United Healthcare Medicare Advantage

UnitedHealthcare Medicare Advantage
Policy Guideline Update Bulletin: September 2022

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Policy Title	Approval Date	Policy Summary
Platelet Rich Plasma Injections for Non-Wound Injections	Aug. 10, 2022	*Guidelines* All platelet rich plasma injections and/or applications as a means of managing musculoskeletal injuries and/or joint conditions or for any use outside of the National Coverage Determination (NCD) 270.3 *Blood-Derived Products for Chronic Non-Healing Wounds* are non-covered. For Prolotherapy, refer to NCD 150.7 for *Prolotherapy, Joint Sclerotherapy, and Ligamentous Injections with Sclerosing Agents*.

Updated

Policy Title	Approval Date	Summary of Changes

Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Programs	Aug. 10, 2022	Policy Summary
		Overview
		• Updated list of indications for coverage of cardiac rehabilitation and intensive cardiac rehabilitation programs:
		  ○ Replaced "stable, chronic heart failure defined as patients with left ventricular ejection fraction of 35 percent or less and New York Heart Association (NYHA) class II to IV symptoms despite being on optimal *medical* therapy for at least 6 weeks" with "stable, chronic heart failure defined as patients with left ventricular ejection fraction of 35% or less and NYHA class II to IV symptoms despite being on optimal *heart failure* therapy for at least 6 weeks"
		  ○ Added language to indicate the National Coverage Determination (NCD) process may be used to specify non-coverage of a cardiac condition for intensive cardiac rehabilitation (ICR) if coverage is not supported by clinical evidence
		Applicable Codes
		• Added place of service codes 02 and 10
		Supporting Information
		• Updated *References* section to reflect the most current information

Clinical Diagnostic Laboratory Services	Aug. 10, 2022	Related Policies
		• Removed reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled:
		  ○ *Blood Platelet Transfusions (NCD 110.8)*
		  ○ *Blood Transfusions (NCD 110.7)*
		  ○ *Obsolete or Unreliable Diagnostic Tests (NCD 300.1)*
		Applicable Codes
		• Added CPT codes 82495, 86890, 86891, and 86985 [previously included in the UnitedHealthcare Medicare Advantage Policy Guidelines titled *Blood Transfusions (NCD 110.7) and Obsolete or Unreliable Diagnostic Tests (NCD 300.1)*]

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Policy Title	**Approval Date**	**Summary of Changes**
Clinical Diagnostic Laboratory Services (continued)	Aug. 10, 2022	• Removed CPT code 87913 Supporting Information • Updated *References* section to reflect the most current information
Hospital Beds (NCD 280.7)	Aug. 10, 2022	Related Policies • Removed reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Air-Fluidized Bed (NCD 280.8)* Supporting Information • Updated *References* section to reflect the most current information
Infusion Pumps (NCD 280.14)	Aug. 10, 2022	Applicable Codes *HCPCS Codes* Medications • Added HCPCS code J1551 • Added notation to indicate HCPCS code J7799 was "deleted Jun. 30, 2022" *ICD-10 Diagnosis Codes* For HCPCS code J1551 • Added D80.0, D80.2, D80.3, D80.4, D80.5, D80.6, D80.7, D81.0, D81.1, D81.2, D81.5, D81.6, D81.7, D81.89, D81.9, D82.0, D82.1, D82.4, D83.0, D83.1, D83.2, D83.8, D83.9, and G11.3 Supporting Information • Updated *References* section to reflect the most current information
Osteopathic Manipulations (OMT)	Aug. 10, 2022	Related Policies • Removed reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Manipulation (NCD 150.1)* Policy Summary *Overview* • Replaced reference to "*craniosacral* techniques" with "*cranial* techniques" Supporting Information • Updated *References* section to reflect the most current information
Percutaneous Ventricular Assist Device	Aug. 10, 2022	Related Policies • Added reference link to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Cardiac Procedures: Pacemakers, Pulmonary Artery Pressure Measurements and Ventricular Assist Devices* • Removed reference link to the: ○ UnitedHealthcare Medicare Advantage Coverage Summary titled *Ventricular Assist Device (VAD)*

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Percutaneous Ventricular Assist Device (continued)	Aug. 10, 2022	○ UnitedHealthcare Medicare Advantage Policy Guideline titled *Artificial Hearts and Related Devices (Formerly NCD 20.9)* **Supporting Information** ● Updated *References* section to reflect the most current information
Ventricular Assist Devices (NCD 20.9.1)	Aug. 10, 2022	**Related Policies** ● Added reference link to the: ○ UnitedHealthcare Medicare Advantage Policy Guideline titled *Percutaneous Ventricular Assist Device* ○ Medicare Advantage Coverage Summary titled *Cardiac Procedures: Pacemakers, Pulmonary Artery Pressure Measurements and Ventricular Assist Devices* ● Removed reference link to the: ○ UnitedHealthcare Medicare Advantage Policy Guideline titled *Artificial Hearts and Related Devices (Formerly NCD 20.9)* ○ Medicare Advantage Coverage Summary titled *Ventricular Assist Device (VAD)* **Supporting Information** ● Updated *References* section to reflect the most current information

