United Healthcare Community Plan

UnitedHealthcare Community Plan
Medical Policy Update Bulletin: March 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.

Medical Policy Updates

Policy Title	Status	Effective Date
Abnormal Uterine Bleeding and Uterine Fibroids (for Nebraska Only)	Revised	May 1, 2022
Airway Clearance Devices (for Nebraska Only)	Revised	May 1, 2022
Balloon Sinus Ostial Dilation (for Nebraska Only)	Revised	May 1, 2022
Breast Imaging for Screening and Diagnosing Cancer (for Nebraska Only)	Revised	May 1, 2022
Functional Endoscopic Sinus Surgery (FESS)	Revised	May 1, 2022
Plagiocephaly and Craniosynostosis Treatment	Revised	May 1, 2022
Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins	Revised	May 1, 2022
Total Artificial Disc Replacement for the Spine (for Nebraska Only)	Updated	May 1, 2022
Transcatheter Heart Valve Procedures (for Nebraska Only)	Revised	May 1, 2022
Visual Information Processing Evaluation and Orthoptic and Vision Therapy (for Nebraska Only)	Revised	May 1, 2022
Whole Exome and Whole Genome Sequencing	Revised	May 1, 2022

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Amondys 45™ (Casimersen)	Updated	Mar. 1, 2022
Benlysta® (Belimumab)	Revised	Apr. 1, 2022
Complement Inhibitors (Soliris® & Ultomiris®)	Revised	Apr. 1, 2022
Denied Drug Codes – Pharmacy Benefit Drugs	Revised	Apr. 1, 2022
Denosumab (Prolia® & Xgeva®)	Updated	Mar. 1, 2022
Erythropoiesis-Stimulating Agents	Updated	Mar. 1, 2022
Givlaari® (Givosiran)	Updated	Mar. 1, 2022
Gonadotropin Releasing Hormone Analogs	Updated	Mar. 1, 2022
Intravenous Enzyme Replacement Therapy (ERT) for Gaucher Disease	Updated	Mar. 1, 2022
Leqvio® (Inclisiran)	New	Apr. 1, 2022
Long-Acting Injectable Antiretroviral Agents for HIV	Updated	Mar. 1, 2022
Oncology Medication Clinical Coverage	Updated	Apr. 1, 2022
Reblozyl® (Luspatercept-Aamt)	Updated	Mar. 1, 2022
Ryplazim® (Plasminogen, Human-Tvmh)	Revised	Apr. 1, 2022
Saphnelo™ (Anifrolumab-Fnia)	Revised	Apr. 1, 2022
Tepezza® (Teprotumumab-Trbw)	Updated	Mar. 1, 2022

Policy Title	Status	Effective Date
Testosterone Replacement or Supplementation Therapy	Updated	Mar. 1, 2022
Tezspire™ (Tezepelumab)	New	Apr. 1, 2022
Viltepso® (Viltolarsen)	Updated	Mar. 1, 2022
Vyepti™ (Eptinezumab-Jjmr)	Updated	Mar. 1, 2022
Vyvgart™ (Efgartigimod Alfa-Fcab)	New	Apr. 1, 2022
Zulresso™ (Brexanolone)	Updated	Mar. 1, 2022

Coverage Determination Guideline Updates

Policy Title	Status	Effective Date
Breast Reconstruction Post Mastectomy and Poland Syndrome (for Nebraska Only)	Updated	May 1, 2022
Breast Reduction Surgery (for Nebraska Only)	Revised	May 1, 2022
Durable Medical Equipment, Orthotics, Medical Supplies and Repairs/Replacements	Revised	May 1, 2022
Durable Medical Equipment, Orthotics, Medical Supplies and Repairs/Replacements (for Nebraska Only)	Revised	May 1, 2022
Panniculectomy and Body Contouring Procedures	Revised	Apr. 1, 2022
Panniculectomy and Body Contouring Procedures (for Nebraska Only)	Revised	May 1, 2022
Pectus Deformity Repair (for Nebraska Only)	Revised	May 1, 2022
Private Duty Nursing (PDN) Services	Updated	Mar. 1, 2022
Private Duty Nursing (PDN) Services (for Florida Only)	Updated	Mar. 1, 2022
Private Duty Nursing (PDN) Services (for Nebraska Only)	Revised	Mar. 1, 2022
Private Duty Nursing (PDN) Services (for New Jersey Only)	Updated	Mar. 1, 2022

Utilization Review Guideline Updates

Policy Title	Status	Effective Date
Chemotherapy Observation or Inpatient Hospitalization	Updated	Mar. 1, 2022
Pediatric Outpatient Intensive Feeding Programs	Retired	Mar. 1, 2022
Pediatric Outpatient Intensive Feeding Programs (for Nebraska Only)	Retired	Mar. 1, 2022
Pediatric Outpatient Intensive Feeding Programs (for New Jersey Only)	Retired	Mar. 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.