to be met using wheelchair cushions, or options or accessories (prefabricated or custom fabricated), which may be added to another power wheelchair base ○ If coverage criterion listed in the first bullet for HCPCS code K0013 is not met, the claim will be denied as not reasonable and necessary ○ If coverage criterion listed in the second bullet for HCPCS code K0013 is not met, the claim will be denied for incorrect coding; refer to related Policy Article for additional information ○ A custom motorized/power wheelchair base is not reasonable and necessary if the expected duration of need for the chair is less than three months (e.g., post-operative recovery) ***Manual Wheelchair*** Manual Wheelchair Bases ● Added language to indicate: ○ For Medicare coding purposes, all manual wheelchair base codes describe a complete product; this includes items described by HCPCS codes:

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<tr><td>Mobility Devices (Non-Ambulatory) and Accessories
(continued)</td><td>May 10, 2023</td><td>

Rollabout chair (E1031)
Transport chairs (E1037, E1038, E1039)
Manual wheelchair bases (E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, and K0009)

Manual wheelchairs with additional options and accessories, other than tilt, are billed by selecting the correct code for the wheelchair base and then using appropriate codes for wheelchair options and accessories; refer to the LCD for Wheelchair Options and Accessories

Options and Accessories
Added language to indicate options and accessories for wheelchairs are covered if the beneficiary has a wheelchair that meets Medicare coverage criteria and the option/accessory itself is medically necessary
Coverage criteria for specific items are located in the LCD-related Policy Article
If these criteria are not met, the item will be denied as not reasonable and necessary
Non-Medical Necessity Coverage and Payment Rules
Revised language to indicate:
There is no separate payment for:
A solid insert (HCPCS code E0992) that is used with a seat or back cushion because a solid base is included in the allowance for a wheelchair seat or back cushion
Mounting hardware for a seat or back cushion
A wheelchair seat or back cushion when it is used with a rollabout chair (HCPCS code E1031)
If the manual wheelchair will be used inside the home and the coverage criteria are not met, it will be denied as not reasonable and necessary
If the manual wheelchair base is not covered, then related accessories will be denied as not reasonable and necessary
Manual wheelchair bases (HCPCS codes K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0008, and K0009) include construction of any type of material, including but not limited to, titanium, carbon, or any other lightweight high strength material
Suppliers must not bill HCPCS code K0108 in addition to the base wheelchair for construction materials or for a “heavy duty package” reflecting the type of material used to construct the manual wheelchair base
Billing for construction material is considered incorrect coding – unbundling
If a skin protection seat cushion, positioning seat cushion, or combination skin protection and positioning seat cushion is provided and if the stated coverage criteria are not met, it will be denied as not reasonable and necessary
If a positioning back cushion is provided for a beneficiary who does not meet the stated coverage criteria, it will be
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Mobility Devices (Non-Ambulatory) and Accessories (continued)	May 10, 2023	denied as not reasonable and necessary ○ If a positioning accessory is provided and the criteria are not met, the item will be denied as not reasonable and necessary ○ A seat or back cushion that is provided for use with a transport chair (HCPCS codes E1037 and E1038) will be denied as not reasonable and necessary ○ The effectiveness of a powered seat cushion (HCPCS code E2610) has not been established ○ Claims for a powered seat cushion will be denied as not reasonable and necessary ○ Wheelchair seat and back cushion codes are all-inclusive ○ Use of HCPCS code K0108 or any other HCPCS code to separately bill for added components such as the foam blocks, gel packs, air cells, or equivalent material, is incorrect coding ○ A non-sealed battery (HCPCS codes E2358, E2360, E2362, E2364, and E2372) will be denied as not reasonable and necessary ○ HCPCS code E2367 is provided as a replacement, it will be denied as not reasonable and necessary ○ A manual standing system for a manual wheelchair (HCPCS code E2230) is non-covered (no benefit category) because it is not primarily medical in nature Warranty, Maintenance, Repairs and Replacements ● Revised language to indicate: ○ Payment is made for only one wheelchair at a time ○ Backup chairs are denied as not reasonable and necessary ○ One month's rental for a standard manual wheelchair (HCPCS code K0001) is covered if a beneficiary-owned wheelchair is being repaired ***Customization Options*** ● Revised language to indicate: ○ A custom manual wheelchair base (HCPCS code K0008) is covered if, in addition to the general coverage criteria [listed in the policy], the specific configuration required to address the beneficiary's physical and/or functional deficits cannot be met using one of the standard manual wheelchair bases plus an appropriate combination of wheelchair seating systems, cushions, options, or accessories (prefabricated or custom fabricated), such that the individual construction of a unique individual manual wheelchair base is required ○ If HCPCS code K0008 is used to describe a prefabricated manual wheelchair base, even one that has been modified in any fashion, the claim will be denied for incorrect coding ○ A custom manual wheelchair is not reasonable and necessary if the expected duration of need is less than three months (e.g., post-operative recovery) ○ A custom manual wheelchair base (HCPCS code K0008) must be uniquely constructed or substantially modified