Revised

Policy Title	Approval Date	Summary of Changes
Ambulatory EEG Monitoring	Aug. 10, 2022	**Title Change** ● Previously titled *Long-Term EEG Monitoring* **Related Policies** ● Removed reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Ambulatory EEG Monitoring (NCD 160.22)* **Policy Summary** ● Replaced references to "monitoring/EEG monitoring" with "*ambulatory* monitoring/*ambulatory* EEG monitoring" ● Removed content addressing: ○ Documentation requirements ○ Utilization guidelines **Applicable Codes** *CPT Codes* ● Added 95700, 95705, 95708, 95717, 95719, and 95721 [previously included in the UnitedHealthcare Medicare Advantage Policy Guideline titled *Ambulatory EEG Monitoring (NCD 160.22)*]

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Ambulatory EEG Monitoring (continued)	Aug. 10, 2022	• Removed 95951 and 95956 *ICD-10 Diagnosis Codes* For CPT Codes 95700, 95705, 95708, 95717, 95719, and 95721 • Added A17.82, A39.81, A42.82, A50.42, A52.14, A83.0, A83.1, A83.2, A83.3, A83.4, A83.5, A83.8, A83.9, A84.0, A84.1, A84.89, A84.9, A85.0, A85.1, A85.2, A85.8, A92.2, A92.31, A92.5, B01.11, B02.0, B05.0, B06.01, B10.01, B10.09, B26.2, B94.1, F44.4, F44.5, F44.6, F44.7, G04.00, G04.01, G04.02, G04.30, G04.31, G04.81, G04.90, G05.3, G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.301, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.42, G40.501, G40.509, G40.801, G40.802, G40.803, G40.804, G40.811, G40.812, G40.813, G40.814, G40.821, G40.822, G40.823, G40.824, G40.833, G40.834, G40.89, G40.901, G40.909, G40.911, G40.919, G40.A01, G40.A09, G40.A11, G40.A19, G40.B01, G40.B09, G40.B11, G40.B19, G93.1, G93.40, G93.49, G93.5, G93.6, H55.00, I45.9, I60.01, I60.02, I60.11, I60.12, I60.2, I60.31, I60.32, I60.4, I60.51, I60.52, I60.6, I60.8, I60.9, I61.0, I61.1, I61.2, I61.3, I61.4, I61.5, I61.6, I61.8, I62.9, I67.1, I67.83, I67.9, R00.0, R06.81, R25.0, R25.1, R25.2, R25.3, R25.8, R25.9, R29.90, R40.0, R40.1, R40.20, R40.2110, R40.2111, R40.2112, R40.2113, R40.2114, R40.2120, R40.2121, R40.2122, R40.2123, R40.2124, R40.2210, R40.2211, R40.2212, R40.2213, R40.2214, R40.2220, R40.2221, R40.2222, R40.2223, R40.2224, R40.2310, R40.2311, R40.2312, R40.2313, R40.2314, R40.2320, R40.2321, R40.2322, R40.2323, R40.2324, R40.2340, R40.2341, R40.2342, R40.2343, R40.2344, R40.2350, R40.2351, R40.2352, R40.2353, R40.2354, R40.2361, R40.2362, R40.2363, R40.2364, R40.4, R41.0, R41.82, R45.1, R47.01, R55, R56.1, R56.9, S06.1X0S, S06.1X1S, S06.1X2S, S06.1X3S, S06.1X4S, S06.1X5S, S06.1X6S, S06.1X9S, S06.890S, S06.891S, S06.892S, S06.893S, S06.894S, S06.895S, and S06.896S Supporting Information • Updated *References* section to reflect the most current information
Durable Medical Equipment Reference List	Aug. 10, 2022	Title Change • Previously titled *Durable Medical Equipment Reference List (NCD 280.1)* Related Policies • Added reference link to the policy UnitedHealthcare Medicare Advantage Policy Guideline titled: ○ *Neuromuscular Electrical Stimulation (NMES) (NCD 160.12)* ○ *Cardiac Pacemakers: Single Chamber and Dual Chamber Permanent Cardiac Pacemakers (NCD 20.8.3)* ○ *Home Use of Oxygen (NCD 240.2)* ○ *Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds (NCD 270.1)* ○ *Porcine Skin and Gradient Pressure Dressings (NCD 270.5)* ○ *Infusion Pumps (NCD 280.14)*

