United Healthcare Community Plan

UnitedHealthcare Community Plan
Medical Policy Update Bulletin: June 2022

Access a policy listed below for complete details on the latest updates. A comprehensive summary of changes is provided at the bottom of every policy document for your reference. To view a detailed version of this bulletin, click here.

Take Note

InterQual® Release Dates Removed

Effective Jun. 1, 2022, all references to specific InterQual® release dates will be removed from the Medical Policies, Coverage Determination Guidelines, and Utilization Review Guidelines which contain language pertaining to InterQual® criteria; refer to the most current version of the InterQual® criteria, when applicable.

Policy Implementation Delayed

Implementation of the new Medical Policy titled Radiation Therapy: Fractionation, Image-Guidance, and Special Services (for New Jersey Only), previously announced for an effective date of Jun. 1, 2022, has been postponed until Jul. 1, 2022.

Community Plan of Nebraska to Use National Policy Versions

Effective Jun. 1, 2022, Community Plan of Nebraska will no longer maintain state-specific Medical Policies or Coverage Determination Guidelines for the following services; coverage guidelines for the state of Nebraska will now be provided in the Community Plan National policy versions listed below:

Policy Title	Policy Type
Athletic Pubalgia Surgery	Medical Policy
Autologous Cellular Therapy	Medical Policy
Balloon Sinus Ostial Dilation	Medical Policy
Blepharoplasty, Blepharoptosis, and Brow Ptosis Repair	Coverage Determination Guideline
Breast Imaging for Screening and Diagnosing Cancer	Medical Policy
Breast Reduction Surgery	Coverage Determination Guideline
Bronchial Thermoplasty	Medical Policy
Cardiac Event Monitoring	Medical Policy
Chelation Therapy for Non-Overload Conditions	Medical Policy
Cochlear Implants	Medical Policy
Cognitive Rehabilitation	Medical Policy
Corneal Hysteresis and Intraocular Pressure Measurement	Medical Policy
Cytological Examination of Breast Fluids for Cancer Screening or Diagnosis	Medical Policy
Diagnostic Spinal Ultrasonography	Medical Policy
Electrical Bioimpedance for Cardiac Output Measurement	Medical Policy
Epiduroscopy, Epidural Lysis of Adhesions and Discography	Medical Policy
Fecal Calprotectin Testing	Medical Policy
Gastrointestinal Motility Disorders, Diagnosis and Treatment	Medical Policy
Hepatitis Screening	Medical Policy
Implantable Beta-Emitting Microspheres for Treatment of Malignant Tumors	Medical Policy

Policy Title	Policy Type
Intraoperative Hyperthermic Intraperitoneal Chemotherapy (HIPEC)	Medical Policy
Lower Extremity Invasive Diagnostic and Endovascular Procedures	Medical Policy
Macular Degeneration Treatment Procedures	Medical Policy
Meniscus Implant and Allograft	Medical Policy
Neuropsychological Testing Under the Medical Benefit	Medical Policy
Prostate Surgeries and Interventions	Medical Policy
Thermography	Medical Policy
Total Artificial Disc Replacement for the Spine	Medical Policy
Total Artificial Heart and Ventricular Assist Devices	Medical Policy
Transpupillary Thermotherapy	Medical Policy
Umbilical Cord Blood Harvesting and Storage for Future Use	Medical Policy
Visual Information Processing Evaluation and Orthoptic and Vision Therapy	Medical Policy

