AVASTIN® (BEVACIZUMAB)

Guideline Number: MPG023.07
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Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>POLICY SUMMARY</td>
<td>1</td>
</tr>
<tr>
<td>APPLICABLE CODES</td>
<td>5</td>
</tr>
<tr>
<td>DEFINITIONS</td>
<td>20</td>
</tr>
<tr>
<td>PURPOSE</td>
<td>20</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>21</td>
</tr>
<tr>
<td>GUIDELINE HISTORY/REVISION INFORMATION</td>
<td>22</td>
</tr>
<tr>
<td>TERMS AND CONDITIONS</td>
<td>22</td>
</tr>
</tbody>
</table>

POLICY SUMMARY

Overview

This policy guideline supplements but does not replace, modify or supersede existing Medicare applicable National Coverage Determinations (NCDs) or payment policy rules and regulations for chemotherapeutic drug and biological services. Federal statute and subsequent Medicare regulations regarding provision and payment for medical services are lengthy. They are not repeated in this policy. All providers who report services for Medicare payment must fully understand and follow all existing laws, regulations and rules for Medicare payment for chemotherapeutic drug and biological services and must properly submit only valid claims for them. Please review and understand them and apply the medical necessity provisions in the policy within the context of the manual rules.

Generally, drugs and biologicals are covered only if all of the following requirements are met:
- They meet the definition of drugs or biologicals;
- They are of the type that are not usually self-administered by the patients who take them;
- They meet all the general requirements for coverage of items as incident to a physician’s services;
- They are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered according to accepted standards of medical practice;
- They are not excluded as immunizations; and
- They have not been determined by the FDA to be less than effective.

It is not appropriate to bill UnitedHealthcare for services that are not covered (as described by this entire policy guideline) as if they are covered. When billing for non-covered services, use the appropriate modifier.

Note: This policy does not describe drug and biological coverage under the Medicare Part D benefit.

Guidelines

Cancer

Bevacizumab is a monoclonal antibody produced by recombinant DNA technology in Chinese hamster ovaries. This monoclonal antibody binds to and inhibits the biologic activity of human vascular endothelial growth factor preventing the formation of new blood vessels.

Unless certain specified conditions are met, UnitedHealthcare will not reimburse for unlabeled use of non-self-administered drugs. However, FDA-approved drugs used for indications other than what is indicated on the official

Terms and Conditions

Related Medicare Advantage Policy Guidelines
- Coverage of Drugs and Biologicals for Label and Off-Label Uses
- Self-Administered Drug(s) (SAD)

Related Medicare Advantage Reimbursement Policy
- Discarded Drugs and Biologicals Policy, Professional
- National Drug Code (NDC) Requirement Professional and Facility Policy

Related Medicare Advantage Coverage Summaries
- Age Related Macular Degeneration (AMD) Therapy: (Macugen®, Lucentis®, Avastin®, EYLEA®)
- Chemotherapy, and Associated Drugs and Treatments
- Vision Services, Therapy and Rehabilitation

See Purpose

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label may be covered by UnitedHealthcare when Medicare determines the use to be medically accepted, taking into consideration the major drug compendia, authoritative medical literature and/or accepted standards of medical practice. In the case of unlabeled use for anti-cancer drugs, the conditions for Medicare coverage and reimbursement have been well outlined.

**Note:** This policy guideline imposes diagnosis limitations that support diagnosis to procedure code automated denials. However, services performed for any given diagnosis must meet all of the indications and limitations stated in this policy, the general requirements for medical necessity as stated in CMS payment policy manuals, and any and all existing CMS national coverage determinations, and all Medicare payment rules.

As published in **CMS Program Integrity Manual, Section 13.5.4**, in order to be covered under Medicare, a service shall be reasonable and necessary.

Drugs and biologicals must be determined to meet the statutory definition. Under the statute §1861(t) (1), payment may be made for a drug or biological only where it is included, or approved for inclusion, in the latest official edition of the United States Pharmacopoeia (USP), the National Formulary (NF), the United States Homeopathic Pharmacopoeia (HPUS), or in New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein). The inclusion of an item in one of these publications does not necessarily mean that the item is a drug or biological. Inclusion in such reference (or approval by a hospital committee) is a necessary condition for a product to be considered a drug or biological under the Medicare program, however, it is not enough. Rather, the product must also meet all other program requirements to be determined to be a drug or biological. Combination drugs are also included in the definition of drugs if the combination itself or all of the therapeutic ingredients of the combination are included, or approved for inclusion, in any of the above drug compendia.