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Durable Medical Equipment Reference List (continued)	Aug. 10, 2022	○ *Pneumatic Compression Devices (NCD 280.6)* ○ *Hospital Beds (NCD 280.7)* ○ *Home Blood Glucose Monitors (NCD 40.2)* • Removed reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Lower Limb Prostheses* **Applicable Codes** ***Augmentative Communication Devices*** • Added HCPCS codes E2500, E2502, E2504, E2506, E2508, E2510, E2511, E2512, and E2599 ***Bead Beds*** • Added reference to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Pressure Reducing Support Surfaces* ***Biofeedback Device*** • Added reference to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Biofeedback Therapy* ***Continuous Positive Airway Pressure (CPAP) Devices*** • Added language to indicate a bi-level positive airway pressure device with back-up rate (E0471) is not reasonable and necessary if the primary diagnosis is OSA; if an E0471 is billed with a diagnosis of OSA, it will be denied as not reasonable and necessary • Added HCPCS codes E0470, E0601, and E0471 [previously included in the UnitedHealthcare Medicare Advantage Guideline titled *Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (OSA) (NCD 240.4)*] ***Diathermy Machines (Standard Pulses Wave Types)*** • Added CPT code 97024 ***Electrical Nerve Stimulators*** • Added language to indicate: ○ Payment may be made under the prosthetic device benefit for implanted peripheral nerve stimulators; refer to the National Coverage Determination (NCD) for *Electrical Nerve Stimulators (NCD 160.7)* ○ The implantation of a phrenic nerve stimulator is covered for selected patients with partial or complete respiratory insufficiency; refer to the NCD for *Phrenic Nerve Stimulators (NCD160.19)* Added HCPCS codes L8679, L8680, L8681, L8682, L8683, L8685, L8686, L8687, L8688, L8689, L8695, and L8696 ***Electrical Stimulation for Wounds*** • Added reference to the NCD for *Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds (NCD 270.1)* ***Electromagnetic Energy Treatment Device***

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Durable Medical Equipment Reference List (continued)	Aug. 10, 2022	• Added reference to the NCD for *Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds (NCD 270.1)* *Intrapulmonary Percussive Ventilator (IPV)* • Added language to indicate studies do not demonstrate any advantage of IPV over that achieved with good pulmonary care in the hospital environment and there are no studies in the home setting; there is no data to support the effectiveness of the device, therefore, IPV in the home setting is not covered *Infrared Therapy Devices* • Added CPT/HCPCS codes 97026, A4639, and E0221 [previously included in the UnitedHealthcare Medicare Advantage Guideline titled *Infrared Therapy Devices (NCD 270.6)*] *Infusion Pumps* • Removed reference to the NCD for *Enteral and Parenteral Nutritional Therapy (NCD 180.2)* *Lower Extremity Prosthesis (Attachment)* • Revised language to indicate: ○ The microprocessor foot or ankle system addition with power assist which includes any type of motor is not covered because there is insufficient information to demonstrate that the item meets the Medicare standard to be considered reasonable and necessary as per the *Payment Integrity Manual (PIM) Chapter 13* ○ A user-adjustable heel height feature will be denied as not reasonable and necessary ○ References may be located in various Centers for Medicare & Medicaid (CMS) sourcing (i.e., Transmittals, Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and/or UnitedHealth Group guidelines) • Added HCPCS codes L5969 and L5990 *Lower Limb Prosthetic Donning Sleeve* • Added language to indicate references may be located in various CMS sourcing (i.e., Transmittals, LCDs, LCAs and/or UnitedHealth Group guidelines) • Added HCPCS code L7600 *Noncontact Normothermic Wound Therapy (NNWT)* • Added language to indicate there is insufficient clinical or scientific evidence to consider this device as reasonable and necessary for the treatment of wounds within the meaning of *§1862(a) (1) (A) of the Social Security Act* and will not be covered by Medicare; refer to the NCD for *Noncontact Normothermic Wound Therapy (NNWT) (NCD 270.2)* • Added HCPCS codes A6000, E0231, and E0232 *Respiratory Assist Devices* • Added language to indicate: ○ A respiratory assist device (E0470, E0471) is covered for those beneficiaries with one of the following clinical

