Cosmetic and Reconstructive Procedures

Guideline Number: CDG.007.20
Effective Date: November 1, 2021

Instructions for Use

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- Cosmetic and Reconstructive Procedures

Coverage Rationale

Some states require benefit coverage for services that UnitedHealthcare considers Cosmetic Procedures, such as repair of external congenital anomalies in the absence of a Functional Impairment. Refer to the member specific benefit plan document.

Indications for Coverage

For plans that include benefits for Cosmetic Procedures, the following are eligible for coverage as 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 efficacy and is deemed likely to significantly improve or restore the patient's physiological function.

Microtia

Microtia repair is reconstructive; although no Functional Impairment may be documented for Microtia, this has been deemed Reconstructive Surgery.

Flap Repair

Flap repair is considered reconstructive and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® 2021, Apr. 2021 Release, CP: Procedures, Local Flap.

Click here to view the InterQual® criteria.

Coverage Limitations and Exclusions

UnitedHealthcare excludes Cosmetic Procedures from coverage including but not limited to the following:

- Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic 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 (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedure
- Procedures that do not meet the reconstructive criteria in the Indications for Coverage section
- 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
- Treatment for skin wrinkles or any treatment to improve the appearance of the skin
- Treatment for spider veins
- Sclerotherapy treatment of veins (Note: Sclerotherapy in excess of 3 sessions per leg within 12 months from the date of the ablation procedure is considered cosmetic)
- Hair removal or replacement by any means

Documentation Requirements

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 documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

CPT/HCPCS Codes*	Required Clinical Information
Muscle Flap Procedures	

15730
15733
15734
15736
15738
15740
15756
	Medical notes documenting the following, when applicable:
	• History of medical conditions requiring treatment or surgical intervention, including:
	  ○ A well-defined physical/physiologic abnormality resulting in a medical condition that requires treatment
	  ○ Recurrent or persistent functional deficit caused by the abnormality
	• Clinical studies/tests addressing the physical/physiologic abnormality confirming its presence and degree to which it causes impairment
	• Color photos, where applicable, of the physical and/or physiological abnormality
	• Physician plan of care with proposed procedures including expected outcome
	
	In addition to the above, additional documentation requirements may apply for the following codes. Review the below listed policies in conjunction with the guidelines in this document.
	• For CPT codes 15734 and 15738, refer to the Medical Policy titled Gender Dysphoria Treatment
	• For CPT code 15736, refer to the Utilization Review Guideline Outpatient Surgical Procedures – Site of Service

Cosmetic and Reconstructive Procedures	
11960, 14000, 14001, 14020,	Medical notes documenting the following, when applicable: • History of medical conditions requiring treatment or surgical invention, including:

CPT/HCPCS Codes*	Required Clinical Information
14021, 14040, 14041, 14060, 14061, 14301, 14302, 15570, 15572, 15574, 15731, 17999, 19316, 19325, 21137, 21138, 21139, 21172, 21175, 21179, 21180, 21181, 21182, 21183, 21184, 21208, 21209, 21230, 21235, 21248, 21249, 21255, 21256, 21260, 21261, 21263, 21267, 21268, 21275, 21295, 21296, 21299, 28344, 30540, 30545, 30560, 30620, 36468, 36470, 36471 L8600, Q2026	○ To prove medical necessity, a well-defined physical/physiologic abnormality resulting in a medical condition that requires treatment ○ Recurrent or persistent functional impairment caused by the abnormality • Clinical studies/tests addressing the physical/physiologic abnormality confirming its presence and degree to which it causes impairment • High-quality color image(s) of the physical/physiologic abnormality: ○ Note: All image(s) must be labeled with the: ▪ Date taken ▪ Applicable case number obtained at time of notification, or member's name and ID number on the image(s) ▪ Submission of color image(s) are required and can be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted • Physician plan of care with proposed procedures and whether this request is part of a staged procedure; indicate how the procedure will improve and/or restore function In addition to the above, additional documentation requirements may apply for the following codes. Review the below listed policies in conjunction with the guidelines in this document. • For CPT codes 19316, 19325, and L8600, refer to the Coverage Determination Guideline titled Breast Reconstruction Post Mastectomy and Poland Syndrome. • For CPT codes 14000, 14001, 14041, 15734, and 15738, refer to the Medical Policy titled Gender Dysphoria Treatment. • For CPT codes 21208, 21209, 21248, 21249, 21255, 21296, and 21299, refer to the Coverage Determination Guideline titled Orthognathic (Jaw) Surgery. • For CPT codes 14040, 14060, 14301, 15731, and 15736, refer to the Utilization Review Guideline titled Outpatient Surgical Procedures – Site of Service.

**For code descriptions, see the Applicable Codes section.*

Definitions

The following definitions may not apply to all plans. Refer to the member specific benefit plan document for applicable definitions.

Adjacent Tissue Transfer: A random pattern local flap which is used to fill in nearby or local defect. To be considered an adjacent tissue transfer an incision must be made by the surgeon which results in a secondary defect. Examples include transposition flaps, advancement flaps and rotation flaps.

