Blood Product Molecular Antigen Typing

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➲ Terms and Conditions

Table of Contents **Page**

Policy Summary 1
Applicable Codes 2
References 7
Guideline History/Revision Information 8
Purpose 8
Terms and Conditions 8

Related Medicare Advantage Policy Guidelines

- Molecular Pathology/Molecular Diagnostics/Genetic Testing
- Pharmacogenomics Testing
- Tier 2 Molecular Pathology Procedures

Related Medicare Advantage Reimbursement Policies

- Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy, Professional
- Laboratory Services Policy, Professional
- Molecular Pathology Policy, Professional and Facility

Related Medicare Advantage Coverage Summary

- Molecular Pathology/Molecular Diagnostics/Genetic Testing

Policy Summary

➲ See Purpose

Overview

Based on the Centers for Medicare & Medicaid Services (CMS) Program Integrity Manual (100-08), this policy addresses the circumstances under which the item or service is reasonable and necessary under the Social Security Act, §1862(a)(1)(A). For laboratory services, a service can be reasonable and necessary if the service is safe and effective; and appropriate, including the duration and frequency that is considered appropriate for the item or service, in terms of whether it is furnished in accordance with accepted standards of medical practice for the diagnosis of the patient's condition; furnished in a setting appropriate to the patient's medical needs and condition; ordered and furnished by qualified personnel; one that meets, but does not exceed, the patient's medical need; and is at least as beneficial as an existing and available medically appropriate alternative.

Guidelines

Limited coverage is provided for molecular phenotyping of blood product antigens as part of the pre-transfusion evaluation for patients who may require or are expected to require a blood product transfusion(s) (Red Blood Cells, Platelets or Leukocytes) when at least one of the following criteria is met:

- Long term, frequent transfusions anticipated to prevent the development of alloantibodies (e.g., sickle cell anemia, thalassemia, chronic transfusion dependent hematologic disorders or other reasons); **or**
- Autoantibodies or other serologic reactivity that impedes the exclusion of clinically significant alloantibodies (e.g., autoimmune hemolytic anemia, warm autoantibodies, patient recently transfused with a positive DAT, high-titer low avidity antibodies, patients about to receive or on daratumumab therapy, other reactivity of no apparent cause); **or**
- Suspected antibody against an antigen for which typing sera is not available; **or**
- Laboratory discrepancies on serologic typing (e.g., rare Rh D antigen variants)

Laboratory developed tests (LDTs) that perform molecular phenotyping of blood product antigens may be considered covered for the same indications if the test demonstrates validity and clinical utility equivalent to or better than covered tests as demonstrated in a technical assessment.

Medicare does not expect molecular testing to be performed on patients undergoing surgical procedures such as bypass or other cardiac procedures, hip or knee replacements or revisions, or patients with alloantibodies identifiable by serologic testing that are not expected to require long term, frequent transfusions. The medical necessity for molecular blood product phenotyping must be documented in the patient's medical record.

Blood product molecular antigen typing tests are considered germline tests and thus must comply with relevant Medicare or Contractor policies regarding germline testing.

As molecular genotyping includes a review of many genes that code for cellular antigens that must be evaluated for proper patient care, single gene tests are not reasonable and necessary.

Nationally Non-Covered Indications

Compliance with the provisions in this policy is subject to monitoring by post payment data analysis and subsequent medical review. Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states " ...no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis and treatment of illness or injury...". Furthermore, it has been longstanding CMS policy that **"tests that are performed in the absence of signs, symptoms, complaints, or personal history of disease or injury are not covered unless explicitly authorized by statute"**.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
Provisional Coverage	
0001U	Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups, utilizing whole blood, common RBC alleles reported
0084U	Red blood cell antigen typing, DNA, genotyping of 10 blood groups with phenotype prediction of 37 red blood cell antigens
0193U	Red cell antigen (JR blood group) genotyping (JR), gene analysis, ABCG2 (ATP binding cassette subfamily G member 2 [Junior blood group]) exons 2-26 [Refer to the Medicare Advantage Medical Policy titled Pharmacogenomics Testing]
Non-Covered	
81105	Human Platelet Antigen 1 genotyping (HPA-1), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (e.g., neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-1a/b (L33P)
81106	Human Platelet Antigen 2 genotyping (HPA-2), GP1BA (glycoprotein Ib [platelet], alpha polypeptide [GPIba]) (e.g., neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-2a/b (T145M)
81107	Human Platelet Antigen 3 genotyping (HPA-3), ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex], antigen CD41 [GPIIb]) (e.g., neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-3a/b (I843S)
81108	Human Platelet Antigen 4 genotyping (HPA-4), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa], antigen CD61 [GPIIIa]) (e.g., neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-4a/b (R143Q)
81109	Human Platelet Antigen 5 genotyping (HPA-5), ITGA2 (integrin, alpha 2 [CD49B, alpha 2 subunit of VLA-2 receptor] [GPIa]) (e.g., neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant (e.g., HPA-5a/b (K505E))
81110	Human Platelet Antigen 6 genotyping (HPA-6w), ITGB3 (integrin, beta 3 [platelet glycoprotein IIIa, antigen CD61] [GPIIIa]) (e.g., neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-6a/b (R489Q)