Drugs and biologicals are considered approved for inclusion in a compendium if approved under the established procedure by the professional organization responsible for revision of the compendium.

Drugs that are usually self-administered by the patient, such as those in pill form, or are used for self-injection, are generally not covered by Part B. [See the Medicare Advantage Policy Guideline titled **Self-Administered Drug(s) (SAD)**].

Use of the drug or biological must be safe and effective and otherwise reasonable and necessary. Drugs or biologicals and cancer chemotherapeutic agents approved for marketing by the Food and Drug Administration (FDA) are considered safe and effective for purposes of this requirement when used for indications specified on the labeling.

Therefore, payment may be made for an FDA-approved chemotherapeutic drug or biological, if:

- It was injected on or after the date of the FDA's approval;
- It is reasonable and necessary for the individual patient; and
- All other applicable coverage requirements are met.

An unlabeled use of a drug is a use that is not included as an indication on the drug's label as approved by the FDA. FDA approved drugs used for indications other than what is indicated on the official label may be covered if the contractor determines the use to be medically accepted, taking into consideration the major drug compendia, authoritative medical literature and/or accepted standards of medical practice.

There are many reasons to consider an unlabeled use for a cancer chemotherapy agent. Some of these are:

- Drugs may be effective for many other cancers in addition to the ones that were considered in the primary labeling of the drug.
- Many chemotherapeutic agents are given in combinations. Any one of the drugs in the combination may not have been approved in the initial labeling of the products. In addition the combination of effective chemotherapeutic agents changes over time.
- Cancer chemotherapeutic agents are always changing and improving over time.
- Oncologists are often left with few approved treatment options if initial treatment regimens have failed.

If a medication is determined not to be reasonable and necessary for diagnosis or treatment of an illness or injury according to these guidelines, the entire charge will be excluded (i.e., for both the drug and its administration). Also excluded from payment is any charge for other services (such as office visits) which are primarily for the purpose of administering a non-covered injection (i.e., an injection that is not reasonable and necessary for the diagnosis or treatment of an illness or injury).

A drug that is less than effective is not eligible for reimbursement, i.e., one that the Food and Drug Administration has determined to lack substantial evidence of effectiveness for all labeled indications. Any other drug product that is identical, similar, or related, will also be ineligible.
Several cancer chemotherapeutic agents and regimes have been developed and approved by the Food and Drug Administration (FDA) to treat various types of cancer. The intended mechanism of action is to interfere with or prevent the growth of malignant (cancerous) cells.

Generally, cancer chemotherapeutic agents are covered only if all of the following requirements are met:

- Documentation is present to support that the drug is safe and effective and is being administered for an approved indication.
- Documentation in the patient’s medical record supports the medical necessity of administering the chemotherapy drug to that individual patient.
- Documentation in the patient’s medical record supports that the chemotherapy drug was administered as billed.

**Medicare Benefit Policy Manual - Pub. 100-02, Chapter 15, Section 50**, describes national policy regarding Medicare guidelines for coverage of drugs and biologicals. Coverage for medication is based on the patient’s condition, the appropriateness of the dose and route of administration, based on the clinical condition and the standard of medical practice regarding the effectiveness of the drug for the diagnosis and condition. The drug must be used according to the indication and protocol listed in the accepted compendia ratings listed below.

- National Comprehensive Cancer Network (NCCN) Drugs and Biologies Compendium
- American Hospital Formulary Service-Drug Information (AHFS-DI)
- Thomson Micromedex DrugDex
- Clinical Pharmacology
- Wolters Kluwer Lexi-Drugs

The compendia employ various rating and recommendation systems that may not be readily cross-walked from compendium to compendium. In general, a use is identified by a compendium as medically accepted if the:

- Indication is a Category 1 or 2A in NCCN
- Class I, Class IIa, or Class IIb in DrugDex; or,
- Listed in Lexi-Drugs as “Use: Off-Label” and rated as “evidence level A”
- Narrative text in AHFS-DI or Clinical Pharmacology is supportive.