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Durable Medical Equipment Reference List (continued)	Aug. 10, 2022	disorders: restrictive thoracic disorders (i.e., neuromuscular diseases or severe thoracic cage abnormalities), severe chronic obstructive pulmonary disease (COPD), CSA or CompSA, or hypoventilation syndrome ○ References may be located in various CMS sourcing (i.e., Transmittals, LCDs, LCAs and/or UnitedHealth Group guidelines) • Added HCPCS codes E0470 and E0471 *Seat Lifts* • Added language [previously included in the UnitedHealthcare Medicare Advantage Policy Guideline titled *Seat Lift (NCD280.4)*] to indicate a seat lift mechanism placed over or on top of a toilet, any type is non-covered • Added HCPCS codes E0627, E0629, and E0172 *Ventilators* • Added language to indicate: ○ The Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations Manual (CMS Pub. 100-03) in Chapter 1, Part 4, Section 280.1 stipulates that ventilators (E0465, E0466, and E0467) are covered with criteria ○ References may be located in various CMS sourcing (i.e., Transmittals, LCDs, LCAs and/or UnitedHealth Group guidelines) • Added HCPCS codes E0465, E0466, and E0467 Supporting Information • Updated *References* section to reflect the most current information
Molecular Pathology/Genetic Testing Reported with Unlisted Codes	Aug. 10, 2022	Policy Summary *Guidelines* ClonoSEQ® Assay • Revised language to indicate: ○ Indicated uses for ClonoSEQ® include acute lymphoblastic leukemia (ALL), multiple myeloma (MM), chronic lymphocytic leukemia (CLL), and diffuse large B-cell lymphoma (DLBCL) ○ For further guidance and coding/billing criteria, refer to the *Minimal Residual Disease Testing for Cancer* section [of the policy] and [the sourcing for] *Minimal Residual Disease Testing for Hematologic Cancers* Germline Testing for Use of PARP Inhibitors • Added language to indicate: ○ The U.S. Food and Drug Administration (FDA) has approved several poly ADP-ribose polymerase (PARP) inhibitor treatments indicated for patients with ovarian cancer, breast cancer, pancreatic cancer, and prostate cancer ○ Results of tests that assess for deleterious variants in homologous recombination repair (HRR) genes such as

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Molecular Pathology/Genetic Testing Reported with Unlisted Codes (continued)	Aug. 10, 2022	BRCA1 and 2 can be used as an aid in patients who are being considered for treatment with PARP inhibitors in accordance with published guidelines and approved therapeutic product labeling ▪ These genes are often tested as part of routine management of these cancer patients as part of services that interrogate a panel of genes ▪ In rare circumstances, limited testing for only a select group of genes may be tested to ensure compliance with FDA indicated drug usage, wherein additional genes outlined in guidelines such as the National Comprehensive Cancer Network (NCCN) are not necessary because the patient does not meet testing criteria for larger panels ○ Billing for these services can occur in the following situation: ▪ The patient meets clinical indication for immediate use of a PARP inhibitor for an FDA-approved use; and ▪ The patient has had no previous germline testing for hereditary cancer or somatic testing of the same cancer that included the genes necessary for testing; and ▪ The patient does not meet germline testing requirements per existing guidelines or standards of care requiring more comprehensive testing; for further guidance and clinical criteria, refer to the sourcing for *Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer* KRAS ● Added language to indicate two tests have met the FDA criteria for KRAS genetic testing: ○ Therascreen® KRAS to detect 7 somatic mutations in the human KRAS oncogene was developed to aid in the identification of colorectal cancer (CRC) patients for treatment with Erbitux® (cetuximab) ○ Cobas® KRAS to detect mutations in codons 12 and 13 of the KRAS gene was developed to aid in identification of CRC patients for treatment with Erbitux® (cetuximab) or Vectibix® (panitumumab) Melanoma Risk Stratification Molecular Testing ● Added language to indicate molecular diagnostic tests used to assist in risk stratification of melanoma patients are covered when all of the following are true: ○ The patient has a personal history of melanoma; and ▪ Either: – Has Stage T1b and above; or – Has T1a with documented concern about adequacy of microstaging ▪ Is undergoing workup or being evaluated for treatment; and ▪ Does not have metastatic disease; and ▪ Presumed risk for a positive Sentinel Lymph Node Biopsy (SLNB) based on clinical, histological, or other information is >5%; and ▪ Has a disease stage, grade, and Breslow thickness (or other qualifying conditions) within the intended use of