CPT Code	Description
Non-Covered	
81111	Human Platelet Antigen 9 genotyping (HPA-9w), ITGA2B (integrin, alpha 2b [platelet glycoprotein IIb of IIb/IIIa complex, antigen CD41] [GPIIb]) (e.g., neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-9a/b (V837M)
81112	Human Platelet Antigen 15 genotyping (HPA-15), CD109 (CD109 molecule) (e.g., neonatal alloimmune thrombocytopenia [NAIT], post-transfusion purpura), gene analysis, common variant, HPA-15a/b (S682Y)
0180U	Red cell antigen (ABO blood group) genotyping (ABO), gene analysis Sanger/chain termination/conventional sequencing, ABO (ABO, alpha 1-3-N-acetylgalactosaminyltransferase and alpha 1-3-galactosyltransferase) gene, including subtyping, 7 exons
0181U	Red cell antigen (Colton blood group) genotyping (CO), gene analysis, AQP1 (aquaporin 1 [Colton blood group]) exon 1
0182U	Red cell antigen (Cromer blood group) genotyping (CROM), gene analysis, CD55 (CD55 molecule [Cromer blood group]) exons 1-10
0183U	Red cell antigen (Diego blood group) genotyping (DI), gene analysis, SLC4A1 (solute carrier family 4 member 1 [Diego blood group]) exon 19
0184U	Red cell antigen (Dombrock blood group) genotyping (DO), gene analysis, ART4 (ADP-ribosyltransferase 4 [Dombrock blood group]) exon 2
0185U	Red cell antigen (H blood group) genotyping (FUT1), gene analysis, FUT1 (fucosyltransferase 1 [H blood group]) exon 4
0186U	Red cell antigen (H blood group) genotyping (FUT2), gene analysis, FUT2 (fucosyltransferase 2) exon 2
0187U	Red cell antigen (Duffy blood group) genotyping (FY), gene analysis, ACKR1 (atypical chemokine receptor 1 [Duffy blood group]) exons 1-2
0188U	Red cell antigen (Gerbich blood group) genotyping (GE), gene analysis, GYPC (glycophorin C [Gerbich blood group]) exons 1-4
0189U	Red cell antigen (MNS blood group) genotyping (GYPA), gene analysis, GYPA (glycophorin A [MNS blood group]) introns 1, 5, exon 2
0190U	Red cell antigen (MNS blood group) genotyping (GYPB), gene analysis, GYPB (glycophorin B [MNS blood group]) introns 1, 5, pseudoexon 3
0191U	Red cell antigen (Indian blood group) genotyping (IN), gene analysis, CD44 (CD44 molecule [Indian blood group]) exons 2, 3, 6
0192U	Red cell antigen (Kidd blood group) genotyping (JK), gene analysis, SLC14A1 (solute carrier family 14 member 1 [Kidd blood group]) gene promoter, exon 9
0194U	Red cell antigen (Kell blood group) genotyping (KEL), gene analysis, KEL (Kell metallo-endopeptidase [Kell blood group]) exon 8
0195U	KLF1 (Kruppel-like factor 1), targeted sequencing (i.e., exon 13)
0196U	Red cell antigen (Lutheran blood group) genotyping (LU), gene analysis, BCAM (basal cell adhesion molecule [Lutheran blood group]) exon 3
0197U	Red cell antigen (Landsteiner-Wiener blood group) genotyping (LW), gene analysis, ICAM4 (intercellular adhesion molecule 4 [Landsteiner-Wiener blood group]) exon 1
0198U	Red cell antigen (RH blood group) genotyping (RHD and RHCE), gene analysis Sanger/chain termination/conventional sequencing, RHD (Rh blood group D antigen) exons 1-10 and RHCE (Rh blood group CcEe antigens) exon 5
0199U	Red cell antigen (Scianna blood group) genotyping (SC), gene analysis, ERMAP (erythroblast membrane associated protein [Scianna blood group]) exons 4, 12
0200U	Red cell antigen (Kx blood group) genotyping (XK), gene analysis, XK (X-linked Kx blood group) exons 1-3
0201U	Red cell antigen (Yt blood group) genotyping (YT), gene analysis, ACHE (acetylcholinesterase [Cartwright blood group]) exon 2