If a use is identified as not indicated by CMS or the FDA or if a use is specifically identified as not indicated (in one or more of the three compendia mentioned) or if it is determined (based on peer reviewed medical literature) that a particular use of a drug is not safe and effective, the off-label usage is not supported and, therefore, the drug is not covered. In this instance, the administration is also not covered.

An invoice may be requested if pricing is not available on the ASP pricing file. This file contains lists for NOC and true codes. This file can be located at the CMS website.

**Coverage**

Bevacizumab (Avastin®) is FDA approved for treatment of select cancers as a systemic drug. Refer also to the NCCN Compendium® for additional off-label indications.

- **Metastatic colorectal cancer**
  - Used in combination with 5-fluorouracil-based chemotherapy as first-line or second-line therapy
  - For the second-line treatment of patients with metastatic colorectal cancer who have progressed on a first-line Avastin®-containing regimen when used in combination with fluoropyrimidine-irinotecan- or fluoropyrimidine-oxaliplatin-based chemotherapy

- **Non-small cell lung cancer**
  - First-line treatment in combination with paclitaxel and carboplatin for unresectable, locally advanced, recurrent or metastatic non-squamous cell disease.
  - Recurrent glioblastoma in adults
  - Metastatic renal cell carcinoma in combination with interferon alfa

- **Cervical cancer**
  - In combination with either a) paclitaxel and cisplatin or b) paclitaxel and topotecan in persistent, recurrent, or metastatic disease

- **Epithelial ovarian, fallopian tube, or primary peritoneal cancer**
  - In combination with paclitaxel, pegylated liposomal doxorubicin, or topotecan for platinum-resistant disease
  - In combination with carboplatin and paclitaxel, followed by Avastin® as a single agent, for stage III or IV disease following initial surgical resection
  - In combination with carboplatin and paclitaxel or carboplatin and gemcitabine, followed by Avastin® as a single agent, for platinum-sensitive disease

**Chemotherapy Administration**
Chemotherapy administration codes apply to parenteral administration of nonradionuclide anti-neoplastic drugs and antineoplastic agents provided for the treatment of non-cancer diagnoses (e.g. cyclophosphamide for autoimmune conditions), or to substances such as monoclonal antibody agents and other biologic response modifiers. The administration of anti-anemia drugs and anti-emetic drugs by injection or infusion for cancer patients are not considered chemotherapy administration. If performed to facilitate the chemotherapy infusion or injection, the following services and items are included and are not separately billable:

- Use of local anesthesia;
- IV access;
- Access to indwelling IV, subcutaneous catheter or port;
- Flush at conclusion of infusion;
- Standard tubing, syringes and supplies; and
- Preparation of chemotherapy agent(s).

**Documentation Requirements**

The patient's medical record must contain documentation that fully supports the medical necessity for services included within this policy guideline. This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

The medical record must include the following information:

- The name of the drug or biological administered;
- The route of administration;
- The dosage (e.g., mgs, mcgs, cc's or IU's); and
- The duration of the administration (for CPT codes that are time based)

**Coding Guidelines**

- Diagnosis codes must be listed to the most specific number
- Use the appropriate J code to report the drug being used (J9035)
- True codes reflect the dosage of the drug; the number of units should indicate the total number of units given in item 24G of the CMS 1500 form. If filing electronically, the total units should be placed in the NSF Format, Record FAO-18.0, ANSI 837 format Segment SV1-05 (3032) or Segment SV2-04 (3052)

**Ophthalmology**

Avastin® (bevacizumab), which was initially approved by the FDA in 2004 for the treatment of metastatic colon cancer, is a monoclonal antibody that binds to VEGF. Vascular endothelial growth factor (VEGF) plays an important role in both physiologic and pathologic angiogenesis and contributes to increased permeability across both the blood-retinal and blood-brain barriers. VEGF is a protein that stimulates the growth, proliferation, and survival of vascular endothelial cells. VEGF, through its promotion of angiogenesis and vascular permeability is a central component of the pathologic process driving wet age-related macular degeneration (AMD), as well as other choroidal and retinal vascular disorders.

