United Healthcare®

UnitedHealthcare West

Medical Management Guideline Update Bulletin: July 2023

In This Issue

Medical Management Guideline Updates — Page

Take Note

Updated

Revised

Take Note

Quarterly CPT® and HCPCS Code Updates

Effective **Jul. 1, 2023**, the following Medical Management Guidelines have been updated to reflect the quarterly Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) code additions and revisions. Refer to the following sources for information on the code updates:

- American Medical Association. Current Procedural Terminology: CPT®
- Centers for Medicare & Medicaid Services. Healthcare Common Procedure Coding System: HCPCS Quarterly Update

Policy Title	Summary of Changes
Cardiovascular Disease Risk Tests	• Revised description for CPT code 0308U
Carrier Testing for Genetic Diseases	• Added CPT cdoe 0400U
Category III Codes	• Added CPT codes 0791T, 0792T, 0793T, 0794T, 0795T, 0796T, 0797T, 0798T, 0799T, 0800T, 0801T, 0802T, 0803T, 0804T, 0805T, 0806T, 0807T, 0808T, 0809T, and 0810T
Genetic Testing for Cardiac Disease	• Added CPT code 0401U
Molecular Oncology Testing for Cancer Diagnosis, Prognosis, and Treatment Decisions	• Added CPT codes 0388U, 0391U, and 0397U
Pharmacogenetic Panel Testing	• Added CPT code 0392U
Preimplantation Genetic Testing and Related Services	• Added CPT code 0396U
Provider Administered Drugs – Site of Care	• Added HCPCS code J1576
Sacroiliac Joint Interventions	• Added CPT code 0809T

Updated

Policy Title	Effective Date	Summary of Changes
Surgery of the Ankle	Aug. 1, 2023	**Applicable Codes** • Revised description for CPT code 27685 **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information
Surgery of the Hand or Wrist	Sep. 1, 2023	**Applicable Codes** • Removed CPT codes 25332 and 25447

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Abnormal Uterine Bleeding and Uterine Fibroids	Aug. 1, 2023	**Related Policies** • Removed reference link to the Medical Management Guideline titled *Preventive Care Services* **Coverage Rationale** • Removed language indicating ultrasound-guided radiofrequency ablation (e.g., Acessa™, Sonata®) is unproven and not medically necessary for treating uterine fibroids due to insufficient evidence of efficacy **Applicable Codes** • Removed CPT codes 0404T and 58674 **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	**Endometrial Ablation** **Endometrial ablation is proven and medically necessary for treating abnormal uterine bleeding in premenopausal women.** For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Hysteroscopy, Operative, Endometrial ablation for abnormal bleeding in premenopausal women. Click here to view the InterQual® criteria. **Levonorgestrel-Releasing Intrauterine Device** **Levonorgestrel-releasing intrauterine devices (LNG-IUD) (e.g., Mirena®, Skyla®, Liletta® or Kyleena™) are proven and medically necessary for treating menorrhagia**. Refer to the *U.S. Food and Drug Administration (FDA)* section of the policy for additional information. **Uterine Fibroids** **Uterine artery embolization (UAE) is proven and medically necessary for treating symptomatic uterine fibroids when there is documentation of evaluation of abnormal uterine bleeding (AUB) including endometrial biopsy for individuals > 40 years of age and a pap smear screening consistent with current guidelines**. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Uterine Artery Embolization (UAE). Click here to view the InterQual® criteria. **UAE is unproven and not medically necessary for the purpose of preserving childbearing potential for women with symptomatic uterine fibroids due to insufficient evidence of efficacy**. **Magnetic resonance-guided focused ultrasound ablation (MRgFUS) is unproven and not medically necessary for treating uterine fibroids due to insufficient evidence of efficacy.**

Medical Management Guideline Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Category III Codes	Aug. 1, 2023	**Coverage Rationale** • Added language to clarify Category III codes are considered experimental, investigational, or unproven and not medically necessary due to insufficient evidence of efficacy *unless otherwise specified in another applicable UnitedHealthcare Policy* **Applicable Codes** • Updated list of experimental, investigational, or unproven and not medically necessary Category III codes: ○ Added CPT code 0779T and corresponding reference link to the Medical Management Guideline titled *Gastrointestinal Motility Disorders, Diagnosis and Treatment* ○ Removed CPT code 0404T and corresponding reference link to the Medical Management Guideline titled *Abnormal Uterine Bleeding and Uterine Fibroids* ○ Added reference link to the Medical Management Guideline titled *Macular Degeneration Treatment Procedures* for CPT codes 0378T and 0379T	**Unless otherwise specified in another applicable UnitedHealthcare Policy, Category III codes are considered experimental, investigational, or unproven and not medically necessary due to insufficient evidence of efficacy.** Refer to the *Category III CPT Codes List* in the *Applicable Codes* section of the policy for specific information surrounding a Category III code.

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**

Cell-Free Fetal DNA Testing	Aug. 1, 2023	**Related Policies**
		• Added reference link to the Medical Policy titled *Preimplantation Genetic Testing and Related Services*
		Coverage Rationale
		DNA-Based Noninvasive Prenatal Tests
		• Replaced language indicating "DNA-based noninvasive prenatal tests of fetal aneuploidy are proven and medically necessary as screening tools for trisomy 21 (Down syndrome), trisomy 18 (Edwards syndrome) or trisomy 13 (Patau syndrome) for individuals with a singleton pregnancy in any one of the [listed] circumstances" with "DNA-based noninvasive prenatal tests of fetal Aneuploidy are proven and medically necessary as screening tools for Trisomy 21 (Down syndrome), Trisomy 18 (Edwards syndrome) or Trisomy 13 (Patau syndrome), *with or without fetal sex chromosomes*, for individuals with a singleton *or twin* pregnancy in any one of the [listed] circumstances
		• Revised list of circumstances in which DNA-based noninvasive prenatal tests of fetal Aneuploidy
			DNA-based noninvasive prenatal tests of fetal Aneuploidy are proven and medically necessary as screening tools for Trisomy 21 (Down Syndrome), Trisomy 18 (Edwards Syndrome) or Trisomy 13 (Patau Syndrome), with or without fetal sex chromosomes, for members with a singleton or twin pregnancy in any one of the following circumstances:
			• Birthing person aged 35 years or older at delivery and/or donor oocyte aged 35 years or older; or
			• Fetal ultrasound findings indicating an increased risk of Aneuploidy; or
			• History of a prior pregnancy with a trisomy due to translocation; or
			• Positive first- or second-trimester screening test results for Aneuploidy; or
			• Parental balanced Robertsonian translocation with an increased risk of fetal Trisomy 13 or Trisomy 21; or
			• Screening after pre-test counseling from a board-certified genetic counselor or from the prenatal care physician or healthcare professional using Shared Decision-Making (SDM).
			