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Molecular Pathology/Genetic Testing Reported with Unlisted Codes (continued)	Aug. 10, 2022	the test ○ The test has demonstrated, as part of a Technical Assessment: ▪ Clinical validity of analytes tested in predicting metastatic disease (or the absence of metastatic disease) in peer-reviewed scientific literature ▪ Utility beyond clinical, histological, and radiographical factors in the ability to accurately stratify patients into risk groups to manage patient care, such by precluding unnecessary sentinel lymph node biopsies ▪ Appropriate analytical validity ▪ Performance characteristics equivalent or superior to other covered, similar tests **Pharmacogenomics Testing (PGx)** • Updated list of genes/genetic tests requiring submission with CPT code 81479 (no specific CPT code available); added: ○ IFNL4 ○ Psychotropic pharmacogenomics gene panel **Applicable Codes** ***Molecular Pathology/Genetic Testing Reported with Unlisted Codes: Diagnosis Codes*** **For CPT Code 81479 (ClonoSEQ® Assay)** • Added C83.30, C83.31, C83.32, C83.33, C83.34, C83.35, C83.36, C83.37, C83.38, and C83.39 **For CPT Code 81479 (Genesight, NeuroIDgenetix, Genomind Professional PGx Express™, Neuropharmagen, or Psychotropic Pharmacogenomics Gene Panel)** • Modified content heading; added "Psychotropic Pharmacogenomics Gene Panel" to list of applicable tests **For CPT Code 81479 (Germline Testing for Use of PARP Inhibitors)** • Added C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C48.0, C48.1, C48.2, C48.8, C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C56.1, C56.2, C56.3, C56.9, C57.00, C57.01, C57.02, C61, C79.61, C79.62, C79.63, C79.9, Z85.07, Z85.3, Z85.43, Z85.44, Z85.46, and Z85.89 **For CPT Code 81479 (KRAS)** • Added C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.01, C78.02, C78.1, C78.2, C78.39, C78.4, C78.5, C78.6, C78.7, C78.80, C78.89, C79.01, C79.02, C79.11, C79.19, C79.2, C79.31, C79.32, C79.49, C79.51, C79.52, C79.61, C79.62, C79.63, C79.71, C79.72, C79.81, C79.82, and C79.89