Non-FDA approved intravitreal use of bevacizumab has been widely reported by practicing ophthalmologists to be beneficial in select individuals with neovascular AMD. Consistent with the statement by the American Academy of Ophthalmology (AAO) in support of intravitreal use of bevacizumab, physicians should provide appropriate informed consent with respect to the off-label use of this drug and maintain it in the patient chart.

**Coverage**

Based on published reports and widespread clinical use, there is compelling evidence of bevacizumab’s safety and efficacy for:

- Choroidal neovascularization (CNV) in age-related macular degeneration (AMD)
- Proliferative diabetic retinopathy
- Neovascular glaucoma
- Diabetic macular edema
- Retinal and iris neovascularizations
- Macular edema following branch and central retinal vein occlusions

Current literature indicates anticipated dosage is 1.25 mg (0.05ml) or less every 4 to 6 weeks, as needed, by aseptic intravitreal injection into affected eye. Treatment frequency should be consistent with the clinical assessment (symptoms, exam, testing when indicated (optical coherence tomography (OCT), fluorescein angiogram, etc.)) as documented in the medical record.
**Limitations**
The CMS On-line Manual System, Pub. 100-08, Program Integrity Manual, Chapter 13, Section 13.5.1 outlines that "reasonable and necessary" services are " ordered and/or furnished by qualified personnel." This service will be considered medically reasonable and necessary only if performed by a Board Certified (ABMS) Ophthalmologist. Bevacizumab is contraindicated in patients with ocular or periocular infections or known hypersensitivity to bevacizumab or any of the inactive ingredients in bevacizumab.

**Documentation Requirements**
Medical record documentation maintained by the performing ophthalmologist must include the following:
- The clinical indication/medical necessity for the bevacizumab injection,
- The actual dosage of bevacizumab given, site of injection and route of administration,
- Test results to firmly establish diagnosis by fluorescein angiogram or optical coherence tomography (OCT), for individuals with proliferative diabetic retinopathy, diabetic macular edema, retinal neovascularization, central retinal vein occlusion, venous tributary (branch) occlusion, exudative macular degeneration, and retinal edema. Tests to confirm the established diagnosis are not required for rubeosis iridis, or in the case of a vitreous hemorrhage in which the neovascularization cannot be visualized.
- Indication that the patient has been provided appropriate informed consent regarding the benefits and risks of this therapy and off-label use of this drug.

**Coding Guidelines**
- Diagnosis codes must be listed to the most specific number
- Use the appropriate J code or C code to report the drug being used
  - Facility Claims will report C9257
  - For ophthalmologic Bevacizumab (Avastin®) coding guidance when administrated in the office setting, please see the Local Coverage Determination for the jurisdiction in which the procedure is performed
- True codes reflect the dosage of the drug; the number of units should indicate the total number of units given in item 24G of the CMS 1500 form. If filing electronically, the total units should be placed in the NSF Format, Record FAO-18.0, ANSI 837 format Segment SV1-05 (3032) or Segment SV2-04 (3052)