Congenital Anomaly: A physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Cosmetic Procedures: Procedures or services that change or improve appearance without significantly improving physiological function.

Cosmetic Procedures (California only): Procedures or services that are performed to alter or reshape normal structures of the body in order to improve your appearance.

Cosmetic Surgery: Defined by the American Society of Plastic Surgeons, "is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem."

Functional or Physical Impairment: A functional or physical or physiological impairment causes deviation from the normal function of a tissue or organ. This results in a significantly limited, impaired, or delayed capacity to move, coordinate actions, or

perform physical activities and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing basic life functions.

Injury: Damage to the body, including all related conditions and symptoms.

Microtia: The most complex congenital ear deformity when the outer ear appears as either a sausage-shaped structure resembling little more than the earlobe. It may or may not be missing the external auditory or hearing canal. Hearing is impaired to varying degrees.

Reconstructive Procedures: Reconstructive Procedures when the primary purpose of the procedure is either of the following:
- Treatment of a medical condition
- Improvement or restoration of physiologic function

Reconstructive Procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that you may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a Reconstructive Procedure.

Reconstructive Procedures (California only): Reconstructive Procedures to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:
- To improve function
- To create a normal appearance, to the extent possible

Reconstructive Procedures include surgery or other procedures which are related to a health condition. The primary result of the procedure is not a changed or improved physical appearance for cosmetic purposes only, but rather to improve function and/or to create a normal appearance, to the extent possible. Covered Health Care Services include dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.

For the purposes of this section, "cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Reconstructive Surgery: Defined by the American Society of Plastic Surgeons, "is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to improve function but may also be done to approximate a normal appearance."

Sickness: Physical illness, disease or Pregnancy. The term Sickness includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

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/HCPCS Code	Description
The following codes may be cosmetic; review is required to determine if considered cosmetic or reconstructive.	
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less

CPT/HCPCS Code	Description
The following codes may be cosmetic; review is required to determine if considered cosmetic or reconstructive.	
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm
11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less
14001	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
14020	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less
14021	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
14061	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm
14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm
14302	Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
15570	Formation of direct or tubed pedicle, with or without transfer; trunk
15572	Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs
15574	Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet
15730	Midface flap (i.e., zygomaticofacial flap) with preservation of vascular pedicle(s)
15731	Forehead flap with preservation of vascular pedicle (e.g., axial pattern flap, paramedian forehead flap)
15733	Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (i.e., buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk
15736	Muscle, myocutaneous, or fasciocutaneous flap; upper extremity
15738	Muscle, myocutaneous, or fasciocutaneous flap; lower extremity
15740	Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel
15756	Free muscle or myocutaneous flap with microvascular anastomosis
15769	Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia)
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate Note: See also the Breast Reconstruction Post Mastectomy and Poland Syndrome Coverage Determination Guideline.
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure) Note: See also the Breast Reconstruction Post Mastectomy and Poland Syndrome Coverage Determination Guideline.

CPT/HCPCS Code	Description
The following codes may be cosmetic; review is required to determine if considered cosmetic or reconstructive.	
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue
19316	Mastopexy
19325	Breast augmentation with implant
21137	Reduction forehead; contouring only
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)
21181	Reconstruction by contouring of benign tumor of cranial bones (e.g., fibrous dysplasia), extracranial
21182	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting less than 40 sq cm
21183	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 40 sq cm but less than 80 sq cm
21184	Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone (e.g., fibrous dysplasia), with multiple autografts (includes obtaining grafts); total area of bone grafting greater than 80 sq cm
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)
21235	Graft; ear cartilage, autogenous, to nose or ear (includes obtaining graft)
21248	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial
21249	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete
21255	Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage (includes obtaining autografts)
21256	Reconstruction of orbit with osteotomies (extracranial) and with bone grafts (includes obtaining autografts) (e.g., micro-ophthalmia)
21260	Periorbital osteotomies for orbital hypertelorism, with bone grafts; extracranial approach
21261	Periorbital osteotomies for orbital hypertelorism, with bone grafts; combined intra- and extracranial approach
21263	Periorbital osteotomies for orbital hypertelorism, with bone grafts; with forehead advancement
21267	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; extracranial approach
21268	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts; combined intra- and extracranial approach
21275	Secondary revision of orbitocraniofacial reconstruction

CPT/HCPCS Code	Description
The following codes may be cosmetic; review is required to determine if considered cosmetic or reconstructive.	
21295	Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); extraoral approach
21296	Reduction of masseter muscle and bone (e.g., for treatment of benign masseteric hypertrophy); intraoral approach
21299	Unlisted craniofacial and maxillofacial procedure
28344	Reconstruction, toe(s); polydactyly
30540	Repair choanal atresia; intranasal
30545	Repair choanal atresia; transpalatine
30560	Lysis intranasal synechia
30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)
L8600	Implantable breast prosthesis, silicone or equal
L8607	Injectable bulking agent for vocal cord medialization, 0.1 ml, includes shipping and necessary supplies
Q2026	Injection, Radiesse, 0.1 ml
Q2028	Injection, sculptra, 0.5 mg
The following codes are considered cosmetic; the codes do not improve a functional, physical or physiological impairment.	
11950	Subcutaneous injection of filling material (e.g., collagen); 1 cc or less
11951	Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10.0 cc
11954	Subcutaneous injection of filling material (e.g., collagen); over 10.0 cc
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15775	Punch graft for hair transplant; 1 to 15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (e.g., tattoo removal)
15786	Abrasion; single lesion (e.g., keratosis, scar)
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
15819	Cervicoplasty
15824	Rhytidectomy; forehead
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap)
15826	Rhytidectomy; glabellar frown lines
15828	Rhytidectomy; cheek, chin, and neck

