

UnitedHealthcare Medicare Advantage Coverage Summary Update Bulletin: January 2023

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Coverage Summary Updates

Updated		
Policy Title	Approval Date	Summary of Changes
Diabetes Management, Equipment and Supplies	Dec. 7, 2022	<p>Coverage Guidelines</p> <p><i>Continuous Glucose Monitors (CGMs)</i></p> <ul style="list-style-type: none"> Added reference link to the Centers for Medicare & Medicaid Services (CMS) <i>Healthcare Common Procedure Coding System (HCPCS) Level II Final Coding, Benefit Category and Payment Determinations</i> application summary <p>Non-Adjunctive CGM Devices and Supplies (HCPCS codes A4239 and E2103)</p> <ul style="list-style-type: none"> Updated list of applicable HCPCS codes: <ul style="list-style-type: none"> Added A4239 and E2103 Removed K0553 and K0554
Revised		
Policy Title	Approval Date	Summary of Changes
Hearing Services and Devices	Dec. 7, 2022	<p>Coverage Guidelines</p> <p><i>Cochlear Implants and Auditory Brainstem Implants</i></p> <ul style="list-style-type: none"> Revised language to indicate cochlear implants and auditory brainstem implants (i.e., devices that replace the function of cochlear structures or auditory nerve and provide electrical energy to auditory nerve fibers and other neural tissue via implanted electrode arrays) are covered when criteria are met; refer to the National Coverage Determination (NCD) for <i>Cochlear Implantation (50.3)</i> <ul style="list-style-type: none"> Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable; these LCDs/LCAs are available at https://www.cms.gov/medicare-coverage-database/search.aspx Effective for services performed on or after Sep. 26, 2022, the Centers for Medicare & Medicaid Services (CMS) is expanding coverage by broadening the patient criteria and removing the requirement that for individuals with hearing test scores of > 40 % and ≤ 60 %, cochlear implantation may be covered only when the provider is participating in and patients are enrolled in either an FDA-approved category B Investigational Devices Exemption (IDE) clinical trial, a trial under the CMS Clinical Trial Policy, or a prospective, controlled comparative trial approved by CMS; refer to the CMS Decision Memo for <i>Cochlear Implantation (CAG-00107R)</i> <ul style="list-style-type: none"> The list of Medicare approved clinical trials is available at http://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Cochlear-Implantation-.html For payment rules for NCDs requiring Coverage with Evidence Development (CED), refer to the: <ul style="list-style-type: none"> UnitedHealthcare Medicare Advantage Coverage Summary titled <i>Experimental Procedures and Items, Investigational Devices and Clinical Trials</i> NCD for <i>Cochlear Implantation (50.3)</i> <i>Medicare Benefit Policy Manual, Chapter 16, §100 – Hearing Aids and Auditory Implants</i>

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Hearing Services and Devices (continued)	Dec. 7, 2022	<ul style="list-style-type: none"> ○ Patients return to the implanting center after 4 to 5 weeks of post-surgery healing to have their speech processor programmed <ul style="list-style-type: none"> ▪ The patient’s age, cognitive skills, and length of deafness are among the factors considered during device programming, which entails selection and fitting of the processing strategy that will be used to translate acoustic stimuli into the electric impulses that will stimulate the auditory nerve ▪ The number of visits needed to accomplish optimum device performance will be influenced by such patient factors as age, previous auditory experience, and ability to participate actively in the task ▪ Long-term audiologic follow-up is also necessary as responses to nerve stimulation may change over time ▪ Refer to the CMS Decision Memo for <i>Cochlear Implantation (CAG-00107N)</i> ○ For repair, maintenance, and replacement, refer to the <i>Repairs, Maintenance and Replacement</i> section of the UnitedHealthcare Medicare Advantage Coverage Summary titled <i>Durable Medical Equipment, Prosthetics, Corrective Appliances/Orthotics and Medical Supplies</i>
Medications/Drugs (Outpatient/Part B)	Dec. 7, 2022	<p>Coverage Guidelines</p> <p><i>Unlabeled Use of a Part B Drug</i></p> <ul style="list-style-type: none"> ● Added language to clarify the list of major drug compendia is for <i>Off-Label Use of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen</i> <p><i>Other Examples of Specific Drugs/Medications</i></p> <ul style="list-style-type: none"> ● Added coverage guidelines for the following drugs/medications: <ul style="list-style-type: none"> ○ Step Therapy Required (refer to the UnitedHealthcare Medicare Advantage Medical Benefit Injectable Policy titled <i>Medicare Part B Step Therapy Programs</i> for details): <ul style="list-style-type: none"> ▪ Evenity® (romosozumab-aqqg) ▪ Gonadotropin Releasing Hormone Analogs ▪ Intravenous Immune Globulin (IVIg) ▪ Leuprolide Acetate ▪ Krystexxa® (pegloticase) ▪ Subcutaneous Immune Globulin (SCIG) ○ Review at Launch (RAL) Required: <ul style="list-style-type: none"> ▪ Hemgenix® (etranacogene dezaparvovec-drlb) ▪ Teplizumab ▪ Tzield™ (teplizumab-mzww) <p>Aduhelm™ (Aducanumab-Avwa)</p> <ul style="list-style-type: none"> ● Added reference link to the National Coverage Determination (NCD) for <i>Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease (AD)</i>