**APPLICABLE CODES**
The following list(s) of 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.

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<th>Description</th>
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<td>C9257</td>
<td>Injection, bevacizumab, 0.25 mg <strong>(Outpatient Facility claims only)</strong></td>
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<tr>
<td>J3490</td>
<td>Unclassified drugs</td>
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<tr>
<td>J3590</td>
<td>Unclassified biologics</td>
</tr>
<tr>
<td>J7999</td>
<td>Compounded drug, not otherwise classified</td>
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<tr>
<td>J9035</td>
<td>Injection, bevacizumab, 10 mg</td>
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<table>
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<th>Modifier</th>
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<td>50</td>
<td>Bilateral procedure</td>
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<tr>
<td>GZ</td>
<td>Item or service expected to be denied as not reasonable and necessary</td>
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<tr>
<td>KX</td>
<td>Requirements specified in the medical policy have been met</td>
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<tr>
<td>LT</td>
<td>Left side (used to identify procedures performed on the left side of the body)</td>
</tr>
<tr>
<td>RT</td>
<td>Right side (used to identify procedures performed on the right side of the body)</td>
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<table>
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<th>ICD-10 Diagnosis Code</th>
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<tr>
<td>C17.0</td>
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<tr>
<td>C17.2</td>
<td>Malignant neoplasm of ileum</td>
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<tr>
<td>C17.8</td>
<td>Malignant neoplasm of overlapping sites of small intestine</td>
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<tr>
<td>C17.9</td>
<td>Malignant neoplasm of small intestine, unspecified</td>
</tr>
<tr>
<td>ICD-10 Diagnosis Code</td>
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<td>C34.11</td>
<td>Malignant neoplasm of upper lobe, right bronchus or lung</td>
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<td>C34.12</td>
<td>Malignant neoplasm of upper lobe, left bronchus or lung</td>
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<td>C34.31</td>
<td>Malignant neoplasm of lower lobe, right bronchus or lung</td>
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<td>C34.32</td>
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<td>Kaposi's sarcoma of lymph nodes</td>
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<td>Kaposi's sarcoma of gastrointestinal sites</td>
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<td>Kaposi's sarcoma of left lung</td>
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<td>C46.7</td>
<td>Kaposi's sarcoma of other sites</td>
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<tr>
<td>C46.9</td>
<td>Kaposi's sarcoma, unspecified</td>
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<td>C47.0</td>
<td>Malignant neoplasm of peripheral nerves of head, face and neck</td>
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<td>C47.11</td>
<td>Malignant neoplasm of peripheral nerves of right upper limb, including shoulder</td>
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<td>C47.5</td>
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<td>C47.8</td>
<td>Malignant neoplasm of overlapping sites of peripheral nerves and autonomic nervous system</td>
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<td>C48.0</td>
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<td>C48.1</td>
<td>Malignant neoplasm of retroperitoneum and peritoneum; specified parts of peritoneum</td>
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<td>Malignant neoplasm of retroperitoneum and peritoneum; peritoneum, unspecified</td>
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<td>C49.10</td>
<td>Malignant neoplasm of connective and soft tissue of unspecified upper limb, including shoulder</td>
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<tr>
<td>C49.11</td>
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<td>C49.12</td>
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<td>Description</td>
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<td>E08.311</td>
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<td>E08.3211</td>
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<td>Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, left eye</td>
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<td>Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, bilateral</td>
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ICD-10 Diagnosis Code | Description
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**For Ophthalmic**
H35.3223 | Exudative age-related macular degeneration, left eye, with inactive scar
H35.3230 | Exudative age-related macular degeneration, bilateral, stage unspecified
H35.3231 | Exudative age-related macular degeneration, bilateral, with active choroidal neovascularization
H35.3232 | Exudative age-related macular degeneration, bilateral, with inactive choroidal neovascularization
H35.3233 | Exudative age-related macular degeneration, bilateral, with inactive scar
H35.351 | Cystoid macular degeneration, right eye
H35.352 | Cystoid macular degeneration, left eye
H35.353 | Cystoid macular degeneration, bilateral
H35.359 | Cystoid macular degeneration, unspecified eye
H35.81 | Retinal edema
H35.82 | Retinal ischemia
H40.51X1 | Glaucoma secondary to other eye disorders, right eye, mild stage
H40.51X2 | Glaucoma secondary to other eye disorders, right eye, moderate stage
H40.51X3 | Glaucoma secondary to other eye disorders, right eye, severe stage
H40.51X4 | Glaucoma secondary to other eye disorders, right eye, indeterminate stage
H40.52X1 | Glaucoma secondary to other eye disorders, left eye, mild stage
H40.52X2 | Glaucoma secondary to other eye disorders, left eye, moderate stage
H40.52X3 | Glaucoma secondary to other eye disorders, left eye, severe stage
H40.52X4 | Glaucoma secondary to other eye disorders, left eye, indeterminate stage
H40.53X1 | Glaucoma secondary to other eye disorders, bilateral, mild stage
H40.53X2 | Glaucoma secondary to other eye disorders, bilateral, moderate stage
H40.53X3 | Glaucoma secondary to other eye disorders, bilateral, severe stage
H40.53X4 | Glaucoma secondary to other eye disorders, bilateral, indeterminate stage
H40.89 | Other specified glaucoma

