United Healthcare Community Plan

UnitedHealthcare Community Plan of Indiana

Medical Policy Update Bulletin: April 2022

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Take Note

Quarterly CPT® and HCPCS Code Updates

Effective Apr. 1, 2022, the following Medical Policies and Medical Benefit Drug Policies have been updated to reflect the quarterly Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) code additions, revisions, and deletions. Refer to the following sources for information on the code updates:

- American Medical Association. Current Procedural Terminology: CPT®
- Centers for Medicare & Medicaid Services. Healthcare Common Procedure Coding System: HCPCS Level II

Policy Title	Policy Type	Summary of Changes
Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes (for Indiana Only)	Medical Policy	• Added A4238 and E2102
Medical Therapies for Enzyme Deficiencies (for Indiana Only)	Medical Benefit Drug Policy	Nexviazyme • Replaced C9085, J3490, and J3590 with J0219
Molecular Oncology Testing for Cancer Diagnosis, Prognosis, and Treatment Decisions (for Indiana Only)	Medical Policy	• Added 0306U, 0307U, 0313U, 0314U, and 0315U • Revised description for 0022U
Omnibus Codes (for Indiana Only)	Medical Policy	Cardiac Contractility Modulation using an Implantable Device • Added K1030
Ryplazim® (Plasminogen, Human-Tvmh) (for Indiana Only)	Medical Benefit Drug Policy	• Replaced C9399 with C9090
Saphnelo™ (Anifrolumab-Fnia) (for Indiana Only)	Medical Benefit Drug Policy	• Replaced C9086, J3490, and J3590 with J0491

Medical Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale

Ablative Treatment for Spinal Pain (for Indiana Only)	May 1, 2022	**Coverage Rationale**
		• Removed list of documentation requirements
		Proven and Medically Necessary
		• Replaced language indicating "*Thermal Radiofrequency Ablation* of lumbar and cervical facet joint *nerves* is proven and medically necessary in certain circumstances" with "*ablative treatment* of cervical, *thoracic*, and lumbar facet joint *pain* is proven and medically necessary in certain circumstances"
		Unproven and Not Medically Necessary
		• Revised list of facet joint nerve ablation techniques that are unproven and not medically necessary:
		  ○ Added "ablative treatment of sacroiliac pain"
		  ○ Removed:
		  ▪ Chemical ablation (including, but not limited to, alcohol, phenol or sodium morrhuate)
		  ▪ Cryoablation (cryodenervation, cryoneurolysis, cryosurgery or cryoanesthesia)
			Ablative Treatment of cervical, thoracic, and lumbar facet joint pain is proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to InterQual® 2021, Jan. 2022 Release, CP: Procedures: Neuroablation, Percutaneous.
			
			Click here to view the InterQual® criteria.
			
			The following facet joint nerve ablation techniques are unproven and not medically necessary due to insufficient evidence of efficacy:
			• Ablative treatment of sacroiliac pain
			• Pulsed Radiofrequency Ablation of the facet nerves of the cervical, thoracic or lumbar region, sacral nerve root or dorsal root ganglion
			• Cooled radiofrequency ablation
			• Intraosseous radiofrequency ablation of the basivertebral nerve (e.g., Intracept®)

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Ablative Treatment for Spinal Pain (for Indiana Only) (continued)	May 1, 2022	▪ Endoscopic radiofrequency ablation/endoscopic rhizotomy ▪ Laser ablation (including pulsed, continuous or low level) • Removed language pertaining to unproven and mot medically necessary indications for: ○ Thermal Radiofrequency Ablation of facet joint nerves ○ Radiofrequency Ablation, including Thermal and Cooled Radiofrequency Ablation **Definitions** • Updated definition of: ○ Conventional (Thermal) Radiofrequency Ablation ○ Cooled Radiofrequency Ablation **Applicable Codes** • Added CPT codes 64628 and 64629 **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect the most current information	
Discogenic Pain Treatment (for Indiana Only)	May 1, 2022	**Coverage Rationale** • Replaced language indicating "*Disc Decompression, Percutaneous Laser (PLDD),*	For medical necessity clinical coverage criteria of decompression procedures, refer to the InterQual® 2021, Jan. 2022 Release, CP: Procedures, Decompression +/- Fusion, Lumbar.