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Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Molecular Pathology/Genetic Testing Reported with Unlisted Codes (continued)	Aug. 10, 2022	For CPT Code 81479 (Minimal Residual Disease Testing for Hematologic Cancers) • Added C81.00, C81.01, C81.02, C81.03, C81.04, C81.05, C81.06, C81.07, C81.08, C81.09, C81.10, C81.11, C81.12, C81.13, C81.14, C81.15, C81.16, C81.17, C81.18, C81.19, C81.20, C81.21, C81.22, C81.23, C81.24, C81.25, C81.26, C81.27, C81.28, C81.29, C81.30, C81.31, C81.32, C81.33, C81.34, C81.35, C81.36, C81.37, C81.38, C81.39, C81.40, C81.41, C81.42, C81.43, C81.44, C81.45, C81.46, C81.47, C81.48, C81.49, C81.70, C81.71, C81.72, C81.73, C81.74, C81.75, C81.76, C81.77, C81.78, C81.79, C81.90, C81.91, C81.92, C81.93, C81.94, C81.95, C81.96, C81.97, C81.98, C81.99, C82.00, C82.01, C82.02, C82.03, C82.04, C82.05, C82.06, C82.07, C82.08, C82.09, C82.10, C82.11, C82.12, C82.13, C82.14, C82.15, C82.16, C82.17, C82.18, C82.19, C82.20, C82.21, C82.22, C82.23, C82.24, C82.25, C82.26, C82.27, C82.28, C82.29, C82.30, C82.31, C82.32, C82.33, C82.34, C82.35, C82.36, C82.37, C82.38, C82.39, C82.40, C82.41, C82.42, C82.43, C82.44, C82.45, C82.46, C82.47, C82.48, C82.49, C82.50, C82.51, C82.52, C82.53, C82.54, C82.55, C82.56, C82.57, C82.58, C82.59, C82.60, C82.61, C82.62, C82.63, C82.64, C82.65, C82.66, C82.67, C82.68, C82.69, C82.80, C82.81, C82.82, C82.83, C82.84, C82.85, C82.86, C82.87, C82.88, C82.89, C82.90, C82.91, C82.92, C82.93, C82.94, C82.95, C82.96, C82.97, C82.98, C82.99, C83.00, C83.01, C83.02, C83.03, C83.04, C83.05, C83.06, C83.07, C83.08, C83.09, C83.10, C83.11, C83.12, C83.13, C83.14, C83.15, C83.16, C83.17, C83.18, C83.19, C83.30, C83.31, C83.32, C83.33, C83.34, C83.35, C83.36, C83.37, C83.38, C83.39, C83.50, C83.51, C83.52, C83.53, C83.54, C83.55, C83.56, C83.57, C83.58, C83.59, C83.70, C83.71, C83.72, C83.73, C83.74, C83.75, C83.76, C83.77, C83.78, C83.79, C83.80, C83.81, C83.82, C83.83, C83.84, C83.85, C83.86, C83.87, C83.88, C83.89, C83.90, C83.91, C83.92, C83.93, C83.94, C83.95, C83.96, C83.97, C83.98, C83.99, C84.00, C84.01, C84.02, C84.03, C84.04, C84.05, C84.06, C84.07, C84.08, C84.09, C84.10, C84.11, C84.12, C84.13, C84.14, C84.15, C84.16, C84.17, C84.18, C84.19, C84.40, C84.41, C84.42, C84.43, C84.44, C84.45, C84.46, C84.47, C84.48, C84.49, C84.60, C84.61, C84.62, C84.63, C84.64, C84.65, C84.66, C84.67, C84.68, C84.7A, C85.10, C85.11, C85.12, C85.13, C85.14, C85.15, C85.16, C85.17, C85.18, C85.19, C85.20, C85.21, C85.22, C85.23, C85.24, C85.25, C85.26, C85.27, C85.28, C85.29, C85.80, C85.81, C85.82, C85.83, C85.84, C85.85, C85.86, C85.87, C85.88, C85.89, C85.90, C85.91, C85.92, C85.93, C85.94, C85.95, C85.96, C85.97, C85.98, C85.99, C86.0, C86.1, C86.2, C86.3, C86.4, C86.5, C86.6, C88.0, C88.2, C88.3, C88.4, C88.8, C90.00, C90.01, C90.02, C90.10, C90.11, C90.12, C90.20, C90.21, C90.22, C90.30, C90.31, C90.32, C91.00, C91.01, C91.02, C91.10, C91.11, C91.12, C91.30, C91.31, C91.32, C91.40, C91.41, C91.42, C91.50, C91.51, C91.52, C91.60, C91.61, C91.62, C91.A0, C91.A1, C91.A2, C91.Z0, C91.Z1, C91.Z2, C92.00, C92.01, C92.02, C92.10, C92.11, C92.12, C92.20, C92.21, C92.22, C92.30, C92.31, C92.32, C92.40, C92.41, C92.42, C92.50, C92.51, C92.52, C92.60, C92.61, C92.62, C92.A0, C92.A1, C92.A2, C92.Z0, C92.Z1, C92.Z2, C92.90, C92.91, C92.92, C93.00, C93.01, C93.02, C93.10, C93.12, C93.Z0, C93.Z2, C93.90, C93.92, C94.00, C94.01, C94.02, C94.20, C94.21, C94.22, C94.30, C94.31, C94.32, C94.40, C94.41, C94.42, C94.6, C94.80, C94.81, C94.82, C95.00, C95.01, C95.02, C95.10, C95.11, C95.12, C96.0, C96.20, C96.21, C96.22, C96.29, C96.4, C96.5, C96.6, C96.A, C96.Z, D45, D46.0, D46.1, D46.20, D46.21, D46.22, D46.A, D46.B, D46.C, D46.4, D46.Z, D46.9, D47.01, D47.02, D47.1, D47.3, D47.4, D47.Z9, D47.9, D60.0, D60.8, D61.01,

Policy Guideline Updates

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Molecular Pathology/Genetic Testing Reported with Unlisted Codes (continued)	Aug. 10, 2022	D61.09, D61.1, D61.2, D61.3, D61.810, D61.811, D61.818, D61.82, D61.89, D61.9, D75.81, Z85.6, Z85.71, Z85.72, and Z85.79 For CPT Code 81479 (Pharmacogenomics Testing IFNL4) • Added B18.0, B18.1, B18.2, C43.0, C43.111, C43.112, C43.121, C43.122, C43.21, C43.22, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.61, C43.62, C43.71, C43.72, C43.8, and C43.9 For CPT Code 81479 or 81599 (DecisionDx; Melanoma Risk Stratification Molecular Testing Classifier) • Modified content heading; revised notation to indicate the list applies to CPT code 81479 for dates of service on or after Jul. 3, 2022 For CPT Code 81479 or 81599 (Predictive Classifiers for Early-Stage Non-Small Cell Lung Cancer) (Razor 14-Gene Lung Cancer Assay) • Modified content heading; revised notation to indicate the list applies to CPT code 81599 for dates of service on or before Jan. 6, 2022 Supporting Information • Updated *References* section to reflect the most current information
Pressure Reducing Support Surfaces	Aug. 10, 2022	Related Policies • Removed reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Air-Fluidized Bed (NCD 280.8)* Policy Summary *Guidelines – Group 3* • Added language [previously included in the UnitedHealthcare Medicare Advantage Policy Guideline titled *Air-Fluidized Bed (NCD 280.8)*] to indicate: ○ Medicare payment for home use of the air-fluidized bed for treatment of pressure sores can be made if such use is reasonable and necessary for the individual patient ○ A decision that use of an air-fluidized bed is reasonable and necessary requires that: ▪ The patient has a stage 3 (full thickness tissue loss) or stage 4 (deep tissue destruction) pressure ulcer; ▪ The patient is bedridden, or chair bound as a result of severely limited mobility; ▪ In the absence of an air-fluidized bed, the patient would require institutionalization; ▪ The air-fluidized bed is ordered in writing by the patient's attending physician based upon a comprehensive assessment and evaluation of the patient after completion of a course of conservative treatment designed to optimize conditions that promote wound healing ▪ This course of treatment must have been at least one month in duration without progression toward wound healing

