United Healthcare Medicare Advantage

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Coverage Summary Update Bulletin: April 2023

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Updated

Policy Title	Approval Date	Summary of Changes

Neurologic Services and Procedures	Mar. 1, 2023	**Coverage Guidelines**
		• Updated notation pertaining to applicable coverage policies for procedures not addressed in this Coverage Summary; removed reference link to the:
		  ○ National Coverage NCD Report
		  ○ Local Coverage Final LCDs Report
		• Removed content/language addressing ambulatory EEG monitoring

Wound Treatments	Mar. 1, 2023	**Coverage Guidelines** ***Topical Application of Oxygen (HCPCS Code E0446)*** • Removed reference link to the National Coverage Determination (NCD) for *Hyperbaric Oxygen (HBO) Therapy (NCD 20.29)* **Supporting Information** • Updated list of available Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) to reflect the most current information

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Cardiac Procedures: Pacemakers, Pulmonary Artery Pressure Measurements and Ventricular Assistive Devices	Mar. 1, 2023	**Coverage Guidelines**
		Pulmonary Artery Pressure Measurements (CardioMEMS™ HF System) (CPT codes 33289, 93264, and C2624)
		• Added reference link to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes*
		• Removed reference link to the:
		  ○ UnitedHealthcare Medicare Advantage Coverage Summary titled *Experimental Procedures and Items, Investigational Devices and Clinical Trials*
		  ○ Centers for Medicare & Medicaid Services (CMS) Approved IDE Studies information website for *CardioMEMS™ HF System/Hemodynamic-GUIDEd Management of Heart Failure (GUIDE-HF)*

Electrical and Ultrasonic Stimulators	Mar. 1, 2023	**Coverage Guidelines** ***Percutaneous Peripheral Nerve Stimulation (PNS) [SPRINT endura® and SPRINT extensa® Systems (CPT Code 64555)]*** *(new to policy)* • Added language to indicate: ○ Medicare does not have a National Coverage Determination (NCD) that specifically addresses the SPRINT endura® and SPRINT extensa® percutaneous peripheral nerve stimulators

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Electrical and Ultrasonic Stimulators (continued)	Mar. 1, 2023	○ Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable; for state specific LCDs/LCAs, refer to the list of available LCDs/LCAs for percutaneous peripheral nerve stimulation (PNS) 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 *Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation* ***Percutaneous Electrical Nerve Stimulation (PENS)/Percutaneous Neuromodulation Therapy (PNT) for Pain Therapy*** • Revised language pertaining to LCD/LCA availability to indicate LCDs/LCAs do not exist; for coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled *Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation* • Removed example of pain management device (BioWave) **Supporting Information** • Updated list of available LCDs/LCAs: ○ Added *Percutaneous Peripheral Nerve Stimulation (PNS) [SPRINT endura® and SPRINT extensa® Systems (CPT Code 64555)]* ○ Removed *Percutaneous Electrical Nerve Stimulation (PENS)/Percutaneous Neuromodulation Therapy (PNT) for Pain Therapy*
Medications/Drugs (Outpatient/Part B)	Mar. 1, 2023	**Coverage Guidelines** ***Other Examples of Specific Drugs/Medications*** • Added coverage guidelines for: Syfovre™ (Pegcetacoplan Injection) ○ Added language to indicate a pre-service review [Review at Launch (RAL)] is required • Revised coverage guidelines for: Hemgenix® (Etranacogene Dezaparvovec-Drlb) ○ Added instruction to refer to the UnitedHealthcare Commercial Medical Benefit Drug Policy titled *Hemgenix® (Etranacogene Dezaparvovec-Drlb* ○ Removed language indicating a pre-service review [Review at Launch (RAL)] is required Spevigo® (Spesolimab-Sbzo) ○ Added instruction to refer to the UnitedHealthcare Commercial Medical Benefit Drug Policy titled *Spevigo® (Spesolimab-Sbzo)* Tzield™ (Teplizumab-Mzwv)

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Medications/Drugs (Outpatient/Part B) (continued)	Mar. 1, 2023	○ Added instruction to refer to the UnitedHealthcare Commercial Medical Benefit Drug Policy titled *Tzield™ (Teplizumab-Mzwv)* ○ Removed language indicating a pre-service review [Review at Launch (RAL)] is required
Respiratory Therapy, Pulmonary Rehabilitation and Pulmonary Services	Mar. 1, 2023	**Coverage Guidelines** • Updated notation pertaining to applicable coverage policies for procedures not addressed in this Coverage Summary; removed reference link to the: ○ National Coverage NCD Report ○ Local Coverage Final LCDs Report **Pulmonary Rehabilitation** • Revised language pertaining to *42 CFR 410.47* to indicate Medicare Part B covers pulmonary rehabilitation for beneficiaries: ○ With moderate to very severe COPD (defined as GOLD classification II, III and IV), when referred by the physician treating the chronic respiratory disease; ○ Who have had confirmed or suspected COVID-19 and experience persistent symptoms that include respiratory dysfunction for at least four weeks (effective Jan. 1, 2022); ○ Additional medical indications for coverage for pulmonary rehabilitation may be established through a National Coverage Determination (NCD) • Revised list of pulmonary rehabilitation program components; added language to indicate the individualized treatment plan must be established, reviewed, and signed by a physician every 30 days • Removed notation pertaining to the Centers for Medicare & Medicaid (CMS) Calendar Year (CY) *2022 Medicare Physician Fee Schedule (PFS) final rule*
Urinary and Fecal Incontinence, Diagnosis and Treatments	Mar. 1, 2023	**Related Policies** • Removed reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Biofeedback Therapy* **Coverage Guidelines** • Removed content/language addressing posterior tibial nerve stimulation (PTNS) ***Sacral Nerve Stimulation (SNS) for Fecal Incontinence*** • Added instruction to refer to the list of available Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) for *Sacral Nerve Stimulation for Fecal Incontinence* **Definitions** • Removed definition of "Posterior Tibial Nerve Stimulation (PTNS)" **Supporting Information** • Removed list of available LCDs/LCAs for *Posterior Tibial Nerve Stimulation (PTNS)*

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

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