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Discogenic Pain Treatment (for Indiana Only) (continued)	May 1, 2022	*Lumbar is proven and medically necessary in certain circumstances;* for medical necessity clinical coverage criteria, refer to the InterQual® 2021, *Apr. 2021* Release, CP: Procedures, Decompression +/- Fusion, Lumbar" with "for medical necessity clinical coverage criteria *of decompression procedures*, refer to the InterQual® 2021, *Jan. 2022* Release, CP: Procedures, Decompression +/- Fusion, Lumbar" • Revised list of unproven and not medically necessary procedures: ○ Added: ▪ Annular closure devices (ACDs) ▪ Percutaneous injection of allogeneic cellular/tissue-based products ○ Removed: ▪ Annulus fibrosus repair following spinal surgery **Applicable Codes** • Added CPT codes 0627T, 0628T, 0629T, and 0630T **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	Click here to view the InterQual® criteria. The following procedures are unproven and not medically necessary due to insufficient evidence of efficacy: • Annular Closure Devices (ACDs) • Percutaneous injection of allogeneic cellular/tissue based products • Thermal intradiscal procedures (TIPs) for treating discogenic pain

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Genetic Testing for Hereditary Cancer (for Indiana Only)	May 1, 2022	**Coverage Rationale** • Replaced coverage guidelines with instruction to refer to the *Indiana Health Coverage Programs Provider Reference Module: Genetic Testing* for medical necessity clinical coverage criteria **Applicable Codes** • Removed CPT codes 0101U, 0102U, 0103U, 0129U, 0130U, 0131U, 0132U, 0133U, 0134U, 0135U, 0138U, 0162U, 0238U, 81212, 81215, 81217, 81432, 81433, 81435, 81436, 81437, and 81438 **Supporting Information** • Updated *References* section to reflect the most current information • Removed *Definitions*, *Description of Services*, and *Clinical Evidence* sections	Genetic counseling is strongly recommended prior to these tests in order to inform persons being tested about the advantages and limitations of the test as applied to a unique person. For medical necessity clinical coverage criteria, refer to the Indiana Health Coverage Programs Provider Reference Module: Genetic Testing.
Molecular Oncology Testing for Cancer Diagnosis, Prognosis, and Treatment Decisions (for Indiana Only)	May 1, 2022	**Coverage Rationale** • Replaced content/language with instruction to refer to the *Indiana Health Coverage Programs Provider Reference Module: Genetic Testing* for medical necessity clinical coverage criteria **Applicable Codes** • Removed CPT/HCPCS codes 0005U, 0011M, 0012M, 0013M, 0013U, 0014U, 0016M, 0017M,	For medical necessity clinical coverage criteria, refer to the Indiana Health Coverage Programs Provider Reference Module: Genetic Testing.

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Molecular Oncology Testing for Cancer Diagnosis, Prognosis, and Treatment Decisions (for Indiana Only) (continued)	May 1, 2022	0018U, 0019U, 0021U, 0022U, 0026U, 0036U, 0037U, 0045U, 0047U, 0048U, 0050U, 0056U, 0069U, 0089U, 0090U, 0091U, 0113U, 0118U, 0153U, 0171U, 0179U, 0204U, 0208U, 0211U, 0239U, 0242U, 0244U, 0245U, 0250U, 0262U, 81425, 81426, 81427, 81445, 81450, 81455, 81479, 81518, 81520, 81521, 81525, 81540, 81541, 81542, 81545, 81551, 81552, 81599, 86152, 86153, and G0327 • Removed ICD-10 diagnosis codes C90.10, C90.11, C90.12, C91.00, C91.01, C91.40, C91.41, C91.42, C92.02, C92.40, C92.41, C92.42, C92.50, C92.51, C92.52, C92.60, C92.61, C92.62, C92.A0, C92.A1, C92.A2, C95.90, C95.91, and C95.92 **Supporting Information** • Updated *References* section to reflect the most current information • Removed *Definitions*, *Description of Services*, and *Clinical Evidence* sections	
Pneumatic Compression Devices (for Indiana Only)	May 1, 2022	**Coverage Rationale** • Replaced language indicating "pneumatic compression devices are proven and medically necessary in certain circumstances" with "pneumatic	Pneumatic compression devices are proven and medically necessary in certain circumstances for the treatment of lymphedema or chronic venous insufficiency with edema and non-healing lower extremity ulcers. For medical necessity clinical coverage criteria, refer to the InterQual® 2021, Apr. 2021 Release, CP: Durable Medical Equipment, Pneumatic Compression Devices.