CPT Code	Description
Non-Covered	
0221U	Red cell antigen (ABO blood group) genotyping (ABO), gene analysis, next-generation sequencing, ABO (ABO, alpha 1-3-N-acetylgalactosaminyltransferase and alpha 1-3-galactosyltransferase) gene
0222U	Red cell antigen (RH blood group) genotyping (RHD and RHCE), gene analysis, next-generation sequencing, RH proximal promoter, exons 1-10, portions of introns 2-3

Diagnosis Code	Description
For CPT Codes 0001U and 0084U	
C85.80	Other specified types of non-Hodgkin lymphoma, unspecified site
C85.89	Other specified types of non-Hodgkin lymphoma, extranodal and solid organ sites
C85.90	Non-Hodgkin lymphoma, unspecified, unspecified site
C85.91	Non-Hodgkin lymphoma, unspecified, lymph nodes of head, face, and neck
C85.92	Non-Hodgkin lymphoma, unspecified, intrathoracic lymph nodes
C85.93	Non-Hodgkin lymphoma, unspecified, intra-abdominal lymph nodes
C85.94	Non-Hodgkin lymphoma, unspecified, lymph nodes of axilla and upper limb
C85.95	Non-Hodgkin lymphoma, unspecified, lymph nodes of inguinal region and lower limb
C85.96	Non-Hodgkin lymphoma, unspecified, intrapelvic lymph nodes
C85.97	Non-Hodgkin lymphoma, unspecified, spleen
C85.98	Non-Hodgkin lymphoma, unspecified, lymph nodes of multiple sites
C85.99	Non-Hodgkin lymphoma, unspecified, extranodal and solid organ sites
C90.00	Multiple myeloma not having achieved remission
C90.01	Multiple myeloma in remission
C90.02	Multiple myeloma in relapse
C91.00	Acute lymphoblastic leukemia not having achieved remission
C91.01	Acute lymphoblastic leukemia, in remission
C91.02	Acute lymphoblastic leukemia, in relapse
C92.60	Acute myeloid leukemia with 11q23-abnormality not having achieved remission
C92.61	Acute myeloid leukemia with 11q23-abnormality in remission
C92.62	Acute myeloid leukemia with 11q23-abnormality in relapse
C92.A0	Acute myeloid leukemia with multilineage dysplasia, not having achieved remission
C92.A1	Acute myeloid leukemia with multilineage dysplasia, in remission
C92.A2	Acute myeloid leukemia with multilineage dysplasia, in relapse
D46.C	Myelodysplastic syndrome with isolated del(5q) chromosomal abnormality
D46.Z	Other myelodysplastic syndromes
D51.0	Vitamin B12 deficiency anemia due to intrinsic factor deficiency
D53.9	Nutritional anemia, unspecified
D55.0	Anemia due to glucose-6-phosphate dehydrogenase [G6PD] deficiency
D55.1	Anemia due to other disorders of glutathione metabolism
D55.29	Anemia due to other disorders of glycolytic enzymes
D55.3	Anemia due to disorders of nucleotide metabolism
D55.8	Other anemias due to enzyme disorders
D55.9	Anemia due to enzyme disorder, unspecified
D56.0	Alpha thalassemia
D56.1	Beta thalassemia
D56.2	Delta-beta thalassemia