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Policy Title	Approval Date	Summary of Changes
Mobility Devices (Non-Ambulatory) and Accessories (continued)	May 10, 2023	for a specific beneficiary according to the description and orders of the beneficiary's treating practitioner ▪ The beneficiary's needs cannot be accommodated by any other existing manual wheelchair and accessories, including customized seating arrangements ▪ Refer to *42 CFR Section 414.224* and Internet-Only Manual, *Publication 100-04 Medicare Claims Processing Manual, Chapter 20, Section 30.3* for more information on customized DME ○ A custom fabricated seat cushion (HCPCS code E2609) is covered if criteria 1 and 3 are met; a custom fabricated back cushion (HCPCS code E2617) is covered if criteria 2 and 3 are met: 1. Beneficiary meets all of the criteria for a prefabricated skin protection seat cushion or positioning seat cushion 2. Beneficiary meets all of the criteria for a prefabricated positioning back cushion 3. There is a comprehensive written evaluation by a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), which clearly explains why a prefabricated seating system is not sufficient to meet the beneficiary's seating and positioning needs; the PT or OT may have no financial relationship with the supplier ○ If a custom fabricated cushion is provided for a beneficiary who does not meet the stated coverage criteria, it will be denied as not reasonable and necessary ○ A custom fabricated seat cushion (HCPCS code E2609) and a custom fabricated back cushion (E2617) are cushions that are individually made for a specific beneficiary starting with basic materials including: ▪ Liquid foam or a block of foam and ▪ Sheets of fabric or liquid coating material ○ The cushion must be fabricated using one or more of the following techniques to capture the individual shape of the beneficiary: ▪ Molded-to-beneficiary-model technique; ▪ Direct molded-to-beneficiary technique; ▪ CAD/CAM technology, which: – Allows for the use of direct digital scanning of the beneficiary or of a mold made directly from the beneficiary; – Allows for direct milling of either (1) a beneficiary-specific model used to shape the cushion contour or (2) the cushion contours; or ▪ Detailed measurements of the beneficiary used to create a configured cushion **Applicable Codes** • Removed language pertaining to bundling guidelines **Definitions** • Added definition of:

Policy Guideline Updates

Revised

Policy Title	Approval Date	Summary of Changes
Mobility Devices (Non-Ambulatory) and Accessories (continued)	May 10, 2023	◦ Attendant Control ◦ Controller ◦ Non-Proportional Interface ◦ Power Wheelchair (PWC) Basic Equipment Package ◦ Proportional ◦ Proportional Interface ◦ Remote Joystick ◦ Tires (*previously listed as Pneumatic, Foam Filled, and Solid Tires*) • Updated definition of: ◦ Direction Change Switch (*previously listed as Direction Switch*) ◦ Expandable Controller ◦ Functional Selection Switch (*previously listed as Function Direct Switch*) ◦ Integrated Proportional Joystick And Controller ◦ Non-Expandable Controller ◦ Patient Weight Capacity ◦ Switch • Removed definition of: ◦ Advanced Coverage Determination (ACD) ◦ Compact Proportional Remote Joystick ◦ Durable Medical Equipment (DME) ◦ Flat Tire Insert ◦ Harness ◦ Headrest ◦ High Strength Lightweight Wheelchair ◦ INDEPENDENCE iBOT 4000 Mobility System ◦ Licensed/Certified Medical Professional (LCMP) ◦ Least Costly Alternative ◦ Lightweight Wheelchair ◦ Mobility Assistive Equipment (MAE) ◦ Mini Proportional Remote Joystick ◦ Mobility Assistive Devices ◦ Power (Motorized) Wheelchair (PWCs) ◦ Standard Wheelchair

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Policy Guideline Updates

Revised

Policy Title	Approval Date	Summary of Changes
Mobility Devices (Non-Ambulatory) and Accessories (continued)	May 10, 2023	○ Standard Hemi-Wheelchair ○ Supplier ○ Treating ○ Treating Practitioner ○ Wheelchair **Supporting Information** • Updated *References* section to reflect the most current information

Retired

The following Policy Guidelines have been retired effective May 10, 2023:

- Acupuncture
- Deep Brain Stimulation for Essential Tremor and Parkinson's Disease (NCD 160.24)

United Healthcare Medicare Advantage

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

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.