Medical Policy Updates

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Pneumatic Compression Devices (for Indiana Only) (continued)	May 1, 2022	compression devices are proven and medically necessary in certain circumstances *for the treatment of lymphedema or chronic venous insufficiency with edema and non-healing lower extremity ulcers*" • Added instruction to refer to the InterQual® 2021, Apr. 2021 Release, Medicare: Durable Medical Equipment, Pneumatic Compression Devices for medical necessity clinical coverage criteria for pneumatic compression devices for the treatment of arterial insufficiency (HCPCS code E0675) • Added language to indicate intermittent limb compression devices are proven and medically necessary in an outpatient setting or upon discharge from an inpatient setting for the prevention of deep venous thrombosis (DVT) when all the following criteria are met: ○ Immobility (i.e., not able to get up from a chair/out of bed and walk to the toilet without the help of another person) ○ Contraindication to pharmaceutical anti-coagulation ○ None of the following contraindications are present:	For medical necessity clinical coverage criteria of pneumatic compression devices for the treatment of arterial insufficiency (E0675), refer to the InterQual® 2021, Apr. 2021 Release, Medicare: Durable Medical Equipment, Pneumatic Compression Devices. Click here to view the InterQual® criteria. Intermittent limb compression devices are proven and medically necessary in an outpatient setting or upon discharge from an inpatient setting for the prevention of deep venous thrombosis (DVT) when all the following criteria are met: • Immobility (i.e., not able to get up from a chair / out of bed and walk to the toilet without the help of another person) • Contraindication to pharmaceutical anti-coagulation • None of the following contraindications are present: ○ Active infection ○ Pulmonary edema ○ Severe arteriosclerosis ○ Severe congestive heart failure ○ Skin or tissue condition that may be negatively impacted by the use of garments ○ Suspected or known DVT

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Pneumatic Compression Devices (for Indiana Only) (continued)	May 1, 2022	▪ Active infection ▪ Pulmonary edema ▪ Severe arteriosclerosis ▪ Severe congestive heart failure ▪ Skin or tissue condition that may be negatively impacted by the use of garments ▪ Suspected or known DVT **Supporting Information** • Added *Description of Services*, *Clinical Evidence*, and *References* sections	
Surgical Treatment for Spine Pain (for Indiana Only)	May 1, 2022	**Coverage Rationale** • Replaced reference to: ○ "InterQual® 2021, *July 2021* Release" with "InterQual® 2021, *Jan. 2022* Release" ○ "InterQual® 2021, *Oct. 2021* Release" with "InterQual® 2021, *Jan. 2022* Release" • Replaced language indicating "a surgical spine procedure that is performed to alleviate symptoms or prevent clinical deterioration of a congenital or idiopathic deformity or bone disease is proven and medically necessary if not addressed in the [InterQual® criteria listed in the policy]" with "a surgical spine procedure that is performed to alleviate symptoms or prevent	Spinal procedures for the treatment of spine pain are proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® 2021, Jan. 2022 Release, CP: Procedures: • Decompression +/- Fusion, Cervical • Decompression +/- Fusion, Thoracic • Decompression +/- Fusion, Lumbar • Fusion, Cervical Spine • Fusion, Lumbar Spine • Fusion, Thoracic Spine Click here to view the InterQual® criteria. The following indications for a surgical spine procedure that is performed to alleviate symptoms or prevent clinical deterioration are considered proven and medically necessary if not addressed in the above criteria: • Congenital or idiopathic deformity or bone disease other than scoliosis • Muscular dystrophy • Laminectomy procedure to provide surgical exposure to treat lesions within

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Surgical Treatment for Spine Pain (for Indiana Only) (continued)	May 1, 2022	clinical deterioration of a congenital or idiopathic deformity or bone disease *other than scoliosis* is proven and medically necessary if not addressed in the [InterQual® criteria listed in the policy]" • Added instruction to refer to the *Indiana Health Coverage Programs Provider Reference Module: Surgical Services* for medical necessity clinical coverage criteria for spinal stabilization procedures for the treatment of spinal stenosis (CPT codes 22867, 22868, 22869, and 22870) • Revised list of unproven and not medically necessary spinal procedures: ○ Added "dividing treatment of symptomatic, multi-site spinal pathology via anterior or posterior approach into serial, multiple, or staged sessions when one session can address all sites" ○ Removed: ▪ Transforaminal lumbar interbody fusion (TLIF) which utilizes only endoscopy visualization (such as a percutaneous incision with video visualization)	the spinal canal For medical necessity clinical coverage criteria for spinal stabilization procedures for the treatment of spinal stenosis (CPT Codes 22867, 22868, 22869 and 22870), refer to the Indiana Health Coverage Programs Provider Reference Module: Surgical Services. The following spinal procedures are unproven and not medically necessary due to insufficient evidence of efficacy (this includes procedures that utilize interbody cages, screws, and pedicle screw fixation devices): • Laparoscopic anterior lumbar interbody fusion (LALIF) • Axial lumbar interbody fusion (AxiaLIF®) • Spinal decompression and interspinous process decompression systems for the treatment of lumbar spinal stenosis (e.g., Interspinous process decompression (IPD), minimally invasive lumbar decompression (MILD®) • Dividing treatment of symptomatic, multi-site spinal pathology via anterior or posterior approach into serial, multiple, or staged sessions when one session can address all sites • Stand-alone facet fusion without an accompanying decompressive procedure ○ This includes procedures performed with or without bone grafting and/or the use of posterior intrafacet implants such as fixation systems, facet screw systems or anti-migration dowels For information on vertebral body tethering, refer to the Medical Policy titled Vertebral Body Tethering for Scoliosis (for Indiana Only). **Documentation Requirements** Medical notes documenting the following, when applicable: • Condition requiring procedure • History and co-morbid medical condition(s) ○ Smoking history/status, including date of last smoking cessation • Member's symptoms, pain, location, and severity including functional

