Surgical Procedures

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➲ Instructions for Use

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Coverage Rationale

Note: The medical necessity criteria referenced in this Medicare Advantage Medical Policy applies to a surgical procedure regardless of the approach, unless noted otherwise.

Appendectomy

Medicare does not have a National Coverage Determination (NCD) for appendectomy. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the InterQual® CP: Procedures, Appendectomy.

Click here to view the InterQual® criteria.

Bariatric Surgery

Medicare does have an NCD for bariatric surgery. Refer to the NCD for Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity (100.1) for coverage guidelines. LCDs/LCAs exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Bariatric Surgical Management of Morbid Obesity.

For states with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Bariatric Surgery for utilization guidelines for all other procedures not listed as nationally non-covered in the NCD for Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity (100.1).

Note: When the NCD or LCDs/LCAs is silent on coverage criteria for bariatric procedures [including revisions, staged procedures, or various surgical approaches (e.g. endoscopic approach)], refer to the UnitedHealthcare Commercial Medical Policy titled Bariatric Surgery for clinical coverage guidance.

Bronchial Thermoplasty

Medicare does not have an NCD for bronchial thermoplasty. LCDs/LCAs do not exist at this time.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Bronchial Thermoplasty.

Colectomy

Medicare does not have an NCD for colectomy. LCDs/LCAs do not exist.

For coverage guidelines, refer to the InterQual® CP: Procedures:

- Colectomy, Left
- Colectomy, Right

Click here to view the InterQual® criteria.

Hernia Repair Procedures

Inguinal or Femoral Hernia Repair

Medicare does not have an NCD for inguinal or femoral hernia repair. LCDs/LCAs do not exist.

For coverage guidelines, refer to the InterQual® CP: Procedures, Herniorrhaphy, Inguinal or Femoral.

Click here to view the InterQual® criteria.

Umbilical Hernia Repair

Medicare does not have an NCD for umbilical hernia repair. LCDs/LCAs do not exist.

For coverage guidelines, refer to the InterQual® CP: Procedures, Herniorrhaphy, Umbilical.

Click here to view the InterQual® criteria.

Hiatal Hernia Repair

Medicare does not have an NCD for hiatal hernia repair. LCDs/LCAs do not exist.

For coverage guidelines, refer to the InterQual® CP: Procedures, Antireflux Surgery or Hiatal Hernia Repair.

Click here to view the InterQual® criteria.

Implantation of Glaucoma Drainage Devices (e.g., ExPRESS™ Mini Glaucoma Shunt, Molteno Implant, Baerveldt Tube Shunt, Krupin Eye Valve, or the Ahmed Glaucoma Valve Implant)

Medicare does not have an NCD for the implantation of glaucoma drainage devices. LCDs/LCAs do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Glaucoma Surgical Treatments.

Laparotomy or Exploratory Laparotomy

Medicare does not have an NCD for laparotomy or exploratory laparotomy. LCDs/LCAs do not exist.

For coverage guidelines, refer to the InterQual® CP: Procedures, Laparotomy or Exploratory Laparotomy.

Click here to view the InterQual® criteria.

Lymphedema Surgical Treatments

Medicare does not have an NCD for lymphedema surgical treatments. LCDs/LCAs do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Surgery for the Prevention and Treatment of Lymphedema.

Nephrectomy

Nephrectomy, Simple

Medicare does not have an NCD for simple nephrectomy. LCDs/LCAs do not exist.

For coverage guidelines, refer to the InterQual® CP: Procedures, Nephrectomy, Simple.

Click here to view the InterQual® criteria.

Nephrectomy, Partial

Medicare does not have an NCD for partial nephrectomy. LCDs/LCAs do not exist.
For coverage guidelines, refer to the InterQual® CP: Procedures, Nephrectomy, Partial.

Click here to view the InterQual® criteria.

Sacrocolpopexy

Medicare does not have an NCD for sacrocolpopexy. LCDs/LCAs do not exist.

For coverage guidelines, refer to the InterQual® CP: Procedures, Sacrocolpopexy.

Click here to view the InterQual® criteria.

Small Bowel Resection

Medicare does not have an NCD for small bowel resection. LCDs/LCAs do not exist.

For coverage guidelines, refer to the InterQual® CP: Procedures, Small Bowel Resection.

Click here to view the InterQual® criteria.