Medical Policy Updates

Policy Title	Status	Effective Date
Ablative Treatment for Spinal Pain (for New Jersey Only)	Revised	Jul. 1, 2022
Abnormal Uterine Bleeding and Uterine Fibroids (for New Jersey Only)	Revised	Jul. 1, 2022
Airway Clearance Devices (for New Jersey Only)	Revised	Jul. 1, 2022
Apheresis (for Nebraska Only)	Revised	Aug. 1, 2022
Apheresis (for New Jersey Only)	Revised	Jul. 1, 2022
Balloon Sinus Ostial Dilation (for New Jersey Only)	Revised	Jul. 1, 2022
Bariatric Surgery (for Nebraska Only)	Revised	Aug. 1, 2022
Bariatric Surgery (for New Jersey Only)	Revised	Jul. 1, 2022
Breast Imaging for Screening and Diagnosing Cancer (for New Jersey Only)	Updated	Jul. 1, 2022
Cardiovascular Disease Risk Tests	Revised	Aug. 1, 2022
Cell-Free Fetal DNA Testing	Revised	Aug. 1, 2022
Computed Tomographic Colonography (for New Jersey Only)	Revised	Jul. 1, 2022
Computer-Assisted Surgical Navigation for Musculoskeletal Procedures (for Nebraska Only)	Updated	Aug. 1, 2022
Discogenic Pain Treatment (for Nebraska Only)	Revised	Aug. 1, 2022
Discogenic Pain Treatment (for New Jersey Only)	Revised	Jul. 1, 2022
Electric Tumor Treatment Field Therapy (for Nebraska Only)	Revised	Aug. 1, 2022
Electrical and Ultrasound Bone Growth Stimulators (for Nebraska Only)	Updated	Aug. 1, 2022
Electrical and Ultrasound Bone Growth Stimulators (for New Jersey Only)	Revised	Jul. 1, 2022
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation (for New Jersey Only)	Revised	Jul. 1, 2022
Epidural Steroid Injections for Spinal Pain	Revised	Aug. 1, 2022
Facet Joint and Medial Branch Block Injections for Spinal Pain	Revised	Aug. 1, 2022
Genetic Testing for Hereditary Cancer	Updated	Aug. 1, 2022
Genetic Testing for Hereditary Cancer (for New Jersey Only)	Revised	Jul. 1, 2022
Implanted Electrical Stimulator for Spinal Cord (for Nebraska Only)	Revised	Aug. 1, 2022
Implanted Electrical Stimulator for Spinal Cord (for New Jersey Only)	Revised	Jul. 1, 2022
Minimally Invasive Procedures for Gastroesophageal Reflux Disease (GERD) and Achalasia (for Nebraska Only)	Revised	Aug. 1, 2022

Policy Title	Status	Effective Date
Percutaneous Vertebroplasty and Kyphoplasty (for Nebraska Only)	Updated	Jun. 1, 2022
Pharmacogenetic Testing (for New Jersey Only)	Revised	Jul. 1, 2022
Plagiocephaly and Craniosynostosis Treatment (for Nebraska Only)	Revised	Aug. 1, 2022
Plagiocephaly and Craniosynostosis Treatment (for New Jersey Only)	Revised	Jul. 1, 2022
Pneumatic Compression Devices (for New Jersey Only)	Revised	Jul. 1, 2022
Prolotherapy and Platelet Rich Plasma Therapies (for Nebraska Only)	Updated	Jul. 1, 2022
Radiation Therapy: Fractionation, Image-Guidance, and Special Services (for New Jersey Only)	New	Jul. 1, 2022
Skin and Soft Tissue Substitutes	Revised	Aug. 1, 2022
Skin and Soft Tissue Substitutes (for New Jersey Only)	Revised	Jul. 1, 2022
Stereotactic Body Radiation Therapy and Stereotactic Radiosurgery (for New Jersey Only)	New	Jul. 1, 2022
Surgery of the Hip (for Nebraska Only)	Revised	Aug. 1, 2022
Surgery of the Knee (for New Jersey Only)	Revised	Jul. 1, 2022
Surgery of the Shoulder (for Nebraska Only)	Revised	Aug. 1, 2022
Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins (for New Jersey Only)	Revised	Jul. 1, 2022
Surgical Treatment for Spine Pain (for Nebraska Only)	Revised	Aug. 1, 2022
Vagus and External Trigeminal Nerve Stimulation (for Nebraska Only)	Revised	Aug. 1, 2022
Vagus and External Trigeminal Nerve Stimulation (for New Jersey Only)	Revised	Jul. 1, 2022