**DEFINITIONS**

**Off-Label Drug Use**: An off-label/unlabeled use of a drug is defined as a use for a non-FDA approved indication, that is, one that is not listed on the drug's official label/prescribing information. An indication is defined as a diagnosis, illness, injury, syndrome, condition, or other clinical parameter for which a drug may be given. Off-label use is further defined as giving the drug in a way that deviates significantly from the labeled prescribing information for a particular indication. This includes but is not necessarily limited to, dosage, route of administration, duration and frequency of administration, and population to whom the drug would be administered. Drugs used for indications other than those in the approved labeling may be covered under Medicare if it is determined that the use is medically accepted, taking into consideration the major drug compendia, authoritative medical literatures and/or accepted standards of medical practice. Determinations as to whether medication is reasonable and necessary for an individual patient are made on appeal on the same basis as all other such determinations (i.e., with support from the peer-reviewed literature, with the advice of medical consultants, with reference to accepted standards of medical practice, and in consideration of the medical circumstance of the individual case).

**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 LCDs, NCDs, 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 below 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.

### REFERENCES

**CMS National Coverage Determinations (NCDs)**

**NCD 110.17 Anti-Cancer Chemotherapy for Colorectal Cancer**

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<thead>
<tr>
<th>LCD</th>
<th>Medicare Part A</th>
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**CMS Local Coverage Determinations (LCDs)**

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<td>A52370 (Bevacizumab (e.g., Avastin™) - Related to LCD L33994) NGS</td>
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<td>A53121 (Billing and Coding Information Regarding Uses, Including Off-Label Uses, of Bevacizumab and Ranibizumab, for The Treatment of Ophthalmological Diseases) Novitas</td>
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###Article | Medicare Part A | Medicare Part B
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A55588 (Vascular endothelial growth factor inhibitors for the treatment of ophthalmological diseases - new Part A and Part B LCD) First Coast | FL, PR, VI | FL, PR, VI
A52425 (Drugs and Biologicals, Coverage of, for Label and Off-Label Uses - Supplemental Instructions Article) CGS | KY, OH | KY, OH
A52701 (Drugs and Biologicals - Chemotherapeutic Agents) Cahaba Retired 02/25/2018 | AL, GA, TN |

###CMS Benefit Policy Manual
**Chapter 15; § 50.2 Determining Self-Administration of Drug or Biological, § 50.4.5 Of-Label Use of Anti-Cancer Drugs and Biologicals**

###CMS Claims Processing Manual
**Chapter 23; § 20.9 National Correct Coding Initiative**

###CMS Transmittals
**Transmittal 38, Change Request 3742, Dated 06/17/2005 (Coverage of Colorectal Anti-Cancer Drugs Included in Clinical Trials)**

###MLN Matters
**Article MM3742, Anti-Cancer Chemotherapy for Colorectal Cancer**

###UnitedHealthcare Commercial Policies
**Macular Degeneration Treatment Procedures**

**Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors**

###Others
**Avastin® Prescribing Information**  
**Maximum Dosage**

**Medicare Program Integrity Manual, Chapter 13 Local Coverage Determinations, § 13.5.4 Reasonable and Necessary Provisions in LCDs, CMS Website**

**NCCN Drugs & Biologics Compendium (NCCN Compendium®), National Comprehensive Cancer Network Website**

**Social Security Act (Title XVIII):**
- **1862(a)(1)(A) Medically Reasonable & Necessary**
- **1862(a)(1)(D) Investigational or Experimental**
- **1833(e) Incomplete Claim**
- **1861(t) (1) Drugs and Biologicals**

###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.

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<td>- Annual review</td>
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<td>- Added ICD-10 codes C51.0, C51.1, C51.2, C51.8 effective 02/01/2019</td>
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<td>- Added ICD-10 codes C51.9, C79.82, C85.89 effective 05/16/2019</td>
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<td>- Removed ICD-10 codes B39.4, B39.5, H32, H44.2A1, H44.2A2, H44.2A3, H44.2B1, H44.2B2, H44.2B3, H44.2C1, H44.2C2, H44.2C3, H44.2D1, H44.2D2, H44.2D3, H44.2E1, H44.2E2, H44.2E3 effective 06/10/2019</td>
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###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.