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 policy does not imply that the service described by the code is a covered or non-covered health service; however, language may be included in the listing below to indicate if a code is non-covered. 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
Appendectomy	
44960	Appendectomy; for ruptured appendix with abscess or generalized peritonitis
44970	Laparoscopy, surgical, appendectomy
Bariatric Surgery	
43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon
43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s)
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum
43659	Unlisted laparoscopy procedure, stomach
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (e.g., gastric band and subcutaneous port components)
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components

CPT Code	Description
Bariatric Surgery	
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy)
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)
43860	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy
43865	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; with vagotomy
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only
43999	Unlisted procedure, stomach
64590	Insertion or replacement of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver
64595	Revision or removal of peripheral, sacral, or gastric neurostimulator pulse generator or receiver, with detachable connection to electrode array
64999	Unlisted procedure, nervous system
Bronchial Thermoplasty	
31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe [Refer to the UnitedHealthcare Commercial Medical Policy titled Bronchial Thermoplasty]
31661	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes [Refer to the UnitedHealthcare Commercial Medical Policy titled Bronchial Thermoplasty]
Colectomy	
44140	Colectomy, partial; with anastomosis
44141	Colectomy, partial; with skin level cecostomy or colostomy
44143	Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure)
44144	Colectomy, partial; with resection, with colostomy or ileostomy and creation of mucofistula
44145	Colectomy, partial; with coloproctostomy (low pelvic anastomosis)
44146	Colectomy, partial; with coloproctostomy (low pelvic anastomosis), with colostomy
44147	Colectomy, partial; abdominal and transanal approach
Inguinal or Femoral Hernia Repair	
49505	Repair initial inguinal hernia, age 5 years or older; reducible
49521	Repair recurrent inguinal hernia, any age; incarcerated or strangulated
49525	Repair inguinal hernia, sliding, any age
49550	Repair initial femoral hernia, any age; reducible

CPT Code	Description
Inguinal or Femoral Hernia Repair	
49553	Repair initial femoral hernia, any age; incarcerated or strangulated
49555	Repair recurrent femoral hernia; reducible
49557	Repair recurrent femoral hernia; incarcerated or strangulated
49650	Laparoscopy, surgical; repair initial inguinal hernia
49651	Laparoscopy, surgical; repair recurrent inguinal hernia
Umbilical Hernia Repair	
49591	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible
49592	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, incarcerated or strangulated
49593	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, reducible
49594	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated
49595	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, reducible
49596	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, incarcerated or strangulated
49613	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible
49614	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, incarcerated or strangulated
49615	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, reducible
49616	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated
49617	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, reducible
49618	Repair of anterior abdominal hernia(s) (i.e., epigastric, incisional, ventral, umbilical, spigelian), any approach (i.e., open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, incarcerated or strangulated
Hiatal Hernia Repair	
43192	Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance
43201	Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance
43210	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed
43211	Esophagoscopy, flexible, transoral; with endoscopic mucosal resection

CPT Code	Description
Hiatal Hernia Repair	
43212	Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)
43236	Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance
43254	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection
43257	Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease
43266	Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
43325	Esophagogastric fundoplasty, with fundic patch (Thal-Nissen procedure)
43327	Esophagogastric fundoplasty partial or complete; laparotomy
43328	Esophagogastric fundoplasty partial or complete; thoracotomy
43332	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis
43333	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis
43334	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis
43335	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; with implantation of mesh or other prosthesis
43336	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis
43337	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; with implantation of mesh or other prosthesis
43338	Esophageal lengthening procedure (e.g., Collis gastroplasty or wedge gastroplasty) (List separately in addition to code for primary procedure)
43499	Unlisted procedure, esophagus
Implantation of Glaucoma Drainage Devices	
66180	Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft
Laparotomy or Exploratory Laparotomy	
44050	Reduction of volvulus, intussusception, internal hernia, by laparotomy
49013	Preperitoneal pelvic packing for hemorrhage associated with pelvic trauma, including local exploration
49014	Re-exploration of pelvic wound with removal of preperitoneal pelvic packing, including repacking, when performed
49040	Drainage of subdiaphragmatic or subphrenic abscess, open
49060	Drainage of retroperitoneal abscess, open
Lymphedema Surgical Treatments	
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15832	Excision, excessive skin and subcutaneous tissue (includes lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (includes lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (includes lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (includes lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (includes lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (includes lipectomy); forearm or hand

