United Healthcare Medicare Advantage

UnitedHealthcare Medicare Advantage

Coverage Summary Update Bulletin: October 2021

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Updated

Revised

Coverage Summary Updates

Updated

Policy Title	Approval Date	Summary of Changes
Electrical and Spinal Cord Stimulators	Sep. 21, 2021	Title Change • Previously titled *Stimulators: Electrical and Spinal Cord Stimulators*
Organ and Tissue Transplants	Sep. 21, 2021	Title Change • Previously titled *Transplants: Organ and Tissue Transplants*
Osteogenic Stimulators	Sep. 21, 2021	Title Change • Previously titled *Stimulators: Osteogenic Stimulators*
Pain Management and Rehabilitation	Sep. 21, 2021	Title Change • Previously titled *Pain Management and Pain Rehabilitation* Supporting Information • Updated list of available Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) to reflect the most current reference links

Revised

Policy Title	Approval Date	Summary of Changes
Chemotherapy and Associated Drugs and Treatments	Sep. 21, 2021	Coverage Guidelines *Off-Label Use of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen* Compendia Access for Providers (NCCN) • Removed language addressing member applicability for the oncology program described in the NCCN Drugs and Biologics Compendium (NCCN Compendium®) *Examples of Chemotherapy Services* Rituximab (Rituxan®) • Updated language to clarify Medicare does not have a National Coverage Determination (NCD) for Rituximab (Rituxan®) *for chemotherapeutic indications* • Revised default guidelines for states/territories with no Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs): ○ Added reference link to the UnitedHealthcare Commercial Medical Benefit Drug Policy titled *Oncology Medication Clinical Coverage* ○ Removed reference link to the National Government Services LCD for *Drugs and Biologicals, Coverage of, for Label and Off-Label Uses (L33394)*
Enteral and Parenteral Nutritional Therapy	Sep. 21, 2021	Title Change • Previously titled *Nutritional Therapy: Enteral and Parenteral Nutritional Therapy*

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Enteral and Parenteral Nutritional Therapy (continued)	Sep. 21, 2021	Coverage Guidelines *Enteral Nutritional Therapy* • Added language to indicate Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable; refer to the Durable Medical Equipment (DME) MAC LCD for *Enteral Nutrition (L38955)* • Removed reference link to the DME MAC Joint Article titled *Retirement of Enteral Nutrition LCD and Related Policy Article* for claims with dates of service on or after Nov. 12, 2020 *Parenteral Nutritional Therapy* • Added language to indicate LCDs/LCAs exist and compliance with these policies is required where applicable; refer to the DME MAC LCD for *Parenteral Nutrition (L38953)* • Removed reference link to the DME MAC Joint Article titled *Retirement of Parenteral Nutrition LCD (L33798) and related Policy Article (A52515)* effective for claims with dates of service on or after Nov.12, 2020

Medications/Drugs (Outpatient/Part B)	Sep. 21, 2021	Coverage Guidelines
		Part D Medications/Drugs
		• Revised language pertaining to “medically-accepted indication” to indicate:
		  ○ Section 1860D-2(e)(4) of the Social Security Act defines “medically-accepted indication” in part by reference to section 1927(k)(6) of the Act, to any use of a covered Part D drug which is approved under the Federal Food, Drug, and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia described in section 1927(g)(1)(B)(i) of the Act
		  ○ The recognized compendia are:
		  ▪ American Hospital Formulary Service Drug Information
		  ▪ DRUGDEX® Information System
		Immunosuppressive Drugs
		• Removed instruction on appropriate billing
		Other Examples of Specific Drugs/Medications
		Colony Stimulating Factors (Short Acting)
		• Updated list of applicable drugs/medications; added:
		  ○ Tbo-Filgrastim
		  ○ Filgrastim
		  ○ Filgrastim-Aafi
		  ○ Filgrastim-Sndz
		Colony Stimulating Factors (Long Acting)