			Due to insufficient evidence of efficacy, DNA-based noninvasive prenatal tests are unproven and not medically necessary for any of the following:
			• For the sole purpose of determining the sex of the fetus unless the determination of fetal sex is essential to the diagnosis of a condition
			• For the sole purpose of determining Twin Zygosity
			• Conditions including, but not limited to, the following:
			  ○ Pregnancies involving one or more of the following three or more fetuses
			  ○ Fetal demise in a multiple gestation pregnancy
			  ○ Vanishing twin syndrome
			  ○ Repeat testing due to low fetal fraction
			  ○ Missed abortion/fetal demise in a single gestation pregnancy
			  ○ Screening for the following:
			  ▪ Aneuploidy other than Trisomies 21, 18, 13 or sex chromosomes
			  ▪ Microdeletions
			  ▪ Single gene disorders (e.g., Vistara™, PreSeek™, Unity™ Carrier Testing)

Revised			
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Cell-Free Fetal DNA Testing (continued)	Aug. 1, 2023	are proven and medically necessary; replaced: ○ "*Maternal age* or oocyte age of 35 years or older at delivery" with "*birthing person* aged 35 years or older at delivery *and/or donor* oocyte aged 35 years or older" ○ "History of a prior pregnancy with a trisomy" with "history of a prior pregnancy with a trisomy *due to translocation*" • Revised list of unproven and not medically necessary indications: ○ Added: ▪ For the sole purpose of determining the sex of the fetus unless the determination of fetal sex is essential to the diagnosis of a condition ▪ Missed abortion/fetal demise in a single gestation pregnancy ▪ Pregnancies involving one or more of the following: – Three or more fetuses – Fetal demise in a multiple gestation pregnancy – Vanishing twin syndrome	▪ Fetal RhD status **Due to insufficient evidence of efficacy, the following DNA-based noninvasive prenatal test is unproven and not medically necessary:** • Vanadis® **Genetic Counseling** Genetic counseling is strongly recommended prior to fetal screening or prenatal diagnosis in order to inform persons being tested about the advantages and limitations of the test as applied to a unique person.

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Cell-Free Fetal DNA Testing (continued)	Aug. 1, 2023	○ Removed "multiple gestation pregnancies" ○ Replaced: ▪ "Twin zygosity" with "*for the sole purpose of determining* twin zygosity" ▪ "Screening for Aneuploidy other than trisomies 21, 18, or 13" with "screening for Aneuploidy other than trisomies 21, 18, 13, *or sex chromosomes*" ▪ "Screening for single gene disorders" with "screening for single gene disorders *(e.g., Vistara™, PreSeek™, Unity™ Carrier Testing)*" **Documentation Requirements** • Updated list of *Required Clinical Information*: ○ Added: ▪ Number of fetuses in current pregnancy ▪ Purpose of test ○ Replaced "*maternal* age" with "age *of birthing person and/or donor oocyte*" **Definitions** • Added definition of "Twin Zygosity" • Updated definition of: ○ Aneuploidy ○ Cell Free Fetal DNA (cffDNA or cfDNA)	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Cell-Free Fetal DNA Testing (continued)	Aug. 1, 2023	**Applicable Codes** • Added ICD-10 diagnosis codes O30.001, O30.002, O30.003, O30.009, O30.011, O30.012, O30.013, O30.019, O30.021, O30.022, O30.023, O30.029, O30.031, O30.032, O30.033, O30.039, O30.041, O30.042, O30.043, O30.049, O30.091, O30.092, O30.093, and O30.099 • Revised description for ICD-10 diagnosis codes O09.10, O09.11, O09.12, and O09.13 **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information	

Chromosome Microarray Testing (Non-Oncology Conditions)	Aug. 1, 2023	**Related Policies**
		• Added reference link to the Medical Management Guideline titled *Whole Exome and Whole Genome Sequencing*
		Coverage Rationale
		• Added language to indicate pre-test genetic counseling is strongly recommended in order to inform persons being tested about the advantages and limitations of the test as applied to a unique person
		• Replaced reference to "*genome-wide* comparative genomic hybridization/microarray testing or single-nucleotide polymorphism
			Pre-test genetic counseling is strongly recommended in order to inform persons being tested about the advantages and limitations of the test as applied to a unique person.
			
			Chromosome microarray testing using array comparative genomic hybridization (aCGH) and/or single-nucleotide polymorphism (SNP) array is proven and medically necessary for the following:
			• Evaluation of an embryo/fetus in the following cases:
			  ○ Intrauterine Fetal Demise or Stillbirth
			  ○ Testing the products of conception following pregnancy loss
			  ○ Individuals undergoing invasive prenatal testing (i.e., amniocentesis, chorionic villus sampling or fetal tissue sampling)
			• Evaluation of individuals with one or more of the following:
			  ○ Autism spectrum disorder
			  ○ Isolated severe congenital heart disease