Diagnosis Code	Description
For CPT Codes 0001U and 0084U	
D56.3	Thalassemia minor
D56.5	Hemoglobin E-beta thalassemia
D56.8	Other thalassemias
D56.9	Thalassemia, unspecified
D57.00	Hb-SS disease with crisis, unspecified
D57.01	Hb-SS disease with acute chest syndrome
D57.02	Hb-SS disease with splenic sequestration
D57.03	Hb-SS disease with cerebral vascular involvement
D57.04	Hb-SS disease with dactylitis (Effective 10/01/2023)
D57.09	Hb-SS disease with crisis with other specified complication
D57.1	Sickle-cell disease without crisis
D57.20	Sickle-cell/Hb-C disease without crisis
D57.211	Sickle-cell/Hb-C disease with acute chest syndrome
D57.212	Sickle-cell/Hb-C disease with splenic sequestration
D57.213	Sickle-cell/Hb-C disease with cerebral vascular involvement
D57.214	Sickle-cell/Hb-C disease with dactylitis (Effective 10/01/2023)
D57.218	Sickle-cell/Hb-C disease with crisis with other specified complication
D57.219	Sickle-cell/Hb-C disease with crisis, unspecified
D57.3	Sickle-cell trait
D57.40	Sickle-cell thalassemia without crisis
D57.411	Sickle-cell thalassemia, unspecified, with acute chest syndrome
D57.412	Sickle-cell thalassemia, unspecified, with splenic sequestration
D57.413	Sickle-cell thalassemia, unspecified, with cerebral vascular involvement
D57.414	Sickle-cell thalassemia, unspecified, with dactylitis (Effective 10/01/2023)
D57.418	Sickle-cell thalassemia, unspecified, with crisis with other specified complication
D57.419	Sickle-cell thalassemia, unspecified, with crisis
D57.42	Sickle-cell thalassemia beta zero without crisis
D57.431	Sickle-cell thalassemia beta zero with acute chest syndrome
D57.432	Sickle-cell thalassemia beta zero with splenic sequestration
D57.433	Sickle-cell thalassemia beta zero with cerebral vascular involvement
D54.434	Sickle-cell thalassemia beta zero with dactylitis (Effective 10/01/2023)
D57.438	Sickle-cell thalassemia beta zero with crisis with other specified complication
D57.439	Sickle-cell thalassemia beta zero with crisis, unspecified
D57.44	Sickle-cell thalassemia beta plus without crisis
D57.451	Sickle-cell thalassemia beta plus with acute chest syndrome
D57.452	Sickle-cell thalassemia beta plus with splenic sequestration
D57.453	Sickle-cell thalassemia beta plus with cerebral vascular involvement
D57.454	Sickle-cell thalassemia beta plus with dactylitis (Effective 10/01/2023)
D57.458	Sickle-cell thalassemia beta plus with crisis with other specified complication
D57.459	Sickle-cell thalassemia beta plus with crisis, unspecified
D57.80	Other sickle-cell disorders without crisis
D57.811	Other sickle-cell disorders with acute chest syndrome
D57.812	Other sickle-cell disorders with splenic sequestration
D57.813	Other sickle-cell disorders with cerebral vascular involvement

Diagnosis Code	Description
For CPT Codes 0001U and 0084U	
D57.814	Other sickle-cell disorders with dactylitis (Effective 10/01/2023)
D57.818	Other sickle-cell disorders with crisis with other specified complication
D57.819	Other sickle-cell disorders with crisis, unspecified
D58.0	Hereditary spherocytosis
D58.1	Hereditary elliptocytosis
D58.9	Hereditary hemolytic anemia, unspecified
D59.0	Drug-induced autoimmune hemolytic anemia
D59.10	Autoimmune hemolytic anemia, unspecified
D59.11	Warm autoimmune hemolytic anemia
D59.12	Cold autoimmune hemolytic anemia
D59.13	Mixed type autoimmune hemolytic anemia
D59.19	Other autoimmune hemolytic anemia
D59.9	Acquired hemolytic anemia, unspecified
D60.0	Chronic acquired pure red cell aplasia
D60.1	Transient acquired pure red cell aplasia
D60.8	Other acquired pure red cell aplasias
D60.9	Acquired pure red cell aplasia, unspecified
D61.01	Constitutional (pure) red blood cell aplasia
D61.02	Shwachman-Diamond syndrome (Effective 10/01/2023)
D61.09	Other constitutional aplastic anemia
D61.1	Drug-induced aplastic anemia
D61.2	Aplastic anemia due to other external agents
D61.3	Idiopathic aplastic anemia
D61.89	Other specified aplastic anemias and other bone marrow failure syndromes
D63.0	Anemia in neoplastic disease
D63.1	Anemia in chronic kidney disease
D63.8	Anemia in other chronic diseases classified elsewhere
D64.0	Hereditary sideroblastic anemia
D64.1	Secondary sideroblastic anemia due to disease
D64.2	Secondary sideroblastic anemia due to drugs and toxins
D64.3	Other sideroblastic anemias
D64.4	Congenital dyserythropoietic anemia
D64.89	Other specified anemias
Z85.72	Personal history of non-Hodgkin lymphomas