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Surgical Treatment for Spine Pain (for Indiana Only) (continued)	May 1, 2022	▪ Interlaminar lumbar instrumented fusion (ILIF) utilizing an interspinous process fusion device ▪ Spinal stabilization systems: – Stabilization systems for the treatment of degenerative spondylolisthesis – Total facet joint arthroplasty, including facetectomy, laminectomy, foraminotomy, vertebral column fixation – Percutaneous sacral augmentation (sacroplasty) with or without a balloon or bone cement for the treatment of back pain ● Removed language indicating interlaminar lumbar instrumented fusion (ILIF) utilizing an interspinous process fusion device is unproven and not medically necessary *Documentation Requirements* ● Added language to indicate medical notes documenting the following are required, when	impairment that is interfering with activities of daily living (meals, walking, getting dressed, driving) ● Failure of Conservative Therapy through lack of clinically significant improvement between at least two measurements, on a validated pain or function scale or quantifiable symptoms despite concurrent Conservative Therapies (Refer to the definition), if applicable ● Progressive deficits with clinically significant worsening based on at least two measurements over time, if applicable ● Disabling Symptoms, if applicable ● Upon request, we may request the specific diagnostic image(s) that shows the abnormality for which surgery is being requested which may include MRI, CT scan, X-ray, and/or bone scan; consultation with requesting surgeon may be needed to select the optimal image(s) ○ Note: When requested, diagnostic images must be labeled with the: ▪ Date taken ▪ Applicable case number obtained at time of notification, or the member's name and ID number on the image(s) ○ Upon request, diagnostic imaging must be submitted via the external portal at www.uhcprovider.com/paan; faxes will not be accepted ● Diagnostic image(s) report(s), including presence or absence of: ○ Segment(s) instability ○ Spinal cord compression ○ Disc herniation ○ Nerve root compression ○ Quantification of subluxation, translation by flexion, angulation when appropriate ○ Discitis ○ Epidural abscess ● Physical exam, including neurologic exam, including degree and progression of curvature (for scoliosis), if applicable ○ Degree and progression of curvature (for scoliosis) ○ Quantification of relevant muscle strength ● Whether the surgery will be performed with direct visualization or only with

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Surgical Treatment for Spine Pain (for Indiana Only) (continued)	May 1, 2022	applicable: ○ Condition requiring procedure ○ History and co-morbid medical condition(s) ▪ Smoking history/status, including date of last smoking cessation ○ Member's symptoms, pain, location, and severity including functional impairment that is interfering with activities of daily living (meals, walking, getting dressed, driving) ○ Failure of Conservative Therapy through lack of clinically significant improvement between at least two measurements, on a validated pain or function scale or quantifiable symptoms despite concurrent Conservative Therapies (Refer to the definition), if applicable ○ Progressive deficits with clinically significant worsening based on at least two measurements over time, if applicable ○ Disabling Symptoms, if applicable ○ Upon request, we may request the specific diagnostic image(s) that shows the	endoscopic visualization ● Complete report(s) of diagnostic tests ○ Results of biopsy(ies) ○ Results of bone aspirate ● Describe the surgical technique(s) planned [e.g., AxiaLIF®, XLIF, ILIF, OLIF, LALIF, image-guided minimally invasive lumbar decompression (MILD®), percutaneous endoscopic discectomy with or without laser, etc.]

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Surgical Treatment for Spine Pain (for Indiana Only) (continued)	May 1, 2022	abnormality for which surgery is being requested which may include MRI, CT scan, X-ray, and/or bone scan; consultation with requesting surgeon may be needed to select the optimal image(s) ▪ Note: When requested, diagnostic images must be labeled with the: – Date taken – Applicable case number obtained at time of notification, or the member's name and ID number on the image(s) ▪ Upon request, diagnostic imaging must be submitted via the external portal at uhcprovider.com/paan; faxes will not be accepted ○ Diagnostic image(s) report(s), including presence or absence of: ▪ Segment(s) instability ▪ Spinal cord compression ▪ Disc herniation ▪ Nerve root compression ▪ Quantification of subluxation, translation by flexion, angulation when	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Surgical Treatment for Spine Pain (for Indiana Only) (continued)	May 1, 2022	appropriate ▪ Discitis ▪ Epidural abscess ○ Physical exam, including neurologic exam, including degree and progression of curvature (for scoliosis), if applicable ▪ Degree and progression of curvature (for scoliosis) ▪ Quantification of relevant muscle strength ○ Whether the surgery will be performed with direct visualization or only with endoscopic visualization ○ Complete report(s) of diagnostic tests ▪ Results of biopsy(ies) ▪ Results of bone aspirate ○ Describe the surgical technique(s) planned [e.g., AxiaLIF®, XLIF, ILIF, OLIF, LALIF, image-guided minimally invasive lumbar decompression (MILD®), percutaneous endoscopic discectomy with or without laser, etc.] **Definitions** ● Added definition of “Staged Multi-Session”	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Surgical Treatment for Spine Pain (for Indiana Only) (continued)	May 1, 2022	Supporting Information • Updated *Clinical Evidence* and *References* sections to reflect the most current information	

