United Healthcare®

UnitedHealthcare Commercial
Medical Policy Update Bulletin: October 2021

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

Annual ICD-10 Diagnosis Code and Quarterly CPT® and HCPCS Code Updates

Effective Oct. 1, 2021, all applicable Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, and Utilization Review Guidelines have been updated to reflect the annual ICD-10 diagnosis code and quarterly CPT/HCPCS code additions, revisions, 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 (CMS) International Classification of Diseases, Tenth Revision (ICD-10) Clinical Modification (CM) (Diagnosis) Codes
- Centers for Medicare & Medicaid Services (CMS) International Classification of Diseases, Tenth Revision (ICD-10) Procedure Coding System (PCS) Codes
- Centers for Medicare & Medicaid Services. Healthcare Common Procedure Coding System: HCPCS Level II

For the list of impacted policies and corresponding details, click here.

Medical Policy Updates

Policy Title	Status	Effective Date
Ablative Treatment for Spine Pain	Updated	Nov. 1, 2021
Computer-Assisted Surgical Navigation for Musculoskeletal Procedures	Updated	Oct. 1, 2021
Deep Brain and Cortical Stimulation	Revised	Nov. 1, 2021
Electric Tumor Treatment Field Therapy	Revised	Nov. 1, 2021
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation	Updated	Nov. 1, 2021
Epidural Steroid Injections for Spinal Pain	Updated	Nov. 1, 2021
Facet Joint Injections for Spinal Pain	Updated	Nov. 1, 2021
Gender Dysphoria Treatment	Updated	Oct. 1, 2021
Gender Dysphoria Treatment	Updated	Nov. 1, 2021
Genetic Testing for Neuromuscular Disorders	Revised	Oct. 1, 2021
Glaucoma Surgical Treatments	Updated	Nov. 1, 2021
Hysterectomy	Updated	Nov. 1, 2021
Implanted Electrical Stimulator for Spinal Cord	Updated	Nov. 1, 2021
Implanted Spinal Drug Delivery Systems	Updated	Nov. 1, 2021
Intrauterine Fetal Surgery	Revised	Nov. 1, 2021
Liposuction for Lipedema	Updated	Nov. 1, 2021
Minimally Invasive Procedures for Gastroesophageal Reflux Disease (GERD) and Achalasia	Revised	Nov. 1, 2021
Obstructive and Central Sleep Apnea Treatment	Updated	Nov. 1, 2021

Policy Title	Status	Effective Date
Prostate Surgeries and Interventions	Updated	Nov. 1, 2021
Sacroiliac Joint Interventions	Updated	Nov. 1, 2021
Spinal Fusion Enhancement Products	Revised	Nov. 1, 2021
Surgery of the Elbow	Updated	Nov. 1, 2021
Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins	Updated	Nov. 1, 2021
Surgical Treatment for Spine Pain	Updated	Nov. 1, 2021
Temporomandibular Joint Disorders	Updated	Nov. 1, 2021
Total Artificial Heart and Ventricular Assist Devices	Updated	Nov. 1, 2021
Vagus and External Trigeminal Nerve Stimulation	Updated	Nov. 1, 2021

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Antiemetics for Oncology	Revised	Nov. 1, 2021
Cimzia® (Certolizumab Pegol)	Updated	Oct. 1, 2021
Medical Therapies for Enzyme Deficiencies	Revised	Oct. 1, 2021
Oncology Medication Clinical Coverage	Revised	Nov. 1, 2021
Respiratory Interleukins (Cinqair®, Fasenra®, & Nucala®)	Revised	Nov. 1, 2021
Ryplazim® (Plasminogen, Human-Tvmh)	New	Oct. 1, 2021
Saphnelo™ (Anifrolumab-Fnia)	New	Oct. 1, 2021
Sodium Hyaluronate	Revised	Nov. 1, 2021
Synagis® (Palivizumab)	Revised	Nov. 1, 2021

Coverage Determination Guideline Updates

Policy Title	Status	Effective Date
Beds and Mattresses	Revised	Nov. 1, 2021
Breast Reconstruction Post Mastectomy and Poland Syndrome	Updated	Nov. 1, 2021
Cosmetic and Reconstructive Procedures	Updated	Nov. 1, 2021
Transcutaneous Electrical Nerve/Joint Stimulators	Updated	Oct. 1, 2021

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