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Medications/Drugs (Outpatient/Part B) (continued)	Sep. 21, 2021	• Updated list of applicable drugs/medications; added:
		  ○ Pegfilgrastim-Jmdb
		  ○ Pegfilgrastim
		  ○ Pegfilgrastim-Apgf
		  ○ Pegfilgrastim-Cbqv
		  ○ Pegfilgrastim-Bmez
		Erythropoietin for Cancer Related Conditions
		• Revised language to indicate Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable
		Erythropoietin for Non-Cancer Related Conditions
		• Added instruction to refer to the UnitedHealthcare Commercial Medical Benefit Drug Policy titled *Erythropoiesis-Stimulating Agents* for states with no LCDs/LCAs
		• Added step therapy requirement; refer to the UnitedHealthcare Medicare Advantage Medical Benefit Injectable Policy titled *Medicare Part B Step Therapy Programs*
		Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors
		• Updated list of applicable drugs/medications; replaced "*Compounded* Avastin® (Bevacizumab)" with "Avastin® (Bevacizumab)"
		Supporting Information
		• Updated list of available LCDs/LCAs to reflect the most current reference links

Orthopedic Procedures, Devices and Products	Sep. 21, 2021	**Coverage Guidelines**
		Collagen Meniscus Implant
		• Revised language to indicate:
		  ○ Collagen meniscus implant (also referred to as collagen scaffold [CS], CMI, or Menaflex™ meniscus implant throughout the published literature) is used to fill meniscal defects that result from partial meniscectomy
		  ○ For claims with dates of service performed on or after May 25, 2010, the Centers for Medicare & Medicaid Services (CMS) has determined that the evidence is adequate to conclude that the collagen meniscus implant does not improve health outcomes and, therefore, is not reasonable and necessary for the treatment of meniscal injury/tear under section 1862(a)(1)(A) of the Social Security Act; thus, the collagen meniscus implant is non-covered by Medicare
		  ○ Refer to the National Coverage Determination (NCD) for *Collagen Meniscus Implant (150.12)*
		Extracorporeal Shock Wave Therapy (ESWT) (CPT codes 28890, 0101T and 0102T)
		• Revised language pertaining to Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) to indicate:

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Orthopedic Procedures, Devices and Products (continued)	Sep. 21, 2021	○ LCDs/LCAs exist and compliance with these policies is required where applicable; -see the list of available LCDs/LCAs for Extracorporeal Shock Wave Therapy (ESWT) in the *Supporting Information* section of the policy ○ For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled *Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions and Soft Tissue Wounds* *Bone or Soft Tissue Healing and Fusion Enhancement* Platelet-Rich Plasma (PRP) (CPT code 0232T) • Revised language pertaining to LCDs/LCAs to indicate: ○ LCDs/LCAs exist and compliance with these policies is required where applicable; see the list of available LCDs/LCAs for Platelet-Rich Plasma (PRP) in the *Supporting Information* section of the policy ○ For coverage guidelines for states/territories with no LCDs/LCAs refer to the UnitedHealthcare Commercial Medical Policy titled *Prolotherapy and Platelet Rich Plasma Therapies* Supporting Information • Added list of available LCDs/LCAs for: ○ Extracorporeal Shock Wave Therapy (ESWT) ○ Platelet-Rich Plasma (PRP)
Prostate: Services and Procedures	Sep. 21, 2021	Coverage Guidelines *UroLift® System (CPT codes 52441, 52442, C9739 and C9740)* • Revised default guidelines for the UroLift® System: ○ Added reference link to the UnitedHealthcare Commercial Medical Policy titled *Prostate Surgeries and Interventions* ○ Removed reference link to the InterQual® CP: Client Defined 2021, CP: Procedures Prostate Surgery (Custom) – UHG

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.

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 Policy Update Bulletin was developed to share important information regarding UnitedHealthcare Medicare Advantage Coverage Summary updates. When information in this bulletin conflicts with applicable state and/or federal law, UnitedHealthcare follows such applicable federal and/or state law.

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 CMS, 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.

Policy Update Classifications

New

New coverage guidelines 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 coverage guidelines; however, items such as the definitions or references may have been updated

Revised

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

Replaced

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

Retired

An existing policy has been retired because national and local coverage determinations from the Centers for Medicare and Medicaid Services (CMS) are no longer available or the applicable coverage guidelines are documented in another policy

The complete library of UnitedHealthcare Medicare Advantage Coverage Summaries is available at UHCprovider.com > Policies and Protocols > Medicare Advantage Policies > Coverage Summaries.