Non-Covered Diagnosis Code

Non-Covered Diagnosis Codes List

This list contains diagnosis codes that are **never covered when given as the primary reason for the test.** If a code from this section is given as the reason for the test and you know or have reason to believe the service may not be covered, call UnitedHealthcare to issue an Integrated Denial Notice (IDN) to the member and you. The IDN informs the member of their liability for the non-covered service or item and appeal rights. You must make sure the member has received the IDN prior to rendering or referring for non-covered services or items in order to collect payment. ☐

References

CMS Local Coverage Determinations (LCDs) and Articles

LCD	Article	Contractor	Medicare Part A	Medicare Part B
Blood Product Molecular Antigen Typing				
L38249 MolDX: Blood Product Molecular Antigen Typing	A57155 Billing and Coding: MolDX: Blood Product Molecular Antigen Typing	CGS	KY, OH	KY, OH
L38331 MolDX: Blood Product Molecular Antigen Typing	A57124 Billing and Coding: MolDX: Blood Product Molecular Antigen Typing	Noridian	AS, CA, GU, HI, MP, NV	AS, CA, GU, HI, MP, NV
L38333 MolDX: Blood Product Molecular Antigen Typing	A57376 Billing and Coding: MolDX: Blood Product Molecular Antigen Typing	Noridian	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
L38240 MolDX: Blood Product Molecular Antigen Typing	A58308 Billing and Coding: MolDX: Blood Product Molecular Antigen Typing	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
L38441 MolDX: Blood Product Molecular Antigen Typing	A57110 Billing and Coding: MolDX: Blood Product Molecular Antigen Typing	WPS	IA, IN, KS, MI, MO, NE	IA, IN, KS, MI, MO, NE
General Molecular Diagnostic Tests				
L36021 Molecular Diagnostic Tests (MDT)	A56973 Billing and Coding: MolDX: Molecular Diagnostic Tests (MDT)	CGS	KY, OH	KY, OH
L35160 MolDX: Molecular Diagnostic Tests (MDT)	A57526 Billing and Coding: MolDX: Molecular Diagnostic Tests (MDT)	Noridian	AS, CA, GU, HI, MP, NV	AS, CA, GU, HI, MP, NV
L36256 MolDX: Molecular Diagnostic Tests (MDT)	A57527 Billing and Coding: MolDX: Molecular Diagnostic Tests (MDT)	Noridian	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
L35025 MolDX: Molecular Diagnostic Tests (MDT)	A56853 Billing and Coding: MolDX: Molecular Diagnostic Tests (MDT)	Palmetto	AL, GA, NC, SC, TN, VA, WV	AL, GA, NC, SC, TN, VA, WV
L36807 MolDX: Molecular Diagnostic Tests (MDT)	A57772 Billing and Coding: MolDX: Molecular Diagnostic Tests (MDT)	WPS	IA, IN, KS, MI, MO, NE	IA, IN, KS, MI, MO, NE
L35062 Biomarkers Overview	A56541 Billing and Coding: Biomarkers Overview	Novitas	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
	A58917 Billing and Coding: Molecular Pathology and Genetic Testing	Novitas	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
L34519 Molecular Pathology Procedures	A57451 Billing and Coding: Molecular Pathology Procedures	First Coast	FL, PR, VI	FL, PR, VI
	A58918 Billing and Coding: Molecular Pathology and Genetic Testing			
L35000 Molecular Pathology Procedures	A56199 Billing and Coding: Molecular Pathology Procedures	NGS	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI

CMS Benefit Policy Manual

Chapter 15; § 80.1 – 80.1.3 Clinical Laboratory Services

CMS Claims Processing Manual

Chapter 12; § 60 Payment for Pathology Services
Chapter 16, § 10.2 General Explanation of Payment; § 20 Calculation of Payment Rates - Clinical Laboratory Test Fee Schedules; § 40 Billing for Clinical Laboratory Tests

Other(s)

Palmetto GBA MolDx Website
Palmetto GBA MolDx Manual, Palmetto GBA MolDx Website

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
08/01/2024	**Related Policies** • Removed reference link to the Medicare Advantage Policy Guideline titled *Laboratory Tests and Services* (retired Aug. 1, 2024) • Updated reference link for the Medicare Advantage Medical Policy titled *Pharmacogenomics Testing*
04/10/2024	**Applicable Codes** ***Non-Covered Diagnosis Codes*** • Added Z02.84 **Administrative** • Archived previous policy version MPG388.09

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section above to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

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*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.