United Healthcare Medicare Advantage

UnitedHealthcare Medicare Advantage

Policy Guideline Update Bulletin: July 2023

In This Issue

Policy Guideline Updates — Page

In This Issue

Revised

Retired

Policy Guideline Updates

Updated		
Policy Title	**Approval Date**	**Summary of Changes**
Category III CPT Codes	Jun. 14, 2023	**Applicable Codes** ***Non-Covered*** • Added CPT codes 0714T, 0738T, 0739T, and 0744T • Removed CPT code 0274T **Supporting Information** • Updated *References* section to reflect the most current information
Infusion Pumps (NCD 280.14)	Jun. 14, 2023	**Applicable Codes** ***HCPCS Codes*** Medications • Removed J1551, J1555, J1558, J1559, J1561, J1562, J1569, and J1575 • Removed notation indicating J7799 was "deleted Jun. 30, 2022" ***Diagnosis Codes*** For HCPCS Codes J1555 and J1575 • Removed list of applicable codes: B20, C91.10, C91.11, C91.12, D59.0, D59.11, D59.12, D59.13, D59.19, D69.3, D69.41, D69.6, D70.8, D80.0, D80.1, D80.2, D80.3, D80.4, D80.5, D80.6, D80.7, D80.8, D81.0, D81.1, D81.2, D81.31, D81.4, D81.5, D81.6, D81.7, D81.82, D81.89, D81.9, D82.0, D82.1, D82.4, D83.0, D83.1, D83.2, D83.8, D83.9, G11.3, G25.82, G35, G61.0, G61.81, G61.82, G61.89, G62.89, G64, G70.00, G70.01, H46.8, L10.0, L10.1, L10.2, L10.3, L10.4, L10.5, L10.81, L10.89, L10.9, L12.0, L12.1, L12.8, L12.9, L13.8, L14, L40.1, M30.3, M33.00, M33.01, M33.02, M33.03, M33.09, M33.10, M33.11, M33.12, M33.13, M33.19, M33.20, M33.21, M33.22, M33.29, M33.90, M33.91, M33.92, M33.93, M33.99, M36.0, T86.00, T86.01, T86.02, T86.03, T86.09, and T86.11 For HCPCS Codes J1558 and J7799 (Cutaquig) • Removed list of applicable codes: D80.0, D80.1, D80.2, D80.3, D80.4, D80.5, D80.6, D80.7, D80.8, D81.0, D81.1, D81.2, D81.31, D81.4, D81.5, D81.6, D81.7, D81.82, D81.89, D81.9, D82.0, D82.1, D82.4, D83.0, D83.1, D83.2, D83.8, D83.9, and G11.3 For HCPCS Code J1559 • Removed list of applicable codes: D80.0, D80.1, D80.2, D80.3, D80.4, D80.5, D80.6, D80.7, D80.8, D81.0, D81.1, D81.2, D81.31, D81.4, D81.5, D81.6, D81.7, D81.82, D81.89, D81.9, D82.0, D82.1, D82.4, D83.0, D83.1, D83.2, D83.8, D83.9, G11.3, and G61.81 **Supporting Information** • Updated *References* section to reflect the most current information

Policy Guideline Updates

Updated

Policy Title	Approval Date	Summary of Changes
Spinal Cord Stimulators for Chronic Pain	Jun. 14, 2023	**Applicable Codes** • Added E10.42 and E11.42 for CPT codes 63650, 63655, and 63685 **Supporting Information** • Updated *References* section to reflect the most current information

