American Society *of* Interventional Pain Physicians®
"The Voice of Interventional Pain Management"
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Stephen J. Hemsley
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Anne Docimo, MD
Chief Medical Officer, United Healthcare
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Re: Referral Requirements for Medicare Advantage HMO/HMO - POS plans.

Dear Mr. Hemsley and Dr. Docimo:

On behalf of the American Society of Interventional Pain Physicians (ASIPP), it's 50 state societies (including affiliation of Texas and Puerto Rico), and our membership, we appreciate your efforts to provide updated coverage for individuals enrolled in Medicare Advantage plans. We also appreciate your process of refinements and keeping us posted on a regular basis.

Thank you for keeping us informed regarding the various issues related to coverage policies. Recently, you revised the referral process, which has become extremely burdensome since its implementation on April 30, 2026. We are now experiencing adverse consequences, including reduced referrals and delays in receiving referrals in a timely manner. In some cases, referrals may be discontinued altogether or redirected elsewhere based on administrative convenience rather than patient need.

Consequently, we respectfully request that UnitedHealthcare either return to the previous standard process of a one-time referral or, if renewal requirements are deemed necessary, limit renewals to once yearly through a simplified process similar to the prior policy. Under the previous process, a referral to a single physician within the group appropriately covered treatment provided by the entire group practice.

As you are aware, the current revised referral process requires that a primary care physician referring a patient to interventional pain management must personally enter the referral not only for one physician, but for every physician within the group, since any provider within the group may evaluate and treat the patient. As an example, our group (Dr. Manchikanti) consists of eight providers. Consequently, this requirement creates a significant administrative burden for primary care physicians and will likely result in missed or delayed referrals. Furthermore, this process must be repeated every six months.

These policies create substantial barriers to patient access and continuity of care. As a result, patients face significant delays, reduced access to medically necessary treatment, and considerable inconvenience. Moreover, these restrictions do not appear to be supported by an accepted evidence

base and may ultimately cause harm to Medicare Advantage beneficiaries by limiting timely access to appropriate medical care and necessary interventional pain management treatments.

These policies are also inconsistent with established Medicare policies. Medicare does provide coverage for interventional pain management services. Under Medicare policy, Medicare Advantage plans are required to follow applicable Local Coverage Determinations (LCDs) and apply the medical necessity and frequency criteria outlined within those LCDs. In situations where no LCD exists, Medicare Advantage plans should apply comparable evidence-based criteria consistent with Medicare standards and practices. When a patient is referred to interventional pain management, the referral is intended not only for specialist consultation, but also for ongoing treatment and management. Appropriate LCDs exist for interventional pain management procedures, and UnitedHealthcare also maintains policies for these interventional techniques, including spinal cord stimulation procedures in certain circumstances. These policies are generally aligned with Medicare coverage principles.

LCD - Facet Joint Interventions for Pain Management (L38773)

LCD - Epidural Steroid Injections for Pain Management (L39015)

LCD - Sacroiliac Joint Injections and Procedures (L39383)

Medicare Advantage (MA) plans are required to follow the coverage guidelines established by traditional Medicare, as mandated under federal law and reinforced by the Centers for Medicare & Medicaid Services (CMS). Specifically, under **42 U.S.C. § 1395w-22(a)(1)(A)**, MA plans must provide coverage that is at least actuarially equivalent to the benefits offered under Original Medicare Parts A and B. Additionally, **CMS Medicare Managed Care Manual, Chapter 4, Section 10.1** explicitly states that Medicare Advantage plans are obligated to "provide all Part A and Part B covered services," and must adhere to the national and local coverage determinations (NCDs and LCDs) established by CMS and the Medicare Administrative Contractors (MACs). Furthermore, **42 C.F.R. § 422.101(b)** mandates that MA plans must follow CMS's national coverage determinations and may not apply coverage rules that are more restrictive than those established under Original Medicare. Deviating from these standards can undermine health equity by creating disparities in access to medically necessary care, especially for vulnerable populations who rely on consistent, evidence-based national coverage criteria. Inconsistent application of benefits across plans can result in delays, denials, or administrative barriers that disproportionately affect individuals from underserved communities, thereby perpetuating systemic health inequities and contradicting CMS's own stated commitment to promoting equity in healthcare delivery.

We are hopeful that UnitedHealthcare will reconsider and revise this policy. Please feel free to contact us if you have any questions or require additional information. We look forward to a favorable resolution in the near future.

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