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Chromosome Microarray Testing (Non-Oncology Conditions) (continued)	Aug. 1, 2023	(SNP) chromosomal *microarray analysis*" with "chromosome microarray *testing using array* comparative genomic hybridization *(aCGH) and*/or single-nucleotide polymorphism (SNP) *array*" • Revised list of proven and medically necessary indications; replaced: ○ "Evaluation of an embryo/fetus in *women* undergoing invasive prenatal testing" with "evaluation of an embryo/fetus in *individuals* undergoing invasive prenatal testing" ○ "Evaluation of individuals with *non-syndromic* Developmental Delay/Intellectual Disability" with "evaluation of individuals with Developmental Delay/Intellectual Disability *where a specific syndrome is not suspected*" ○ "Evaluation of biological parent of a fetus or child with an equivocal chromosome microarray result" with "evaluation of biological parent of a fetus or child with an *abnormal or* equivocal *finding on* chromosome microarray *testing* results" • Removed list of examples of unproven and not medically	○ Multiple anomalies that are not specific to a Well-Delineated Genetic Syndrome and cannot be identified by a clinical evaluation alone ○ Developmental Delay/Intellectual Disability where a specific syndrome is not suspected • Evaluation of biological parent of a fetus or child with an abnormal or equivocal finding on chromosome microarray testing results **Chromosome microarray testing using aCGH or SNP array is unproven and not medically necessary for all other populations and conditions due to insufficient evidence of efficacy.** Preimplantation genetic testing (PGT) is addressed in the Medical Management Guideline titled Preimplantation Genetic Testing and Related Services.

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Chromosome Microarray Testing (Non-Oncology Conditions) (continued)	Aug. 1, 2023	necessary conditions • Removed reference link to the Medical Management Guideline titled *Molecular Oncology Testing for Cancer Diagnosis Prognosis, and Treatment Decisions* for genome-wide comparative genomic hybridization microarray testing or SNP chromosomal microarray analysis for the evaluation of cancer **Definitions** • Updated definition of: ○ Intellectual Disability ○ Well-Delineated Genetic Syndrome **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect the most current information	
Cosmetic and Reconstructive Procedures	Aug. 1, 2023	**Related Policies** • Added reference link to the Medical Management Guideline titled *Liposuction for Lipedema* • Removed reference link to the Medical Management Guideline titled *Brow Ptosis and Eyelid Repair* **Coverage Rationale** ***Cosmetic Procedures*** • Added language to indicate cosmetic procedures are	**Reconstructive Procedures** ***Oklahoma, Oregon, Texas, Washington*** **A procedure is considered Reconstructive and Medically Necessary when all of the following criteria are met**: • There is documentation that the physical abnormality and/or physiological abnormality is causing a Functional Impairment that requires correction; and • The proposed treatment is of proven/medically necessary efficacy; and is deemed likely to significantly improve or restore the member's physiological function

Revised			
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Cosmetic and Reconstructive Procedures (continued)	Aug. 1, 2023	procedures or services that change or improve appearance without significantly improving physiological function; a procedure is considered to be a cosmetic procedure when it does not meet the reconstructive criteria in the *Reconstructive Procedures* section [of the policy]
		• Removed list of unproven and not medically necessary cosmetic procedures
		• Added instruction to refer to the *Benefit Considerations* section [of the policy] for additional information on cosmetic services and exclusions
		Documentation Requirements
		• Updated list of *Required Clinical Information*; removed reference link to the policy titled *Outpatient Surgical Procedures – Site of Service* for CPT code 15736
		Definitions
		• Removed definition of:
		  ○ Adjacent Tissue Transfer
		  ○ Congenital Defect
		  ○ Injury
		  ○ Medically Necessary
		• Updated definition of "Microtia"
		Applicable Codes
		• Removed coding clarifications and CPT coding tips
			Note: Microtia repair is considered reconstructive although no Functional Impairment may be documented.
			
			California
			A procedure is considered reconstructive and Medically Necessary when all of the following criteria are met:
			• To improve function; or
			• To create a normal appearance, to the extent possible.
			
			Note: Microtia repair is considered reconstructive although no Functional Impairment may be documented.
			
			Tissue Transfer (Flap) Repair
			Flap repair is considered reconstructive and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Tissue Transfer (Flap).
			
			Click here to view the InterQual® criteria.
			
			Cosmetic Procedures
			Cosmetic Procedures are procedures or services that change or improve appearance without significantly improving physiological function. A procedure is considered to be a Cosmetic Procedure when it does not meet the Reconstructive criteria in the *Reconstructive Procedures* section above.
			
			Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiological function are considered Cosmetic Procedures. The fact that a covered person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery for other procedures done to relieve such consequences or behavior) as a Reconstructive Procedure.

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**

Cosmetic and Reconstructive Procedures (continued)	Aug. 1, 2023	**Benefit Considerations**
		• Added language to indicate:
		  ○ Cosmetic Procedures are excluded from coverage
		  ○ In most benefit plans, the following cosmetic procedures are specifically excluded from coverage:
		  ▪ Pharmacological regimens, nutritional procedures, or treatments
		  ▪ Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery, and other such skin abrasion procedures)
		  ▪ Skin abrasion procedures performed as a treatment for acne
		  ▪ Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple; this exclusion does not apply to reconstructive liposuction
		  ▪ Treatment for skin wrinkles or any treatment to improve the appearance of the skin
		  ▪ Treatment for spider veins
			Note: Refer to the *Benefit Considerations* section of the policy for additional information on cosmetic services and exclusions.