Retired		
Policy Title	**Effective Date**	**Summary of Changes**
Sublingual Immunotherapy (for Indiana Only)	Apr. 1, 2022	• Policy retired; sublingual immunotherapy services no longer require clinical review

Medical Benefit Drug Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Lemtrada® (Alemtuzumab) (for Indiana Only)	May 1, 2022	**Coverage Rationale** • Revised language to indicate Lemtrada (alemtuzumab) is proven and medically necessary for treatment of certain conditions outlined within the InterQual criteria; for medical necessity clinical coverage criteria, refer to the current release of the InterQual® guideline, CP: Specialty Rx Non-Oncology, Alemtuzumab (Lemtrada) **Applicable Codes** • Removed ICD-10 diagnosis code G35 **Supporting Information** • Removed *Background*, *Clinical Evidence*, *FDA*, and *References* sections	Lemtrada (alemtuzumab) is proven and medically necessary for treatment of certain conditions outlined within the InterQual criteria. For medical necessity clinical coverage criteria, refer to the current release of the InterQual® guideline, CP: Specialty Rx Non-Oncology, Alemtuzumab (Lemtrada). Click here to view the InterQual® criteria.
Long-Acting Injectable Antiretroviral Agents for HIV (for Indiana Only)	May 1, 2022	**Coverage Rationale** • Revised list of applicable long-acting injectable antiretroviral products; added Apretude (cabotegravir) • Added language to indicate: ○ Apretude (cabotegravir) has been added to the Review at Launch program and some members may not be eligible for coverage of this medication at this time; refer to the Medical Benefit Drug Policy titled *Review at Launch for*	This policy refers to the following long-acting injectable antiretroviral products: • Apretude (cabotegravir) • Cabenuva (cabotegravir/rilpivirine) Apretude (cabotegravir) is proven to reduce the risk of sexually acquired HIV-1 infection in at-risk adults and adolescents weighing at least 35kg. Apretude is medically necessary when the following additional criteria are met: • For initial therapy, all of the following: ○ Used for HIV-1 pre-exposure prophylaxis (PrEP); and ○ Patient has a negative HIV-1 test; and ○ Provider confirms that the patient will be tested for HIV-1 infection with each subsequent injection; and ○ Patient is not an appropriate candidate for oral PrEP (e.g., difficulty with adherence to prior oral PrEP, significant renal disease); and

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Long-Acting Injectable Antiretroviral Agents for HIV (for Indiana Only) (continued)	May 1, 2022	*New to Market Medications* for additional details ○ Apretude (cabotegravir) is proven to reduce the risk of sexually acquired HIV-1 infection in at-risk adults and adolescents weighing at least 35kg ○ Apretude is medically necessary when the following additional criteria are met: *Initial Therapy* ▪ Used for HIV-1 pre-exposure prophylaxis (PrEP) ▪ Patient has a negative HIV-1 test ▪ Provider confirms that the patient will be tested for HIV-1 infection with each subsequent injection ▪ Patient is not an appropriate candidate for oral PrEP (e.g., difficulty with adherence to prior oral PrEP, significant renal disease) ▪ Provider attests that patient demonstrates treatment readiness by both of the following: – Patient understands the risks of missed	○ Provider attests that patient demonstrates treatment readiness by both of the following: ▪ Patient understands the risks of missed doses of Apretude ▪ Patient has the ability to adhere to the required every 2 months injection and testing appointments; and ○ Dosing is in accordance with the United States Food and Drug Administration approved labeling; and ○ Initial authorization is for no more than 12 months. • For continuation therapy, all of the following: ○ Patient has previously received treatment with Apretude; and ○ Patient has a negative HIV-1 test; and ○ Provider confirms that the patient will be tested for HIV-1 infection with each subsequent injection; and ○ Dosing is in accordance with the United States Food and Drug Administration approved labeling; and ○ Authorization is for no more than 12 months. Apretude is unproven and not medically necessary for the treatment of human immunodeficiency virus type-1 (HIV-1). Cabenuva (cabotegravir/rilpivirine) is proven for the treatment of a human immunodeficiency virus type-1 (HIV-1) in patients who are virologically suppressed (HIV-1 RNA less than 50 copies per mL). Cabenuva is medically necessary when the following additional criteria are met: • For initial therapy, all of the following: ○ Diagnosis of HIV-1 infection; and ○ Patient has no prior virologic failures or baseline resistance to either cabotegravir or rilpivirine; and ○ Patient is currently on a stable antiretroviral regimen; and ○ Submission of medical records (e.g., chart notes, laboratory results) showing viral suppression (HIV-1 RNA less than 50 copies per mL) for at least 6 months prior to initiation of Cabenuva; and