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
17-Alpha-Hydroxyprogesterone Caproate (Makena® and 17P)	Updated	Jun. 1, 2022
Amondys 45™ (Casimersen)	Updated	Jul. 1, 2022
Amondys 45™ (Casimersen) (for New Jersey Only)	Revised	Jul. 1, 2022
Antiemetics for Oncology	Updated	Jun. 1, 2022
Botulinum Toxins A and B	Revised	Aug. 1, 2022
Brineura® (Cerliponase Alfa)	Updated	Jun. 1, 2022
Cimzia® (Certolizumab Pegol)	Revised	Jul. 1, 2022
Complement Inhibitors (Soliris® & Ultomiris®)	Revised	Jul. 1, 2022
Entyvio® (Vedolizumab)	Revised	Aug. 1, 2022
Erythropoiesis-Stimulating Agents	Revised	Aug. 1, 2022
Exondys 51® (Eteplirsen)	Updated	Jul. 1, 2022
Exondys 51® (Eteplirsen) (for New Jersey Only)	Revised	Jul. 1, 2022
Gamifant® (Emapalumab-Lzsg)	Updated	Jun. 1, 2022
Gonadotropin Releasing Hormone Analogs	Updated	Jun. 1, 2022
Hereditary Angioedema (HAE), Treatment and Prophylaxis	Updated	Jun. 1, 2022
Immune Globulin (IVIG and SCIG)	Revised	Aug. 1, 2022
Infliximab (Avsola™, Inflectra®, Remicade®, & Renflexis®)	Revised	Aug. 1, 2022
Intravenous Iron Replacement Therapy (Feraheme®, Injectafer®, & Monoferric®)	Revised	Aug. 1, 2022
Long-Acting Injectable Antiretroviral Agents for HIV	Updated	Jun. 1, 2022
Luxturna® (Voretigene Neparvovec-Rzyl)	Updated	Jun. 1, 2022
Ocrevus® (Ocrelizumab)	Revised	Aug. 1, 2022

Policy Title	Status	Effective Date
Oncology Medication Clinical Coverage	Updated	Jun. 1, 2022
Onpattro® (Patisiran)	Updated	Jun. 1, 2022
Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors	Revised	Jul. 1, 2022
Orencia® (Abatacept) Injection for Intravenous Infusion	Revised	Aug. 1, 2022
Reblozyl® (Luspatercept-Aamt)	Updated	Jun. 1, 2022
Repository Corticotropin Injections	Updated	Jun. 1, 2022
Respiratory Interleukins (Cinqair®, Fasenra®, & Nucala®)	Revised	Aug. 1, 2022
Sodium Hyaluronate	Revised	Aug. 1, 2022
Uplizna® (Inebilizumab-Cdon)	Updated	Jun. 1, 2022
Viltepso® (Viltolarsen)	Updated	Jul. 1, 2022
Viltepso® (Viltolarsen) (for New Jersey Only)	Revised	Jul. 1, 2022
Vyepti™ (Eptinezumab-Jjmr)	Updated	Jun. 1, 2022
Vyondys 53™ (Golodirsen)	Updated	Jul. 1, 2022
Vyondys 53™ (Golodirsen) (for New Jersey Only)	Revised	Jul. 1, 2022
White Blood Cell Colony Stimulating Factors	Revised	Jul. 1, 2022
Xolair® (Omalizumab)	Revised	Aug. 1, 2022
Zulresso™ (Brexanolone)	Updated	Jun. 1, 2022

Coverage Determination Guideline Updates

Policy Title	Status	Effective Date
Ambulance Services (for Nebraska Only)	Updated	Jun. 1, 2022
Breast Reconstruction Post Mastectomy and Poland Syndrome (for New Jersey Only)	Revised	Jul. 1, 2022
Breast Repair/Reconstruction Not Following Mastectomy (for Nebraska Only)	Revised	Aug. 1, 2022
Breast Repair/Reconstruction Not Following Mastectomy (for New Jersey Only)	Revised	Jul. 1, 2022
Cosmetic and Reconstructive Procedures (for Nebraska Only)	Revised	Aug. 1, 2022
Prosthetic Devices, Specialized, Microprocessor or Myoelectric Limbs (for Nebraska Only)	Updated	Jul. 1, 2022

Utilization Review Guideline Updates

Policy Title	Status	Effective Date
Elective Inpatient Services (for Nebraska Only)	Updated	Aug. 1, 2022
Observation Services (for Nebraska Only)	Revised	Aug. 1, 2022
Outpatient Surgical Procedures – Site of Service	Updated	Jun. 1, 2022
Provider Administered Drugs – Site of Care	Revised	Aug. 1, 2022

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 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 Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, and Utilization Review Guidelines is available at UHCprovider.com > Policies and Protocols > Community Plan Policies > Medical & Drug Policies and Coverage Determination Guidelines for Community Plan.