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Cosmetic and Reconstructive Procedures (continued)	Aug. 1, 2023	▪ Sclerotherapy treatment of veins ▪ Hair removal or replacement by any means, except for hair removal as part of genital reconstruction prescribed by a Physician for the treatment of gender dysphoria; for laser or electrolysis hair removal in advance of genital reconstruction, refer to the Medical Policy titled *Gender Dysphoria Treatment* ○ Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry; other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other covered health care service ○ If the original service was not a covered benefit under the	

Revised			
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Cosmetic and Reconstructive Procedures (continued)	Aug. 1, 2023	contract or UnitedHealthcare guidelines (e.g., cosmetic, investigational, not a covered health service, etc.), then benefits are limited to the treatment of the complication ▪ Examples include, but are not limited to, removal of a leaking or defective silicone breast prosthesis is a covered health care service ▪ However, benefits for replacement of the breast prosthesis are only available if the original prosthesis was considered "reconstructive" **Supporting Information** • Updated *Description of Services* and *References* sections to reflect the most current information	
Epidural Steroid Injections for Spinal Pain	Aug. 1, 2023	**Coverage Rationale** • Revised coverage criteria: ○ Added criterion requiring "evidence of structural and/or functional nerve root involvement" ○ Removed criterion requiring: ▪ Evidence of nerve impingement by imaging or electromyography (EMG)	**Epidural Steroid Injections (ESI) are proven and medically necessary when all of the following criteria are met:** • The injection is intended for the management of Radicular Pain as evidenced by history and physical exam; **and** • The Radicular Pain is unresponsive to the following conservative treatment for ≥ 4 weeks: ○ Pharmacotherapy such as NSAIDS or acetaminophen; **or** ○ Activity modification (including but not limited to heavy lifting, bending, spinal torsion activities); **or** ○ PT or home exercise **and**

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Epidural Steroid Injections for Spinal Pain (continued)	Aug. 1, 2023	▪ No evidence of a condition that would contraindicate Epidural Steroid Injections (ESIs) • Updated list of examples of conditions that would contraindicate ESIs; removed "infection at the site of injection" ***Epidural Steroid Injection Limitations*** • Replaced language indicating "subsequent ESIs may be provided if pain has returned or deterioration in function has occurred" with "subsequent ESIs may be provided if *Radicular* Pain has returned *and/*or deterioration in function has occurred" **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information	• There is evidence of structural and/or functional nerve root involvement; **and** • The injection is performed under fluoroscopic or CT guidance; **and** • Conditions that would contraindicate ESIs include but are not limited to: ○ Spinal neoplasm ○ Rapidly progressing neurological deficit ○ Epidural abscess **The following are unproven and not medically necessary due to insufficient evidence of efficacy:** • The use of ultrasound guidance for ESIs • ESI for **all** other indications of the spine not included above **Epidural Steroid Injection Limitations** • A maximum of four (4) ESI sessions (per region, regardless of level, location, or side) per year ○ A session is defined as one date of service in which ESI injection(s) are performed ○ A region is defined by either the region of the cervical, thoracic or lumbosacral ○ A year is defined as the 12-month period starting from the date of service of the first approved injection • Subsequent ESIs may be provided only if: ○ Radicular pain has returned and/or deterioration in function has occurred; **and** ○ The previous injection resulted in ≤ 50% pain relief or functional improvement for less than three months as measured by validated measurement tools and there has been a reassessment of the individual and the injection site and technique; **or** ○ The previous injection resulted in ≥ 50% pain relief or functional improvement for three or more months as measured by validated measurement tools.

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Gender Dysphoria Treatment Excluding California and Washington	Jul. 1, 2023	**Notice of Revision**: The following summary of changes has been modified. Revisions to the previous policy update announcement are outlined in red below. Please take note of the amended updates to be applied on **Jul. 1, 2023**. **Coverage Rationale** • Revised list of indications for surgical treatment for Gender Dysphoria; replaced "breast surgery" with "breast surgery *(mastectomy, breast reduction or breast augmentation)*" • Replaced references to: ○ "*Psychological* assessment" with "*clinical* assessment" ○ "*Qualified Behavioral Health Provider*" with "*Qualified Healthcare Professional*" • Added language to indicate thyroid cartilage reduction and/or voice modification surgery (e.g., laryngoplasty, glottoplasty, or shortening of the vocal cords) for Gender Dysphoria may be indicated for members who provide a written clinical assessment from at least one Qualified Healthcare Professional experienced in treating Gender Dysphoria is required; the assessment must document that an individual meets	Notes: • This Medical Management Guideline does not apply to members with ambiguous genitalia or disorders of sexual development. • This Medical Management Guideline does not apply to policies in California. Refer to the California-specific Benefit Interpretation Policy titled Gender Dysphoria (Gender Identity Disorder) Treatment. • This Medical Policy does not apply to fully-insured group policies in the state of Washington. Refer to the Washington-specific Benefit Interpretation Policy titled Gender Dysphoria (Gender Identity Disorder) Treatment. **Surgical treatment for Gender Dysphoria may be indicated for members who provide the following documentation**: • For breast surgery (mastectomy, breast reduction or breast augmentation), a written clinical assessment from at least one Qualified Healthcare Professional experienced in treating Gender Dysphoria, is required. The assessment must document that a member meets **all** of the following criteria: ○ Persistent, well-documented Gender Dysphoria ○ Capacity to make a fully informed decision and to consent for treatment ○ Must be at least 18 years of age ○ Favorable psychosocial-behavioral evaluation to provide screening and identification of risk factors or potential postoperative challenges ○ For breast augmentation, continued Gender Dysphoria following the completion of 12 months of continuous hormone therapy prior to the breast procedure is required • For thyroid cartilage reduction and/or voice modification surgery (e.g., laryngoplasty, glottoplasty or shortening of the vocal cords), a written clinical assessment from at least one Qualified Healthcare Professional experienced in treating Gender Dysphoria is required. The assessment must document that an individual meets all of the following criteria: ○ Persistent, well-documented Gender Dysphoria ○ Capacity to make a fully informed decision and to consent for treatment ○ Must be at least 18 years of age