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Long-Acting Injectable Antiretroviral Agents for HIV (for Indiana Only) (continued)	May 1, 2022	doses of Apretude – Patient has the ability to adhere to the required every 2 months injection and testing appointments ▪ Dosing is in accordance with the United States Food and Drug Administration approved labeling ▪ Initial authorization is for no more than 12 months *Continuation Therapy* ▪ Patient has previously received treatment with Apretude ▪ Patient has a negative HIV-1 test ▪ Provider confirms that the patient will be tested for HIV-1 infection with each subsequent injection ▪ Dosing is in accordance with the United States Food and Drug Administration approved labeling ▪ Authorization is for no more than 12 months ○ Apretude is unproven and not medically necessary for the treatment of human	○ Provider attests that patient demonstrates treatment readiness by both of the following: ▪ Patient understands the risks of missed doses of Cabenuva ▪ Patient has the ability to adhere to the required monthly or every 2 months injection appointments and ○ Provider confirms that tolerability will be assessed using a 28-day oral lead-in of Vocabria (cabotegravir) and Edurant® (rilpivirine) tablets prior to the first injection of Cabenuva; and ○ Dosing is in accordance with the United States Food and Drug Administration approved labeling; and ○ Initial authorization is for no more than 12 months ● For continuation therapy, all of the following: ○ Patient has previously received treatment with Cabenuva; and ○ Provider confirms that the patient has achieved and maintained viral suppression (HIV-1 RNA less than 50 copies per mL) while on Cabenuva therapy; and ○ Dosing is in accordance with the United States Food and Drug Administration approved labeling; and ○ Authorization is for no more than 12 months Cabenuva is unproven and not medically necessary for the treatment of human immunodeficiency virus type-1 (HIV-1) in patients who are not currently virally suppressed (HIV-1 RNA less than 50 copies per mL).

Medical Benefit Drug Policy Updates

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Long-Acting Injectable Antiretroviral Agents for HIV (for Indiana Only) (continued)	May 1, 2022	immunodeficiency virus type-1 (HIV-1) **Applicable Codes** • Added HCPCS codes C9399 and J3490 • Added ICD-10 diagnosis codes Z11.3, Z11.4, Z20, Z20.2, Z20.6, Z72.5, Z72.51, Z72.52, and Z72.53 **Supporting Information** • Updated *Background*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	

Parsabiv® (Etelcalcetide) (for Indiana Only)	May 1, 2022	**Coverage Rationale**
		• Revised medical necessity criteria for initial therapy; replaced criterion requiring "history of failure, *contraindication, or intolerance* to Sensipar (cinacalcet hydrochloride)" with "history of failure *of maximum tolerated* dosage, adverse reaction, or contraindication to Sensipar (cinacalcet hydrochloride)"
		Supporting Information
		• Updated *References* section to reflect the most current information
			Initial Therapy
			Parsabiv (etelcalcetide) is medically necessary for the treatment of secondary hyperparathyroidism with chronic kidney disease when the following criteria are met:
			• Diagnosis of secondary hyperparathyroidism with chronic kidney disease; and
			• Patient is on dialysis; and
			• All of the following:
			  ○ History of failure, contraindication, or intolerance to one phosphate binder (e.g., PhosLo, Fosrenol, Renvela, Renagel, etc.); and
			  ○ History of failure, contraindication, or intolerance to one vitamin D analog (e.g., calcitriol, Hectorol, Zemplar, etc.); and
			  ○ History of failure of maximum tolerated dosage, adverse reaction, or contradiction to Sensipar (cinacalcet hydrochloride)
			and
			• Patient is not receiving Parsabiv (etelcalcetide) in combination with Sensipar (cinacalcet hydrochloride); and
			• Prescribed by or in consultation with an endocrinologist or nephrologist; and