Revised

Policy Title	Approval Date	Summary of Changes

Avastin® (Bevacizumab)	Jun. 14, 2023	**Policy Summary**
		Guidelines
		• Removed language [included in the referenced *Medicare Benefit Policy Manual – Pub. 100-02, Chapter 15, Section* 50] indicating:
		  ○ Generally, drugs and biologicals are covered only if all of the following requirements are met:
		  ▪ They meet the definition of drugs or biologicals;
		  ▪ They are of the type that are not usually self-administered by the patients who take them;
		  ▪ They meet all the general requirements for coverage of items as incident to a physician's services;
		  ▪ They are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered according to accepted standards of medical practice;
		  ▪ They are not excluded as immunizations; and
		  ▪ They have not been determined by the Food and Drug Administration (FDA) to be less than effective
		  ○ Coverage for medication is based on the patient's condition, the appropriateness of the dose and route of administration, based on the clinical condition, medical necessity, and the standard of medical practice regarding the effectiveness of the drug for the diagnosis and condition; the drug must be used according to the indication and protocol listed in any of the accepted compendia below:
		  ▪ National Comprehensive Cancer Network (NCCN) Drugs and Biologies Compendium
		  ▪ American Hospital Formulary Service-Drug Information (AHFS-DI)
		  ▪ Micromedex DrugDex
		  ▪ Clinical Pharmacology
		  ▪ Lexi-Drugs
		  ○ The compendia employ various rating and recommendation systems that may not be readily cross walked from compendium to compendium
		Cancer
		• Added language to indicate:
		  ○ Drugs or biologicals approved for marketing by the FDA are considered safe and effective when used for

Policy Guideline Updates

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Avastin® (Bevacizumab) (continued)	Jun. 14, 2023	indications specified on the labeling; refer to the *Medicare Benefit Policy Manual – Pub. 100-02, Chapter 15, Section 50.4.1* for the approved use of an FDA approved drug or biological ○ In the case of drugs used in an anti-cancer chemotherapeutic regimen, off-label uses are covered for a medically accepted indication as defined in the *Medicare Benefit Policy Manual – Pub. 100-02, Chapter 15, Section 50.4.5* • Removed language indicating: ○ Use of the drug or biological must be safe and effective and otherwise reasonable and necessary ○ Drugs or biologicals and cancer chemotherapeutic agents approved for marketing by the FDA are considered safe and effective for purposes of this requirement when used for indications specified on the labeling; therefore, payment may be made for an FDA-approved chemotherapeutic drug or biological if: ▪ It was injected on or after the date of the FDA's approval; ▪ It is reasonable and necessary for the individual patient; and ▪ All other applicable coverage requirements are met ○ An unlabeled use of a drug is a use that is not included as an indication on the drug's label as approved by the FDA; FDA approved drugs used for indications other than what is indicated on the official label may be covered if the contractor determines the use to be medically accepted, taking into consideration the major drug compendia, authoritative medical literature and/or accepted standards of medical practice ○ There are many reasons to consider an unlabeled use for a cancer chemotherapy agent; some of these are: ▪ Drugs may be effective for many other cancers in addition to the ones that were considered in the primary labeling of the drug ▪ Many chemotherapeutic agents are given in combinations ▪ Any one of the drugs in the combination may not have been approved in the initial labeling of the products; in addition, the combination of effective chemotherapeutic agents changes over time ▪ Cancer chemotherapeutic agents are always changing and improving over time ▪ Oncologists are often left with few approved treatment options if initial treatment regimens have failed • Removed coding guidelines Ophthalmology • Revised language to indicate vascular endothelial growth factor (VEGF) is a protein that stimulates the growth, proliferation, and survival of vascular endothelial cells ○ VEGF plays a critical role in the development of new blood vessels (angiogenesis), increases vascular permeability in small blood vessels and prevents apoptosis of vascular endothelial cells in immature blood vessels ○ VEGF has been implicated in blood-retinal barrier breakdown and pathological ocular neovascularization *Coverage* • Revised language to indicate:

Policy Guideline Updates

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Avastin® (Bevacizumab) (continued)	Jun. 14, 2023	○ Current scientific literature published in the peer-reviewed core medical journals supports these uses of this drug: ▪ Neovascular age-related macular degeneration (AMD) ▪ Proliferative diabetic retinopathy ▪ Neovascular glaucoma ▪ Diabetic macular edema (DME) ▪ Retinal and iris neovascularizations ▪ Macular edema secondary to branch retinal vein occlusion (BRVO) or central retinal vein occlusions (CRVO) ○ Consistent with the statement by the American Academy of Ophthalmology (AAO) in support of intravitreal use of bevacizumab, physicians should provide appropriate informed consent with respect to the off-label use of this drug and maintain it in the patient chart ○ Dose and frequency should be in accordance with recognized compendia (for off-label uses) ○ When services are performed in excess of established parameters, they may be subject to review for medical necessity *Limitations* • Added language [relocated from the *Questions and Answers (Q&A)* section] to indicate: ○ Bevacizumab is not currently packaged and prepared by the manufacturer in doses appropriate for intravitreal injection ○ Physicians routinely obtain single doses prepared by qualified compounding pharmacies to minimize risk of contamination of the injected drug • Removed language indicating: ○ This service will be considered medically reasonable and necessary only when furnished by a qualified Ophthalmologist ○ Bevacizumab is contraindicated in patients with ocular or periocular infections and in patients with known hypersensitivity to bevacizumab or any of its inactive ingredients ***Coding Guidelines*** • Removed language indicating diagnosis codes must be listed to the most specific number ***Documentation Requirements*** • Relocated and revised documentation requirements to indicate the patient's medical record must contain documentation that fully supports the medical necessity for services included within this policy guideline ○ All documentation must be maintained in the patient's medical record and made available to the contractor upon request ○ Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s])

Policy Guideline Updates

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Avastin® (Bevacizumab) (continued)	Jun. 14, 2023	○ The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient ○ The submitted medical record must support the use of the selected ICD-10-CM code(s) ○ The submitted HCPCS code must describe the service performed **Applicable Codes** ***HCPCS Codes*** • Added HCPCS C9142, J3590, Q5126, and Q5129 ***Diagnosis Codes*** For Cancer • Added C72.1, D19.1, D48.1, Z85.038, Z85.09, Z85.41, and Z85.42 • Removed C79.82 For Ophthalmic • Added notation to indicate H35.141, H35.142, H35.143, H35.151, H35.152, H35.153, H35.161, H35.162, H35.163, H40.51X1, H40.51X2, H40.51X3, H40.51X4, H40.52X1, H40.52X2, H40.52X3, H40.52X4, H40.53X1, H40.53X2, H40.53X3, and H40.53X4 were "deleted Feb. 22, 2023" ***Modifier Codes*** • Removed list of applicable modifiers: KX **Questions and Answers (Q&A)** • Removed Q&A pertaining to HCPCS codes J3490 and J3495 (no longer addressed in the policy) **Supporting Information** • Updated *References* section to reflect the most current information
Immune Globulin	Jun. 14, 2023	**Title Change** • Previously titled *Intravenous Immune Globulin (IVIG)* **Policy Summary** • Revised language to indicate: ***Overview*** ○ Immune serums (immune globulin) provide passive immunity to infectious disease ▪ The protection will be of rapid onset, but of short duration ▪ Immune sera are obtained from pooled human plasma of either general population donors or hyperimmunized donors ▪ It may be administered either by intravenous (IV) or subcutaneous (SC) injection

Policy Guideline Updates

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Immune Globulin (continued)	Jun. 14, 2023	***Guidelines*** Intravenous Immune Globulin (IVIG) ○ IVIg is a solution of human immunoglobulins specifically prepared for intravenous infusion; immunoglobulin contains a broad range of antibodies that specifically act against bacterial and viral antigens ▪ There are several off-label uses for IVIg, especially in neurological disorders ▪ There is good scientific evidence that supports use in a few of the disorders; in others, however, the evidence is either poor or absent ○ This policy addresses the off-label uses of IVIg in certain neurological conditions ○ This policy does not address the use of IVIg in any condition covered by a National Coverage Determination (NCD) or CMS manual instruction; refer to the NCD for *Intravenous Immune Globulin for the Treatment of Autoimmune Mucocutaneous Blistering Diseases (NCD 250.3):* ▪ Idiopathic Thrombocytopenic Purpura (ITP) in Pregnancy ▪ Neurological Disorders ▪ Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) ▪ Acute Immune thrombocytopenia (ITP) ▪ Chronic Refractory Immune thrombocytopenia (ITP) ▪ Symptomatic Human Immunodeficiency Virus (HIV) ▪ Immunoglobulin Deficiencies ▪ Other Disorders for treatment may include but are not limited to: – Chronic Lymphocytic Leukemia with associated hypogammaglobulinemia – Bone Marrow/Stem Cell Transplantation – Kawasaki Disease (Mucocutaneous Lymph Node Syndrome) – Transplantation rejection – Kidney, stem cell or heart, antibody-mediated – Desensitization for a pre-kidney or pre-heart transplantation and – Autoimmune retinopathy (limited to three months unless there is improvement on therapy) Subcutaneous Immune Globulin (SCIG) ○ As in IVIG therapy, subcutaneous immune globulin (SCIG) administration should be individualized for each patient; currently, SCI therapy is Federal Drug Administration (FDA) approved for use in the treatment of PI diseases and CIDP only ○ Many studies have shown that SCIG and IVIG therapy are equivalent for managing PI diseases, and noninferiority has been a standard prerequisite of FDA approval; outcome measures in patients receiving reduced doses of SCIG contrasted with IVIG are not available, with the exception of hospitalization, which was 30% higher in those