Revised			
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Gender Dysphoria Treatment Excluding California and Washington (continued)	Jul. 1, 2023	all of the following criteria: ○ Persistent, well-documented Gender Dysphoria ○ Capacity to make a fully informed decision and to consent for treatment ○ Must be at least 18 years of age ○ Favorable psychosocial-behavioral evaluation to provide screening and identification of risk factors or potential postoperative challenges ○ Completion of 6 months of continuous hormone therapy prior to surgery is required for voice masculinization ○ For voice modification surgery, documentation of presurgical voice lessons and/or therapy • Removed language indicating when bilateral mastectomy or breast reduction is performed as a stand-alone procedure, without genital reconstruction procedures, completion of hormone therapy prior to the breast procedure is not required • Revised criteria that must be met and documented in the written clinical assessment for:	○ Favorable psychosocial-behavioral evaluation to provide screening and identification of risk factors or potential postoperative challenges ○ Completion of 6 months of continuous hormone therapy prior to surgery is required for voice masculinization ○ For voice modification surgery, documentation of presurgical voice lessons and/or therapy • For genital surgery, a written clinical assessment from at least two Qualified Healthcare Professionals experienced in treating Gender Dysphoria*, who have independently assessed the individual, is required. The assessment must document that a member meets **all** of the following criteria: ○ Persistent, well-documented Gender Dysphoria ○ Capacity to make a fully informed decision and to consent for treatment ○ Must be at least 18 years of age ○ Favorable psychosocial-behavioral evaluation to provide screening and identification of risk factors or potential postoperative challenges ○ Complete at least 12 months of successful continuous full-time real-life involvement in the Identified gender ○ Complete 12 months of continuous hormone therapy appropriate for the experienced gender (unless medically contraindicated) ○ Treatment plan that includes ongoing follow-up and care by a Qualified Healthcare Professional experienced in treating Gender Dysphoria **When the above criteria are met, the following surgical procedures and/or therapies to treat Gender Dysphoria are medically necessary and covered as a proven benefit**: • Bilateral mastectomy or breast reduction • Breast augmentation with breast implants or fat transfer • Clitoroplasty (creation of clitoris) • Hysterectomy (removal of uterus) • Labiaplasty (creation of labia) • Laser or electrolysis hair removal in advance of genital reconstruction prescribed by a physician for the treatment of Gender Dysphoria • Metoidioplasty (creation of penis, using clitoris)

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Gender Dysphoria Treatment Excluding California and Washington (continued)	Jul. 1, 2023	***Breast Surgery*** ○ Replaced criterion requiring the individual "must be 18 years of age *(age of majority)*" with "must be 18 years of age" ○ Added criterion for breast augmentation requiring continued Gender Dysphoria following the completion of 12 months of continuous hormone therapy prior to the breast procedure is required ***Genital Surgery*** ○ Replaced criterion requiring an individual must: ▪ "Be at least 18 years of age *(age of majority)*" with "be at least 18 years of age" ▪ "Complete at least 12 months of successful continuous full-time real-life involvement in the *experienced* gender" with "complete at least 12 months of successful continuous full-time real-life involvement in the *identified* gender" ***Medically Necessary and Covered as a Proven Benefit*** • Revised list of procedures and/or therapies that are medically	• Orchiectomy (removal of testicles) • Penectomy (removal of penis) • Penile prosthesis • Phalloplasty (creation of penis) • Salpingo-oophorectomy (removal of fallopian tubes and ovaries) • Scrotoplasty (creation of scrotum) • Testicular prostheses • Thyroid cartilage reduction/reduction thyroid chondroplasty/tracheal shave (removal or reduction of the Adam's apple) • Urethroplasty (reconstruction of female urethra) • Urethroplasty (reconstruction of male urethra) • Vaginectomy (removal of vagina) • Vaginoplasty (creation of vagina) • Voice lessons and/or voice therapy • Voice modification surgery (e.g., laryngoplasty, glottoplasty or shortening of the vocal cords) • Vulvectomy (removal of vulva) **Certain ancillary procedures, including but not limited to the following, are considered cosmetic and not medically necessary, when performed as part of surgical treatment for Gender Dysphoria**: Refer to the *Benefit Considerations* section of the policy as member specific benefit plan document language may vary. • Abdominoplasty (also refer to the Medical Management Guideline titled Panniculectomy and Body Contouring Procedures) • Blepharoplasty (also refer to the Medical Management Guideline titled Brow Ptosis and Eyelid Repair) • Body contouring (e.g., fat transfer, lipoplasty, panniculectomy) (also refer to the Medical Management Guideline titled Panniculectomy and Body Contouring Procedures) • Brow lift • Calf implants • Cheek, chin and nose implants

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Gender Dysphoria Treatment Excluding California and Washington (continued)	Jul. 1, 2023	necessary and covered as a proven benefit; added: ○ Breast augmentation with breast implants or fat transfer ○ Thyroid cartilage reduction/reduction thyroid chondroplasty/tracheal shave (removal or reduction of the Adam's apple) ○ Voice lessons and/or voice therapy ○ Voice modification surgery (e.g., laryngoplasty, glottoplasty, or shortening of the vocal cords) ***Cosmetic and Not Medically Necessary*** • Revised list of ancillary procedures that are considered cosmetic and not medically necessary when performed as part of surgical treatment for Gender Dysphoria; removed: ○ Breast enlargement, including augmentation mammaplasty and breast implants ○ Thyroid cartilage reduction/reduction thyroid chondroplasty/trachea shave (removal or reduction of the Adam's apple) ○ Voice lessons and voice therapy	• Injection of fillers or neurotoxins • Face/forehead lift and/or neck tightening • Facial bone remodeling for facial feminization • Laser or electrolysis hair removal not related to genital reconstruction • Hair transplantation • Lip augmentation • Lip reduction • Liposuction (suction-assisted lipectomy) (also refer to the Medical Management Guideline titled Panniculectomy and Body Contouring Procedures) • Mastopexy • Pectoral implants for chest masculinization • Rhinoplasty (also refer to the Medical Management Guideline titled Rhinoplasty and Other Nasal Surgeries) • Skin resurfacing (e.g., dermabrasion, chemical peels, laser)