Medical Benefit Drug Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Parsabiv® (Etelcalcetide) (for Indiana Only) (continued)	May 1, 2022		• Dosing is in accordance with the United States Food and Drug Administration approved labeling; and • Initial authorization will be for no longer than 12 months **Continuation Therapy** Parsabiv (etelcalcetide) will be reauthorized based on all of the following criteria: • Documentation of a reduction in serum calcium from baseline; and • Patient is not receiving Parsabiv (etelcalcetide) in combination with Sensipar (cinacalcet hydrochloride); and • Prescribed by or in consultation with an endocrinologist or nephrologist; and • Dosing is in accordance with the United States Food and Drug Administration approved labeling; and • Reauthorization will be for no longer than 12 months
Repository Corticotropin Injections (for Indiana Only)	May 1, 2022	**Title Change** • Previously titled *Repository Corticotropin Injection (Acthar® Gel) (for Indiana Only)* **Coverage Rationale** • Revised language to indicate Acthar® Gel (repository corticotropin injection) and Purified Cortrophin Gel (repository corticotropin injection USP) are proven and medically necessary for the treatment of certain conditions outlined within the InterQual® criteria; for medical necessity clinical coverage criteria, refer to the current release of the InterQual® guideline, CP: Specialty Rx Non-	Acthar® Gel (repository corticotropin injection) and Purified Cortophin Gel (repository corticotropin injection USP) are proven and medically necessary for the treatment of certain conditions outlined within the InterQual® criteria. For medical necessity clinical coverage criteria, refer to the current release of the InterQual® guideline, CP: Specialty Rx Non-Oncology, Repository Corticotropins. Click here to view the InterQual® criteria.

Medical Benefit Drug Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Repository Corticotropin Injections (for Indiana Only) (continued)	May 1, 2022	Oncology, Repository Corticotropins **Applicable Codes** • Removed list of applicable ICD-10 diagnosis codes: G25.3, G25.9, G40.821, G40.822, G40.823, G40.824, and H55.89 **Supporting Information** • Removed *Background*, *Clinical Evidence*, *FDA*, and *References* sections	
Rituximab (Riabni™, Rituxan®, Ruxience™, & Truxima®) (for Indiana Only)	May 1, 2022	**Coverage Rationale** • Revised language to indicate: ○ This policy refers only to the following drug products: ▪ Riabni™ (rituximab-arrx) ▪ Rituxan® (rituximab)† ▪ Rituxan Hycela® (rituximab and hyaluronidase human) ▪ Ruxience™ (rituximab-pvvr) ▪ Truxima® (rituximab-abbs) ▪ Any FDA-approved rituximab biosimilar product not listed here ○ The following drug products are medically necessary for the treatment of certain conditions outlined within the InterQual® criteria; for medical necessity clinical coverage criteria, refer to the current release of the InterQual® guideline: ▪ Riabni™ (rituximab-arrx):	This policy refers only to the following drug products: • Riabni™ (rituximab-arrx) • Rituxan® (rituximab)† • Rituxan Hycela® (rituximab and hyaluronidase human)* • Ruxience™ (rituximab-pvvr) • Truxima® (rituximab-abbs) • Any FDA-approved rituximab biosimilar product not listed here† The following drug products are medically necessary for the treatment of certain conditions outlined within the InterQual® criteria. For medical necessity clinical coverage criteria, refer to the current release of the InterQual® guideline: • Riabni™ (rituximab-arrx): CP: Specialty Rx Non-Oncology, Rituximab-arrx (Riabni) or CP: Specialty Rx Oncology, Rituximab-arrx (Riabni) • Rituxan® (rituximab): CP: Specialty Rx Non-Oncology, Rituximab (Rituxan) or CP: Specialty Rx Oncology, Rituximab (Rituxan) • Ruxience™ (rituximab-pvvr): CP: Specialty Rx Non-Oncology, Rituximab-pvvr (Ruxience) or CP: Specialty Rx Oncology, Rituximab-pvvr (Ruxience) • Truxima® (rituximab-abbs): CP: Specialty Rx Non-Oncology, Rituximab-abbs (Truxima) or CP: Specialty Rx Oncology, Rituximab-abbs (Truxima) • Any FDA-approved rituximab biosimilar product not listed here†

Medical Benefit Drug Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Rituximab (Riabni™, Rituxan®, Ruxience™, & Truxima®) (for Indiana Only) (continued)	May 1, 2022	CP: Specialty Rx Non-Oncology, Rituximab-arrx (Riabni) or CP: Specialty Rx Oncology, Rituximab-arrx (Riabni) ▪ Rituxan® (rituximab) : CP: Specialty Rx Non-Oncology, Rituximab (Rituxan) or CP: Specialty Rx Oncology, Rituximab (Rituxan) ▪ Ruxience™ (rituximab-pvvr) : CP: Specialty Rx Non-Oncology, Rituximab-pvvr (Ruxience) or CP: Specialty Rx Oncology, Rituximab-pvvr (Ruxience) ▪ Truxima® (rituximab-abbs) : CP: Specialty Rx Non-Oncology, Rituximab-abbs (Truxima) or CP: Specialty Rx Oncology, Rituximab-abbs (Truxima) ▪ Any FDA-approved rituximab biosimilar product not listed here – Any U.S. Food and Drug Administration approved and launched rituximab biosimilar product not listed by name in this policy will be	*Rituxan Hycela is unproven and not medically necessary for the treatment of non-oncology indications. For oncology indications and for Rituxan Hycela (rituximab/hyaluronidase human), refer to the Medical Benefit Drug Policy titled Oncology Medication Clinical Coverage (for Indiana Only) for updated information based upon the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium® (NCCN Compendium®). †Any U.S. Food and Drug Administration approved and launched rituximab biosimilar product not listed by name in this policy will be considered non-preferred until reviewed by UnitedHealthcare.