Policy Guideline Updates

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Pressure Reducing Support Surfaces (continued)	Aug. 10, 2022	▪ This month of prerequisite conservative treatment may include some period in an institution as long as there is documentation available to verify that the necessary conservative treatment has been rendered – Conservative treatment must include: ● Frequent repositioning of the patient with particular attention to relief of pressure over bony prominences (usually every 2 hours); ● Use of a specialized support surface (Group II) designed to reduce pressure and shear forces on healing ulcers and to prevent new ulcer formation; ● Necessary treatment to resolve any wound infection; ● Optimization of nutrition status to promote wound healing; ● Debridement by any means (including wet to dry dressings-which does not require an occlusive covering) to remove devitalized tissue from the wound bed; and ● Maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings protected by an occlusive covering, while the wound heals – In addition, conservative treatment should generally include: ● Education of the beneficiary and caregiver on the prevention and management of pressure ulcers; and ● Assessment by a physician, nurse, or other licensed healthcare practitioner at least weekly, and ● Appropriate management of moisture/incontinence – An occlusive barrier is required, when necessary, to maintain a moist wound-healing environment that may otherwise be compromised by the drying action of airflow generated by air-fluidized therapy; if moist dressings are not required because of the wound characteristics (e.g., heavily exudative wound, etc.), the occlusive barrier is not required as a condition for reimbursement – Use of wet-to-dry dressings for wound debridement, begun during the period of conservative treatment and which continue beyond 30 days, will not preclude coverage of air-fluidized bed ● Should additional debridement again become necessary, while a patient is using an air-fluidized bed (after the first 30-day course of conservative treatment) that will not cause the air-fluidized bed to become noncovered ● In all instances, documentation verifying the continued need for the bed must be available ▪ A trained adult caregiver is available to assist the patient with activities of daily living, fluid balance, dry skin care, repositioning, recognition, and management of altered mental status, dietary needs, prescribed treatments, and management and support of the air-fluidized bed system and its problems such as leakage; ▪ A physician directs the home treatment regimen, and reevaluates and recertifies the need for the air-fluidized bed on a monthly basis; and

Policy Guideline Updates

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Pressure Reducing Support Surfaces (continued)	Aug. 10, 2022	▪ All other alternative equipment has been considered and ruled out ○ Home use of the air-fluidized bed is not covered under any of the following circumstances: ▪ The patient has coexisting pulmonary disease (the lack of firm back support makes coughing ineffective, and dry air inhalation thickens pulmonary secretions); ▪ The patient requires treatment with wet soaks or moist wound dressings that are not protected with an impervious covering such as plastic wrap or other occlusive material; ▪ The caregiver is unwilling or unable to provide the type of care required by the patient on an air-fluidized bed; ▪ Structural support is inadequate to support the weight of the air-fluidized bed system (it generally weighs 1600 pounds or more); ▪ Electrical system is insufficient for the anticipated increase in energy consumption; or ▪ Other known contraindications exist ○ Coverage of an air-fluidized bed is limited to the equipment itself ▪ Payment for this covered item may only be made if the written order from the attending physician is furnished to the supplier prior to the delivery of the equipment ▪ Payment is not included for the caregiver or for architectural adjustments such as electrical or structural improvement ○ The continued coverage of an air-fluidized bed as reasonable and necessary must be documented by the treating practitioner every month ▪ Continued use of an air fluidized bed is covered until the ulcer is healed or, if healing does not continue, there is documentation to show that: – Other aspects of the care plan are being modified to promote healing, or – The use of the bed is reasonable and necessary for wound management ○ If the stated coverage criteria for an air-fluidized bed are not met, the claim will be denied as not reasonable and necessary Applicable Codes *HCPCS Codes* Group 3 Codes ● Added E0194 *ICD-10 Diagnosis Codes* For HCPCS Code E0194 ● Added L89.003, L89.004, L89.013, L89.014, L89.023, L89.024, L89.103, L89.104, L89.113, L89.114, L89.123, L89.124, L89.133, L89.134, L89.143, L89.144, L89.153, L89.154, L89.203, L89.204, L89.213, L89.214, L89.223, L89.224,