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Gender Dysphoria Treatment Excluding California and Washington (continued)	Jul. 1, 2023	○ Voice modification surgery (e.g., laryngoplasty, glottoplasty, or shortening of the vocal cords) **Documentation Requirements** • Updated list of *Required Clinical Information* to reflect/include: ○ ~~When requested, high quality color photographs of the physical and/or physiological abnormality~~ ▪ ~~Note: All images must be labeled with the:~~ – ~~Date taken~~ – ~~Applicable case number obtained at time of notification, or member's name and ID number~~ ▪ ~~Submission of photographs can be submitted via the external portal at uhcprovider.com/paan; faxes will not be accepted~~ ○ The number of months member has completed continuous hormone therapy or reason for medical contraindication or non-indication ○ A written clinical assessment from a Qualified Healthcare	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Gender Dysphoria Treatment Excluding California and Washington (continued)	Jul. 1, 2023	Professional experienced in treating Gender Dysphoria, who has independently assessed the individual; the assessment should include all of the following: ▪ Persistent, well-documented gender dysphoria ▪ The member is capable to make a fully informed decision and to consent for treatment ▪ Member's age ▪ Results of psychosocial-behavioral evaluation including management of coexisting mental health condition ○ Treatment plan that includes ongoing and follow-up care by a Qualified Healthcare Professional experienced in treating Gender Dysphoria, and whether request is part of a staged procedure ○ For voice modification surgery, in addition to the above, also include documentation of presurgical voice lessons and/or therapy ○ For genital surgery, in addition to the above, also include:	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Gender Dysphoria Treatment Excluding California and Washington (continued)	Jul. 1, 2023	▪ Clinical written assessment from a second Qualified Healthcare Professional experienced in treating Gender Dysphoria, who has independently assessed the individual ▪ Documentation the member has completed at least 12 months of successful continuous full-time real-life experience in identified gender **Definitions** • Added definition of "Qualified Healthcare Professional" • Removed definition of "Qualified Behavioral Health Provider" **Applicable Codes** • Removed CPT codes 19340 and 19342 **Supporting Information** • Updated *Description of Services*, *Benefit Considerations*, *Clinical Evidence*, and *References* sections to reflect the most current information	
Genetic Testing for Hereditary Cancer	Sep. 1, 2023	**Applicable Codes** • Removed CPT codes 81165, 81166, 81167, and 81216	Pre-test genetic counseling is strongly recommended in order to inform persons being tested about the advantages and limitations of the test as applied to a unique person. **Single gene testing and known mutation testing for familial cancer is proven and medically necessary.**

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**

Genetic Testing for Hereditary Cancer (continued)	Sep. 1, 2023		**Hereditary Breast and Ovarian Cancer Panel Testing**
			Genetic testing Panels for High Penetrance Breast Cancer Susceptibility Genes are proven and medically necessary for members with a personal history of a *BRCA*-Related Cancer for any of the following indications:
			• Personal history of Breast Cancer and at least one of the following:
			  ○ Diagnosed at age 50 or younger
			  ○ Metastatic Breast Cancer diagnosed at any age
			  ○ Multiple primary Breast Cancers diagnosed at any age (prior diagnosis or bilateral cancer)
			  ○ Triple Negative Breast Cancer diagnosed at any age
			  ○ Lobular Breast Cancer diagnosed at any age with a personal or family history of diffuse gastric cancer diagnosed at any age
			  ○ Ashkenazi Jewish ancestry
			  ○ Cisgender, transgender, or gender-diverse individual assigned male at birth
			  ○ Male Breast Cancer at any age
			  ○ Unknown or Limited Family History
			  ○ At least one first- or second-degree relative with a BRCA-Related Cancer
			• Personal history of one of the following cancers at any age:
			  ○ Ovarian Cancer
			  ○ Pancreatic cancer
			  ○ Metastatic prostate cancer
			• A *BRCA* 1/2 pathogenic variant detected in tumor tissue
			• Member has a Tyrer-Cuzick, BRCAPro or Penn11 Score of 2.5% or greater for a *BRCA1/2* pathogenic variant
			
			Genetic testing Panels for High Penetrance Breast Cancer Susceptibility Genes for members with no personal history of a *BRCA*-Related Cancer are proven and medically necessary for any of the following indications:
			• At least one first- or second-degree relative with a *BRCA*-Related Cancer; or
			• Ashkenazi Jewish ancestry and at least one Close Blood Relative with a *BRCA*-Related Cancer; or
			• Member has a Tyrer-Cuzick, BRCAPro or Penn11 Score of 5% or greater for

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Genetic Testing for Hereditary Cancer (continued)	Sep. 1, 2023		a *BRCA1/2* pathogenic variant. **Genetic testing Panels for High Penetrance Breast Cancer Susceptibility Genes are unproven and not medically necessary for all other indications including:** • Screening for cancer risk for members not listed in the proven indications above; or • Risk assessment of other cancers; or • Confirmation of direct to consumer genetic testing without meeting any of the proven indications above. **Other Hereditary Cancer Syndrome Multi-Gene Panel Testing** **Genetic testing with a Multi-Gene hereditary cancer Panel for members with a personal history of a Primary Solid Tumor cancer (excluding basal or squamous cell carcinoma) is proven and medically necessary if the following criteria are met:** • The suspected hereditary cancer syndromes can be diagnosed by testing two or more genes included in the specific hereditary cancer Panel; and • At least one of the following: ○ A personal history of at least two different Primary Solid Tumor cancers (excluding basal or squamous cell carcinoma); or ○ A personal history of *BRCA*-related cancer diagnosed at age 40 or younger; or ○ A personal history of *BRCA*-related cancer and at least one Close Blood Relative with a Cancer associated with Lynch Syndrome; or ○ At least one Close Blood Relative diagnosed with a *BRCA*-Related Cancer at age 40 or younger; or ○ At least two Close Blood Relatives (in addition to affected member) on the same side of the family diagnosed with any Primary Solid Tumor cancer (excluding basal or squamous cell carcinoma); or ○ A personal history of paraganglioma or pheochromocytoma; or ○ A personal history of Cancer associated with Lynch Syndrome; or ○ A personal history of cancer where tumor testing results demonstrate