Medical Benefit Drug Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Rituximab (Riabni™, Rituxan®, Ruxience™, & Truxima®) (for Indiana Only) (continued)	May 1, 2022	considered non-preferred until reviewed by UnitedHealthcare • Rituxan Hycela is unproven and not medically necessary for the treatment of non-oncology indications; for oncology indications and for Rituxan Hycela (rituximab/hyaluronidase human), refer to the Medical Benefit Drug Policy titled *Oncology Medication Clinical Coverage (for Indiana Only)* for updated information based upon the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium® (NCCN Compendium®) **Applicable Codes** • Removed list of applicable ICD-10 diagnosis codes **Supporting Information** • Removed *Background*, *Clinical Evidence*, *FDA*, and *References* sections	
Tysabri® (Natalizumab) (for Indiana Only)	May 1, 2022	**Coverage Rationale** • Revised language to indicate Tysabri (natalizumab) is proven and medically necessary for the treatment of certain conditions outlined within the InterQual criteria; for medical necessity clinical coverage criteria, refer to	Tysabri® (natalizumab) is proven and medically necessary for the treatment of certain conditions outlined within the InterQual criteria. For medical necessity clinical coverage criteria, refer to the current release of the InterQual® guideline, CP: Specialty Rx Non-Oncology Natalizumab (Tysabri). Click here to view the InterQual® criteria.

Medical Benefit Drug Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Tysabri® (Natalizumab) (for Indiana Only) (continued)	May 1, 2022	the current release of the InterQual® guideline, CP: Specialty Rx Non-Oncology, Natalizumab (Tysabri) **Applicable Codes** • Removed list of applicable ICD-10 diagnosis codes: G35, K50.00, K50.011, K50.012, K50.013, K50.014, K50.018, K50.019, K50.10, K50.111, K50.112, K50.113, K50.114, K50.118, K50.119, K50.80, K50.811, K50.812, K50.813, K50.814, K50.818, K50.819, K50.90, K50.911, K50.912, K50.913, K50.914, K50.918, and K50.919 **Supporting Information** • Removed *Background*, *Clinical Evidence*, *FDA*, and *References* sections	

General Information

The inclusion of a health service (e.g., test, drug, device or procedure) in this bulletin indicates only that UnitedHealthcare is adopting a new policy and/or updated, revised, replaced or retired an existing policy; it does not imply that UnitedHealthcare provides coverage for the health service. Note that most benefit plan documents exclude from benefit coverage health services identified as investigational or unproven/not medically necessary. Physicians and other health care professionals may not seek or collect payment from a member for services not covered by the applicable benefit plan unless first obtaining the member's written consent, acknowledging that the service is not covered by the benefit plan and that they will be billed directly for the service.

Note: The absence of a policy does not automatically indicate or imply coverage. As always, coverage for a health service must be determined in accordance with the member's benefit plan and any applicable federal or state regulatory requirements. Additionally, UnitedHealthcare reserves the right to review the clinical evidence supporting the safety and effectiveness of a medical technology prior to rendering a coverage determination.

UnitedHealthcare respects the expertise of the physicians, health care professionals, and their staff who participate in our network. Our goal is to support you and your patients in making the most informed decisions regarding the choice of quality and cost-effective care, and to support practice staff with a simple and predictable administrative experience. The Medical Policy Update Bulletin was developed to share important information regarding UnitedHealthcare Community Plan of Indiana Medical Policy, Medical Benefit Drug Policy, Coverage Determination Guideline, and Utilization Review Guideline updates. When information in this bulletin conflicts with applicable state and/or federal law, UnitedHealthcare follows such applicable federal and/or state law.

Policy Update Classifications

New

New clinical coverage criteria have been adopted for a health service (e.g., test, drug, device or procedure)

Updated

An existing policy has been reviewed and changes have not been made to the clinical coverage criteria; however, items such as the clinical evidence, FDA information, and/or list(s) of applicable codes may have been updated

Revised

An existing policy has been reviewed and revisions have been made to the clinical coverage criteria

Replaced

An existing policy has been replaced with a new or different policy

Retired

The health service(s) addressed in the policy are no longer being managed or are considered to be proven/medically necessary and are therefore not excluded as unproven/not medically necessary services, unless coverage guidelines or criteria are otherwise documented in another policy

The complete library of UnitedHealthcare Community Plan of Indiana Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, and Utilization Review Guidelines is available at UHCprovider.com/Indiana > Medicaid (Community Plan) > Current Policies and Clinical Guidelines > UnitedHealthcare Community Plan of Indiana Medical & Drug Policies and Coverage Determination Guidelines.