Policy Guideline Updates

Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Immune Globulin (continued)	Jun. 14, 2023	receiving the reduced dose **Applicable Codes** ***CPT Codes*** • Added 90283 and 90284 ***HCPCS Codes*** • Added codes J1551, J1555, J1558, J1559, J1562, J1575, and J1576 • Removed C9072 ***Procedure Codes*** For HCPCS Codes J1551, J1555, J1558, J1559, J1561, J1562, J1569, and J1575 • Added list of applicable codes: D80.0, D80.1, D80.2, D80.3, D80.4, D80.5, D80.6, D80.7, D80.8, D81.0, D81.1, D81.2, D81.31, D81.4, D81.5, D81.6, D81.7, D81.82, D81.89, D81.9, D82.0, D82.1, D82.4, D83.0, D83.1, D83.2, D83.8, D83.9, G11.3, and G61.81 ***Coding Clarification*** • Added notation to indicate the ICD procedure codes listed [in the policy] are for SCIG indications/administration; for IVIG indications/administration and/or home use, refer to the related Local Coverage Determinations (LCDs) and Local Coverage Articles (LCAs) **Supporting Information** • Updated *References* section to reflect the most current information
Lucentis® (Ranibizumab)	Jun. 14, 2023	**Policy Summary** ***Guidelines*** • Removed language indicating: ○ Coverage for medication is based on the patient's condition, the appropriateness of the dose and route of administration, based on the clinical condition and the standard of medical practice regarding the effectiveness of the drug for the diagnosis and condition ○ The drug must be used according to the indication and protocol listed in any of the accepted compendia listed below: ▪ National Comprehensive Cancer Network (NCCN) Drugs and Biologies Compendium ▪ Micromedex DrugDex ▪ American Hospital Formulary Service-Drug Information (AHFS-DI) ▪ Clinical Pharmacology ▪ Lexi-Drugs

Policy Guideline Updates

Revised

Policy Title	Approval Date	Summary of Changes
Lucentis® (Ranibizumab) (continued)	Jun. 14, 2023	**Applicable Codes** • Added HCPCS code Q5128 **Supporting Information** • Updated *References* section to reflect the most current information

Retired

The following Policy Guidelines have been retired effective Jun. 14, 2023:

- Abortion (NCD 140.1)
- Implantable Automatic Defibrillators (NCD 20.4)
- Percutaneous Left Atrial Appendage Closure (LAAC) (NCD 20.34)
- Photodynamic Therapy
- Routine Costs in Clinical Trials (NCD 310.1)
- Wrong Surgical or Other Invasive Procedure

General Information

This bulletin provides a list of new, updated, revised, replaced and/or retired UnitedHealthcare Medicare Advantage Policy Guidelines to reflect the most current clinical coverage rules and guidelines developed by the Centers for Medicare & Medicaid Services (CMS). The inclusion of a health service (e.g., test, drug, device or procedure) in this bulletin indicates only that UnitedHealthcare has recently adopted 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. In the event of an inconsistency or conflict between the information provided in this bulletin and the posted policy, the provisions of the posted policy will prevail. 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 Policy 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 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

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 Policy Guidelines is available at **UHCprovider.com** > Policies and Protocols > Medicare Advantage Policies > Policy Guidelines.