CPT Code	Description
Lymphedema Surgical Treatments	
15838	Excision, excessive skin and subcutaneous tissue (includes lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure)
15876	Suction assisted lipectomy; head and neck
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity
49906	Free omental flap with microvascular anastomosis
Nephrectomy, Simple	
50225	Nephrectomy, including partial ureterectomy, any open approach including rib resection; complicated because of previous surgery on same kidney
Nephrectomy, Partial	
50543	Laparoscopy, surgical; partial nephrectomy
Sacrocolpopexy	
57283	Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy)
Small Bowel Resection	
44127	Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; with tapering
44128	Enterectomy, resection of small intestine for congenital atresia, single resection and anastomosis of proximal segment of intestine; each additional resection and anastomosis (List separately in addition to code for primary procedure)
44203	Laparoscopy, surgical; each additional small intestine resection and anastomosis (List separately in addition to code for primary procedure)

Centers for Medicare and Medicaid Services (CMS) Related Documents

After checking the table below and searching the Medicare Coverage Database, if no NCD, LCD, or LCA is found, refer to the criteria as noted in the Coverage Rationale section above.

NCD	LCD	LCA	Contractor Type	Contractor Name
Bariatric Surgical Management of Morbid Obesity				
100.1 Bariatric Surgery for Treatment of Co-Morbid Conditions Related to Morbid Obesity	L33411 Surgical Management of Morbid Obesity	A57145 Billing and Coding: Surgical Management of Morbid Obesity	Part A and B MAC	First Coast
	N/A	A52447 Laparoscopic Sleeve Gastrectomy (LSG) – Medical Policy Article	Part A and B MAC	NGS
	L35022 Bariatric Surgical Management of Morbid Obesity	A56422 Billing and Coding: Bariatric Surgical Management of Morbid Obesity	Part A and B MAC	Novitas**
	L34576 Laparoscopic Sleeve Gastrectomy for Severe Obesity	A56852 Billing and Coding: Laparoscopic Sleeve Gastrectomy for Severe Obesity	Part A and B MAC	Palmetto**

Medicare Administrative Contractor (MAC) With Corresponding States/Territories	
MAC Name (Abbreviation)	**States/Territories**
CGS Administrators, LLC (CGS)	KY, OH
First Coast Service Options, Inc. (First Coast)	FL, PR, VI
National Government Services, Inc. (NGS)	CT, IL, ME, MA, MN, NH, NY, RI, VT, WI
Noridian Healthcare Solutions, LLC (Noridian)	AS, AK, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY
Novitas Solutions, Inc. (Novitas)	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX, VA**
Palmetto GBA (Palmetto)	AL, GA, NC, SC, TN, VA**, WV
Wisconsin Physicians Service Insurance Corporation (WPS)*	IA, IN, KS, MI, MO, NE
Notes	
*Wisconsin Physicians Service Insurance Corporation: Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers. **For the state of Virginia: Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction.	

Policy History/Revision Information

Date	Summary of Changes
04/01/2025	**Applicable Codes** • Removed CPT codes 38999 and 49659 **Supporting Information** • Archived previous policy version MMP108.03

Instructions for Use

The Medicare Advantage Policy documents are generally used to support UnitedHealthcare coverage decisions. It is expected providers retain or have access to appropriate documentation when requested to support coverage. This document may be used as a guide to help determine applicable:

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

Medicare Advantage Policies are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates. This Policy is provided for informational purposes and does not constitute medical advice. It is intended to serve only as a general reference and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. 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 this policy. 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.

Medicare Advantage Policies 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 Policies at any time by publishing a new version on this website. Medicare source materials used to develop these policies may include, but are not limited to, CMS statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. The information presented in this Policy is believed to be accurate and current as of the date of publication. Where there is a conflict between this document and Medicare source

materials, the Medicare source materials apply. Medicare Advantage Policies are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing certain items or services referenced in this Medical Policy have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, in these circumstances, UnitedHealthcare applies internal coverage criteria as referenced in this Medical Policy. The internal coverage criteria in this Medical Policy was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Providers are responsible for submission of accurate claims. Medicare Advantage Policies are intended to ensure that coverage decisions are made accurately. UnitedHealthcare Medicare Advantage Policies 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.

For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate’s requirements need to be followed.