Policy Guideline Updates

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Pressure Reducing Support Surfaces (continued)	Aug. 10, 2022	L89.303, L89.304, L89.313, L89.314, L89.323, L89.324, L89.43, L89.44, L89.503, L89.504, L89.513, L89.514, L89.523, L89.524, L89.603, L89.604, L89.613, L89.614, L89.623, L89.624, L89.813, L89.814, L89.893, L89.894, L89.93, and L89.94 **Questions and Answers (Q&A)** • Added Q&A addressing prior authorization **Supporting Information** • Updated *References* section to reflect the most current information
Zoledronic Acid (Zometa® & Reclast®)	Aug. 10, 2022	**Related Policies** • Removed reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Coverage of Drugs and Biologicals for Label and Off-Label Uses* **Policy Summary** ***Overview*** • Removed list of conditions for which treatment with Reclast® and Zometa® is indicated • Removed content addressing utilization guidelines ***Guidelines*** **Zometa®** • Added language to indicate retreatment with Zometa® 4 mg may be considered if serum calcium does not return to normal or remain normal after treatment **Zometa® for Hypercalcemia of Malignancy** • Removed criterion requiring the date of last treatment must be indicated **Zometa® for Multiple Myeloma and Metastatic Bone Lesions of Solid Tumors** • Removed criterion requiring "a 4 mg IV infusion over no less than 15 minutes was administered every 3-4 weeks by a healthcare provider for the patient with a creatinine clearance of > 60 mL/min" **Reclast** • Revised language to indicate Reclast® used for prevention without a confirmed diagnosis of osteoporosis in postmenopausal women will not be covered because it is not considered medically reasonable and necessary in the diagnosis and treatment of a specific illness or injury as defined in the *Social Security Act, Section 1862(a)(1)(A)* and as stated in the *Centers for Medicare & Medicaid Services (CMS) IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 50.4* **Reclast® for Glucocorticoid-Induced Osteoporosis in Men and Women** • Added criterion requiring "the patient is taking at least 1,200 mg calcium and 800-1,000 IU vitamin D per day"

Policy Guideline Updates

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Zoledronic Acid (Zometa® & Reclast®) (continued)	Aug. 10, 2022	Supporting Information • Updated *References* section to reflect the most current information

Replaced		
Policy Title	**Approval Date**	**Summary of Changes**
Air-Fluidized Bed (NCD 280.8)	Aug. 10, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Pressure Reducing Support Services*
Ambulatory EEG Monitoring (NCD 160.22)	Aug. 10, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Ambulatory EEG Monitoring*
Blood Platelet Transfusions (NCD 110.8)	Aug. 10, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Platelet Rich Plasma Injections for Non-Wound Injections*
Blood Transfusions (NCD 110.7)	Aug. 10, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Clinical Diagnostic Laboratory Services*
Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (OSA) (NCD 240.4)	Aug. 10, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Durable Medical Equipment Reference List*
Infrared Therapy Devices (NCD 270.6)	Aug. 10, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Durable Medical Equipment Reference List*
Noncontact Normothermic Wound Therapy (NNWT) (NCD 270.2)	Aug. 10, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Durable Medical Equipment Reference List*
Obsolete or Unreliable Diagnostic Tests (NCD 300.1)	Aug. 10, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Clinical Diagnostic Laboratory Services*

Policy Guideline Updates

Replaced

Policy Title	Approval Date	Summary of Changes
Seat Lift (NCD 280.4)	Aug. 10, 2022	• Policy replaced; refer to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Durable Medical Equipment Reference List*

Retired

The following Policy Guidelines have been retired effective Aug. 10, 2022:

- Artificial Hearts and Related Devices (Formerly NCD 20.9)
- Bladder Stimulators (Pacemakers) (NCD 230.16)
- Blood Brain Barrier Osmotic Disruption for Treatment of Brain Tumors (NCD 110.20)
- Chimeric Antigen Receptor (CAR) T-cell Therapy (NCD 110.24)
- Coverage of Drugs and Biologicals for Label and Off-Label Uses
- Percutaneous Image-Guided Breast Biopsy (NCD 220.13)
- Percutaneous Image-Guided Lumbar Decompression for Lumbar Spinal Stenosis (NCD 150.13)
- Screening for Depression in Adults (NCD 210.9)
- Thermography (NCD 220.11)
- Vertebral Augmentation Procedure (VAP)/Percutaneous Vertebroplasty

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.