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Revised		
Policy Title	Approval Date	Summary of Changes
Medications/Drugs (Outpatient/Part B) (continued)	Dec. 7, 2022	<ul style="list-style-type: none"> Removed reference link to the Centers for Medicare & Medicaid (CMS) Final Decision Memo for <i>Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease (CAG-00460N)</i> <p>Amvuttra™ (Vutrisiran)</p> <ul style="list-style-type: none"> Added instruction to refer to the UnitedHealthcare Commercial Medical Benefit Drug Policy titled <i>RNA-Targeted Therapies (Amvuttra™ and Onpattro®)</i> for states with no Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) Revised coverage guidelines to indicate a pre-service review [Review at Launch (RAL)] is no longer required <p>Colony Stimulating Factors (Long Acting)</p> <ul style="list-style-type: none"> Updated list of applicable drugs/medications; added: <ul style="list-style-type: none"> Fylnetra® (pegfilgrastim-pbbk) Rolvedon™ (eflapegastim-xnst) Stimufend® (pegfilgrastim-fpgk) <p>Denosumab</p> <ul style="list-style-type: none"> Revised coverage guidelines to indicate step therapy is now required (refer to the UnitedHealthcare Medicare Advantage Medical Benefit Injectable Policy titled <i>Medicare Part B Step Therapy Programs</i> for details) <p>Intravenous Iron Therapy for Non-Dialysis Patients</p> <ul style="list-style-type: none"> Revised coverage guidelines to indicate step therapy is now required (refer to the UnitedHealthcare Medicare Advantage Medical Benefit Injectable Policy titled <i>Medicare Part B Step Therapy Programs</i> for details) <p>Intravitreal Vascular Endothelial Growth Factor (VEGF) Inhibitors</p> <ul style="list-style-type: none"> Updated list of applicable drugs/medications; added Cimerli™ (ranibizumab-eqrn) <p>Saphnelo™ (Anifrolumab-Fnia)</p> <ul style="list-style-type: none"> Revised coverage guidelines to indicate step therapy is now required (refer to the UnitedHealthcare Medicare Advantage Medical Benefit Injectable Policy titled <i>Medicare Part B Step Therapy Programs</i> for details) <p>Skyrizi® (Risankizumab-Rzaa)</p> <ul style="list-style-type: none"> Added instruction to refer to the UnitedHealthcare Commercial Medical Benefit Drug Policy titled <i>Skyrizi® (Risankizumab-Rzaa)</i> for states with no LCDs/LCAs Revised coverage guidelines to indicate a pre-service review [Review at Launch (RAL)] is no longer required <p>Spevigo® (Spesolimab-Sbzo)</p> <ul style="list-style-type: none"> Revised coverage guidelines to indicate a pre-service review [Review at Launch (RAL)] is no longer required <p>Supporting Information</p> <ul style="list-style-type: none"> Updated list of available LCDs/LCAs 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.

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.



The complete library of UnitedHealthcare Medicare Advantage Coverage Summaries is available at UHCprovider.com > Policies and Protocols > Medicare Advantage Policies > [Coverage Summaries](#).

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