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Genetic Testing for Hereditary Cancer (continued)	Sep. 1, 2023		that the cancer was MSI-high or had immunohistochemical staining showing the absence of one or more mismatch repair proteins (*MLH1*, *MSH2*, *MSH6* or *PMS2*); or ○ A personal history of colorectal polyposis with at least 10 adenomatous polyps, at least 2 hamartomatous polyps or at least 5 serrated polyps/lesions proximal to the rectum; or ○ Member has a PREMM5, MMRpro or MMRpredict Score of 2.5% or greater for having a Lynch syndrome gene mutation **Genetic testing with a Multi-Gene hereditary cancer Panel for members with no personal history of a Primary Solid Tumor cancer is proven and medically necessary if the following criteria are met:** ● The suspected hereditary cancer syndromes can be diagnosed by testing two or more genes included in the specific hereditary cancer Panel; and ● At least one of the following: ○ At least one first-degree relative diagnosed with at least two different Primary Solid Tumor cancers (excluding basal or squamous cell carcinoma); or ○ At least one first- or second-degree relative diagnosed with a *BRCA*-Related Cancer at age 40 or younger; or ○ At least three Close Blood Relatives, on the same side of the family, diagnosed with any Primary Solid Tumor cancer (excluding basal or squamous cell carcinoma); or ○ At least one first-degree relative with paraganglioma or pheochromocytoma; or ○ At least one first-degree relative with a Cancer associated with Lynch Syndrome; or ○ At least one second-degree relative with a Cancer associated with Lynch Syndrome diagnosed at age 50 or younger; or ○ At least one second-degree relative with at least two Cancer associated with Lynch Syndrome; or ○ Two or more second-degree relatives with a Cancer associated with Lynch Syndrome; or

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Genetic Testing for Hereditary Cancer (continued)	Sep. 1, 2023		○ At least one first- or second-degree relative with a clinical diagnosis of familial adenomatous polyposis, attenuated familial adenomatous polyposis, juvenile polyposis syndrome or Peutz-Jeghers Syndrome; or ○ Member has a PREMM5, MMRpro or MMRpredict Score of 5% or greater for having a Lynch syndrome gene mutation **Genetic testing with a Multi-Gene hereditary cancer Panel for members diagnosed with cancer at age 18 or younger is proven and medically necessary.** **Multi-Gene hereditary cancer Panels are unproven and not medically necessary for all other indications.** **RNA Panel testing for hereditary cancers is unproven and not medically necessary for all indications.**
Glaucoma Surgical Treatments	Sep. 1, 2023	**Coverage Rationale** • Revised list of unproven and not medically necessary indications for treating any type of glaucoma; replaced: ○ "Canaloplasty (ab interno) and gonioscopy-assisted transluminal trabeculotomy (e.g., OMNI® Surgical System)" with "*combined* canaloplasty (ab interno) and gonioscopy-assisted transluminal trabeculotomy (e.g., OMNI® Surgical System)" ○ "Goniotomy or gonioscopy-assisted transluminal trabeculotomy (for all other *conditions not [listed in the*	**The following are proven and medically necessary:** • Goniotomy or Gonioscopy-assisted transluminal trabeculotomy for pediatric glaucoma (age 18 years or less) • iStent®, iStent Inject®, or the Hydrus® Microstent when used in combination with cataract surgery for treating mild to moderate open-angle glaucoma (OAG) and a cataract in adults currently being treated with ocular hypotensive medication • Some glaucoma drainage devices (specifically: XEN System, EX-PRESS, Molteno Implant, Baerveldt Tube Shunt, Ahmed Glaucoma Valve Implant and Krupin-Denver Valve Implant) for treating refractory glaucoma when medical or surgical treatments have failed or are inappropriate **The following are unproven and not medically necessary for treating any type of glaucoma due to insufficient evidence of efficacy and/or safety:** • Canaloplasty (ab interno) • Combined Canaloplasty (ab interno) and gonioscopy-assisted transluminal trabeculotomy (e.g., OMNI® Surgical System) • Glaucoma drainage devices that are not FDA approved

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Glaucoma Surgical Treatments (continued)	Sep. 1, 2023	*policy as proven or medically necessary]*)" with "goniotomy or gonioscopy-assisted transluminal trabeculotomy (for all other *indications [not listed in the policy as proven or medically necessary]*)" **Applicable Codes** • Removed CPT codes 66184 and 66185 **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	• Goniotomy or Gonioscopy-Assisted Transluminal Trabeculotomy (for all other indications)
Macular Degeneration Treatment Procedures	Aug. 1, 2023	**Coverage Rationale** • Added language to indicate: ○ Home visual field monitoring (e.g., ForeseeHome) for detection of age-related macular degeneration (AMD)-associated choroidal neovascularization (CNV) is proven and medically necessary when **all** of the following criteria are met: ▪ The individual is at risk for developing CNV with **one** of the following: – Bilateral large drusen; or – Large drusen in one eye and advanced	**The following is proven and medically necessary:** • The Implantable Miniature Telescope (IMT) when used according to U.S. Food and Drug Administration (FDA) labeled indications, contraindications, warnings and precautions for treating members with end-stage, age-related macular degeneration **The following are unproven and not medically necessary due to insufficient evidence of efficacy:** • Conjunctival incision with posterior extrascleral placement of a pharmacologic agent for treating ocular disorders including age-related macular degeneration • Laser photocoagulation for treating macular drusen • Radiation therapy for age-related macular degeneration (i.e., epimacular and/or epiretinal brachytherapy and stereotactic radiotherapy and/or radiosurgery) **Home visual field monitoring (e.g., ForeseeHome) for detection of age-related macular degeneration (AMD)-associated choroidal neovascularization**

