United Healthcare Community Plan

UnitedHealthcare Community Plan of Louisiana
Medical Policy Update Bulletin: July 2022

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Quarterly CPT® and HCPCS Code Updates

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 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
Cell-Free Fetal DNA Testing (for Louisiana Only)	Medical Policy	• Added CPT code 0327U
Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes (for Louisiana Only)	Medical Policy	• Added HCPCS codes G0308 and G0309
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation (for Louisiana Only)	Medical Policy	• Added CPT code 0720T
Immune Globulin (IVIG and SCIG) (for Louisiana Only)	Medical Benefit Drug Policy	• Added HCPCS code J1551
Molecular Oncology Testing for Cancer Diagnosis, Prognosis, and Treatment Decisions (for Louisiana Only)	Medical Policy	• Added CPT codes 0326U, 0329U, and 0331U
Ryplazim® (Plasminogen, Human-Tvmh) (for Louisiana Only)	Medical Benefit Drug Policy	• Replaced J3490 and J3590 with J2998 • Removed C9090
Surgical Treatment for Spine Pain (for Louisiana Only)	Medical Policy	• Added CPT code 0719T
Tezspire™ (Tezepelumab) (for Louisiana Only)	Medical Benefit Drug Policy	• Replaced HCPCS codes C9399, J3490, and J3590 with J2356

Medical Policy Updates

New		
Policy Title	**Effective Date**	**Coverage Rationale**

Liposuction for Lipedema (for Louisiana Only)	Aug. 1, 2022	**Lipedema**
		Liposuction for lipedema is considered reconstructive and medically necessary to treat Functional Impairment when all of the following criteria are met:
		• A diagnosis of lipedema that meets the following criteria:
		  ○ Absence of pitting edema from lipedema; and
		  ○ Bilateral and symmetrical manifestation with minimal involvement of the feet; and
		  ○ Disproportionate adipocyte hypertrophy of the lower extremities in relationship to the trunk; and
		  ○ Photographs of the area to be treated that document disproportional fat distribution consistent with diagnosis; and
		  ○ Failure of the limb adipose hypertrophy to respond to recommended bariatric surgery or other medically supervised weight loss modalities, if Class II or III Obesity; and
		  ○ Negative Stemmer Sign; and
		  ○ Pressure induced pain and tenderness on palpation
		• Failure to respond to 6 or more months of Conservative Treatment (compression or manual therapy); and
		• Treatment plan includes all of the following:
		  ○ Assessment by the referring primary care provider or a specialist in vascular conditions (different from the treating surgeon) confirms that lipedema is an independent cause of the Functional Impairment (interference with activities of daily living) and the surgery is expected to restore or improve the Functional Impairment; and
		  ○ Treatment for each body area (e.g., extremity) will take place within a 12-month period following the initial surgical treatment of that body area, unless it is medically contraindicated to proceed with complete surgical intervention during the allotted time; and
		  ○ Documentation that the request is not a re-treatment of a previously treated area; and
		  ○ The postoperative plan of care is to continue to wear compression garments as instructed and continue Conservative Treatment
		
		Liposuction for lipedema is not medically necessary when performed for cosmetic purposes (i.e., procedures or services that change or improve appearance without significantly improving Functional Impairment).

Medical Benefit Drug Policy Updates

New

Policy Title	Effective Date	Coverage Rationale
Vyvgart™ (Efgartigimod Alfa-Fcab) (for Louisiana Only)	Aug. 1, 2022	**Myasthenia Gravis** Vyvgart proven and medically necessary when the following criteria are met: • Initial Therapy: ○ Submission of medical records (e.g., chart notes, laboratory values, etc.) to support the diagnosis of generalized myasthenia gravis (gMG) by a neurologist or in consultation with a neurologist confirming all of the following: ▪ Patient has not failed a previous course of Vyvgart therapy; and ▪ Positive serologic test for anti-AChR antibodies; and ▪ One of the following: – History of abnormal neuromuscular transmission test demonstrated by single-fiber electromyography (SFEMG) or repetitive nerve stimulation – History of positive anticholinesterase test, e.g., edrophonium chloride test – Patient has demonstrated improvement in MG signs on oral cholinesterase inhibitors, as assessed by the treating neurologist and ▪ Patient has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of class II, III, or IV at initiation of therapy; and ▪ Patient has a Myasthenia Gravis-specific Activities of Daily Living scale (MG-ADL) total score ≥ 5 at initiation of therapy and ○ Both of the following: ▪ History of failure of at least two immunosuppressive agents over the course of at least 12 months [e.g., azathioprine, methotrexate, cyclosporine, mycophenylate, etc.]; and ▪ Patient has required 2 or more courses of plasmapheresis/ plasma exchanges and/or intravenous immune globulin for at least 12 months without symptom control and ○ Patient is currently on a stable dose (at least 2 months) of immunosuppressive therapy; and ○ Patient is not receiving Vyvgart in combination with Soliris (eculizumab); and ○ Vyvgart is initiated and titrated according to the US FDA labeled dosing for gMG, up to a maximum of 1200 mg per dose; and ○ Prescribed by, or in consultation with, a neurologist; and ○ Initial authorization will be for no more than 6 months. • Continuation of Therapy: ○ Patient has previously been treated with Vyvgart; and

Medical Benefit Drug Policy Updates

New

Policy Title	Effective Date	Coverage Rationale
Vyvgart™ (Efgartigimod Alfa-Fcab) (for Louisiana Only) (continued)	Aug. 1, 2022	○ Submission of medical records (e.g., chart notes, laboratory tests) to demonstrate a positive clinical response from baseline as demonstrated by all of the following: ▪ Improvement and/or maintenance of at least a 2 point improvement (reduction in score) in the MG-ADL score from pre-treatment baseline. ▪ Reduction in signs and symptoms of myasthenia gravis ▪ Maintenance, reduction, or discontinuation of dose(s) of baseline immunosuppressive therapy (IST) prior to starting Vyvgart. Note: Add on, dose escalation of IST, or additional rescue therapy from baseline to treat myasthenia gravis or exacerbation of symptoms while on Vyvgart therapy will be considered as treatment failure. and ○ Patient is not receiving Vyvgart in combination with Soliris (eculizumab); and ○ Vyvgart is dosed according to the US FDA labeled dosing for gMG: up to a maximum of 1200 mg per dose; and ○ Prescribed by, or in consultation with, a neurologist; and ○ Reauthorization will be for no more than 12 months.

Updated

Policy Title	Effective Date	Summary of Changes
Medical Therapies for Enzyme Deficiencies (for Louisiana Only)	Jul. 1, 2022	Coverage Rationale ● Removed reference to the Medical Benefit Drug Policy titled *Review at Launch for New to Market Medications* for Nexviazyme (avalglucosidase alfa-ngpt) Supporting Information ● Updated *References* section to reflect the most current information

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