CPT/HCPCS Code	Description
The following codes are considered cosmetic; the codes do not improve a functional, physical or physiological impairment.	
15829	Rhytidectomy; superficial musculoaponeurotic system (SMAS) flap
17380	Electrolysis epilation, each 30 minutes
21270	Malar augmentation, prosthetic material
69090	Ear piercing
69300	Otoplasty, protruding ear, with or without size reduction
J0591	Injection, deoxycholic acid, 1 mg
The following code for treatment for spider veins is considered cosmetic; does not improve a functional, physical or physiological impairment. (2019 Amendment)	
36468	Injection(s) of sclerosant for spider veins (telangiectasia), limb or trunk
The following codes for sclerotherapy in excess of 3 sessions per leg within 12 months from the date of the ablation procedure are considered cosmetic; do not improve a functional, physical or physiological impairment. (2019 Amendment)	
36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)
36471	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg

Coding Clarifications

Flaps (Skin and/or Deep Tissues) Procedures: 15570-15738

- Codes 15733–15738 are described by donor site of the muscle, myocutaneous, or fasciocutaneous flap.
- A repair of a donor site requiring a skin graft or local flaps is considered an additional separate procedure.
  - For microvascular flaps, see 15756–15758.
  - For flaps without inclusion of a vascular pedicle, see 15570–15576.
  - For adjacent tissue transfer flaps, see instruction for 14000–14302 below.
- The regions listed refer to the recipient area (not the donor site) when a flap is being attached in a transfer or to a final site.
- Codes 15570–15738 do not include extensive immobilization (e.g., large plaster casts and other immobilizing devices are considered additional separate procedures).

Other Flaps and Grafts Procedures: 15740-15777

- Neurovascular pedicle procedures are reported with 15750. This code includes not only skin but also a functional motor or sensory nerve(s). The flap serves to reinnervate a damaged portion of the body dependent on touch or movement (e.g., thumb). Repair of donor site requiring skin graft or local flaps should be reported as an additional procedure.
- Code 15740 describes a cutaneous flap, transposed into a nearby but not immediately adjacent defect, with a pedicle that incorporates an anatomically named axial vessel into its design. The flap is typically transferred through a tunnel underneath the skin and sutured into its new position. The donor site is closed directly.
- For random island flaps, V-Y subcutaneous flaps, advancement flaps, and other flaps from adjacent areas without clearly defined anatomically named axial vessels, see instruction for 14000–14302 below.

CPT Coding Tips

- For codes 15570, 15734, 15736, 15738 and 15740, refer to the following CPT assistant monthly newsletter for additional coding guidelines for flap procedures:
  - MAR 10:4
  - MAR 13:13
  - MAR 04:11
  - APR 10:3
  - APR 14:10
  - SEP 03:15
  - SEP 04:12
  - OCT 04:15
  - OCT 13:15
  - NOV 02:7
  - DEC 12:6
- For codes 14000–14302, refer to the following CPT assistant monthly newsletter for additional coding guidelines for adjacent tissue transfer or rearrangement:

- JAN 06:47
- JAN 12:8
- MAR 10:4
- APR 10:3
- APR 14:10
- MAY 12:13
- JUL 00:10
- JUL 08:5
- JUL 99:3
- AUG 96:8
- AUG 12:13
- SEP 96:11
- NOV 12:13
- DEC 12:6
- DEC 06:15

References

American Medical Association (AMA). CPT® Assistant Online. Available at: https://www.ama-assn.org/practice-management/cpt. Accessed May 13, 2021.

American Society of Plastic Surgeons (ASPS) available at: http://www.plasticsurgery.org/. Accessed May 13, 2021.

UnitedHealthcare Insurance Company Generic Certificate of Coverage 2018.

Guideline History/Revision Information

Date	Summary of Changes
11/01/2021	**Documentation Requirements** • Updated list of applicable CPT codes with associated documentation requirements; added 14020, 14021, 14061, 14302, 15730, 15733, 15570, 15572, 15574, 15740, 15756, 36470, and 36471 **Supporting Information** • Archived previous policy version CDG.007.19

Instructions for Use

This Coverage Determination Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this guideline, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice.

This Coverage Determination Guideline may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. UnitedHealthcare Coverage Determination Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

For self-funded plans with SPD language other than fully-insured Generic COC language, please refer to the member specific benefit plan document for coverage.