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Macular Degeneration Treatment Procedures (continued)	Aug. 1, 2023	AMD in the fellow eye ▪ Best corrected visual acuity of 20/60 or better in the affected eye(s) ▪ The individual is able to operate the device ▪ The individual does not have **any** of the following: – Medial opacities that prevent quality fundus photographs – Other retinal disorders (e.g., diabetic retinopathy) ○ Home visual field monitoring is unproven and not medically necessary due to insufficient evidence of efficacy for **all** other indications not listed as proven **Applicable Codes** • Added CPT codes 0378T and 0379T **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	**(CNV) is proven and medically necessary when all of the following criteria are met:** • The individual is at risk for developing CNV with one of the following: ○ Bilateral large drusen; or ○ Large drusen in one eye and advanced AMD in the fellow eye and • Best corrected visual acuity of 20/60 or better in the affected eye(s); and • The individual is able to operate the device; and • The individual does not have any of the following: ○ Medial opacities that prevent quality fundus photographs ○ Other retinal disorders (e.g., diabetic retinopathy) **Home visual field monitoring is unproven and not medically necessary due to insufficient evidence of efficacy for all other indications not listed as proven.**
Provider Administered Drugs – Site of Care	Aug. 1, 2023	**Coverage Rationale** • Revised coverage criteria for outpatient hospital facility-based intravenous medication infusion; replaced criterion requiring "initial	This guideline addresses the criteria for consideration of allowing hospital outpatient facility infusion services for specialty medications and intravenous Immune Globulin (IVIG) and subcutaneous Immune Globulin (SCIG) therapy. This includes claim submission for hospital-based services with the following CMS/AMA Place of Service codes:

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Provider Administered Drugs – Site of Care (continued)	Aug. 1, 2023	infusion or re-initiation of therapy after more than 6 months" with "initial infusion or re-initiation of therapy after more than 6 months *for a short duration of time (e.g., 4 weeks)*"	• 19 Off Campus-Outpatient Hospital, and • 22 On Campus-Outpatient Hospital Alternative Sites of Care, such as non-hospital outpatient infusion, physician office, ambulatory infusion suites or home infusion services are well accepted places of service for medication infusion therapy. If an individual does not meet criteria to for outpatient hospital facility infusion, alternative sites of care may be used. **Outpatient hospital facility-based intravenous medication infusion is medically necessary for individuals who meet at least one of the following criteria (submission of medical records is required):** • Documentation that the individual is medically unstable for administration of the prescribed medication at the alternative sites of care as determined by any of the following: ○ The individual's complex medical status or therapy requires enhanced monitoring and potential intervention above and beyond the capabilities of the alternate Site of Care; **or** ○ The individual's documented history of a significant comorbidity (e.g., cardiopulmonary disorder or fluid overload) status that precludes treatment at an alternative Site of Care; **or** ○ Treatment at an alternate Site of Care presents a health risk due to a clinically significant physical or cognitive impairment; **or** ○ Difficulty establishing and maintaining patent vascular access **or** • Documentation (e.g., infusion records, medical records) of episodes of severe or potentially life-threatening adverse events (e.g., anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure), not including the first or second infusion and, while receiving requested therapy that have not been responsive to acetaminophen, steroids, diphenhydramine, fluids, infusion rate reductions, or other pre-medications, thereby increasing risk to the individual when administration at an alternate Site of Care; **or**

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**

Provider Administered Drugs – Site of Care (continued)	Aug. 1, 2023		• Initial infusion or re-initiation of therapy after more than 6 months for a short duration of time (e.g., 4 weeks); **or**
			• **For IVIG or SCIG only**: Individual has immunoglobulin A (IgA) deficiency with anti-IgA antibodies; **or**
			• Homecare or infusion provider has deemed that the individual, home caregiver, or home environment is not suitable for home infusion therapy and **both** of the following:
			  ○ The prescriber is unable to infuse in the office setting
			  ○ There are no ambulatory infusion suite options available for this member
			
			Ongoing outpatient hospital facility-based infusion duration of therapy will be no more than 6 months to allow for reassessment of the individual's ability to receive therapy at an alternative Site of Care.
			
			Note: If more than one of the above criteria are met, then the greatest of the applicable approval time periods will be allowed.
			
			This guideline applies to these specialty medication(s) that require healthcare provider administration:
			• Asceniv™ (IV)
			• Bivigam® (IV)
			• Carimune® NF (IV)
			• Cutaquig® (SC)
			• Cuvitru® (SC)
			• Flebogamma® DIF (IV)
			• Gammagard® Liquid (IV, SC)
			• Gammagard® S/D (IV)
			• Gammaked™ (IV, SC)
			• Gammaplex® (IV)
			• Gamunex®-C (IV, SC)
			• Hizentra® (SC)
			• HyQvia® (SC)

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Provider Administered Drugs – Site of Care (continued)	Aug. 1, 2023		• Octagam® (IV) • Panzyga® (IV) • Privigen® (IV) • Soliris® (eculizumab) • Xembify® (SC)
Skin and Soft Tissue Substitutes	Sep. 1, 2023	**Coverage Rationale** • Revised list of skin and soft tissue substitutes that are unproven and not medically necessary for any indication; added: ○ Complete™ FT ○ Complete™ SL ○ Kerecis® Omega3 MariGen® Shield ○ NeoMatriX ○ NeoStim Membrane ○ NeoStim TL Membrane ○ NeoStimDL ○ SurGraft® FT ○ SurGraft® XT **Applicable Codes** • Added HCPCS codes A2019, A2021, Q4265, Q4266, Q4267, Q4268, Q4269, Q4270, and Q4271 **Supporting Information** • Updated *Clinical Evidence* section to reflect the most current information	Refer to the policy for complete details.

General Information

The inclusion of a health service (e.g., test, drug, device or procedure) in this bulletin indicates only that UnitedHealthcare is adopting 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. 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.

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 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.

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 Medical Management Guideline Update Bulletin was developed to share important information regarding UnitedHealthcare West Medical Management 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 clinical coverage criteria 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 clinical coverage criteria; however, items such as the clinical evidence, FDA information, and/or list(s) of applicable codes may have been updated

Revised

An existing policy has been reviewed and revisions have been made to the clinical coverage criteria

Replaced

An existing policy has been replaced with a new or different policy

Retired

The health service(s) addressed in the policy are no longer being managed or are considered to be proven/medically necessary and are therefore not excluded as unproven/not medically necessary services, unless coverage guidelines or criteria are otherwise documented in another policy

The complete library of UnitedHealthcare West Medical Management Guidelines is available at **UHCprovider.com** > Policies and Protocols > Commercial Policies > UnitedHealthcare West Medical Management Guidelines.