

UnitedHealthcare Community Plan Medical Policy Update Bulletin: January 2024

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 CPT/HCPCS Code Updates

Beginning **Jan. 1, 2024**, all applicable Medical Policies and Medical Benefit Drug Policies will be updated to reflect the 2024 Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (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: Healthcare Common Procedure Coding System \(HCPCS\) Quarterly Update](#)

For the list of impacted policies and corresponding details, click [here](#).

Medical Policy Updates

Policy Title	Status	Effective Date
Ablative Treatment for Spinal Pain	Updated	Jan. 1, 2024
Ablative Treatment for Spinal Pain (for New Jersey Only)	Updated	Jan. 1, 2024
Abnormal Uterine Bleeding and Uterine Fibroids	Revised	Mar. 1, 2024
Ambulance Services (for Nebraska Only)	Updated	Mar. 1, 2024
Apheresis	Revised	Mar. 1, 2024
Autologous Cellular Therapy (for New Jersey Only)	Updated	Jan. 1, 2024
Bariatric Surgery (for Nebraska Only)	Revised	Mar. 1, 2024
Computer-Assisted Surgical Navigation for Musculoskeletal Procedures	Updated	Jan. 1, 2024
Computer-Assisted Surgical Navigation for Musculoskeletal Procedures (for New Jersey Only)	Updated	Jan. 1, 2024
Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/Replacements (for New Jersey Only)	Revised	Feb. 1, 2024
Elective Inpatient Services	Revised	Mar. 1, 2024
Elective Inpatient Services (for New Jersey Only)	Revised	Mar. 1, 2024
Electric Tumor Treatment Field Therapy	Revised	Mar. 1, 2024
Electric Tumor Treatment Field Therapy (for New Jersey Only)	Revised	Mar. 1, 2024
Habilitation and Rehabilitation Therapy (Occupational, Physical, and Speech) (for New Jersey Only)	Revised	Feb. 1, 2024
Hepatitis Screening (for Nebraska Only)	Updated	Jan. 1, 2024
Hepatitis Screening (for New Jersey Only)	Updated	Jan. 1, 2024
Home Health, Skilled, and Custodial Care Services (for Nebraska Only)	Revised	Mar. 1, 2024
Implanted Electrical Stimulator for Spinal Cord	Updated	Mar. 1, 2024

Policy Title	Status	Effective Date
Implanted Electrical Stimulator for Spinal Cord (for New Jersey Only)	Updated	Mar. 1, 2024
Lithotripsy for Salivary Stones (for New Jersey Only)	Updated	Jan. 1, 2024
Minimally Invasive Procedures for Gastric and Esophageal Diseases	Revised	Mar. 1, 2024
Minimally Invasive Procedures for Gastric and Esophageal Diseases (for New Jersey Only)	Revised	Mar. 1, 2024
Molecular Oncology Companion Diagnostic Testing	Revised	Mar. 1, 2024
Molecular Oncology Companion Diagnostic Testing (for Nebraska Only)	Revised	Mar. 1, 2024
Molecular Oncology Testing for Hematologic Cancer Diagnosis, Prognosis, and Treatment Decisions	Revised	Mar. 1, 2024
Molecular Oncology Testing for Hematologic Cancer Diagnosis, Prognosis, and Treatment Decisions (for Nebraska Only)	Revised	Mar. 1, 2024
Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions	Revised	Mar. 1, 2024
Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions (for Nebraska Only)	Revised	Mar. 1, 2024
Neurophysiologic Testing and Monitoring	Updated	Mar. 1, 2024
Neurophysiologic Testing and Monitoring (for New Jersey Only)	Updated	Mar. 1, 2024
Obstructive and Central Sleep Apnea Treatment	Revised	Mar. 1, 2024
Obstructive and Central Sleep Apnea Treatment (for Nebraska Only)	Revised	Mar. 1, 2024
Obstructive and Central Sleep Apnea Treatment (for New Jersey Only)	Revised	Mar. 1, 2024
Percutaneous Patent Foramen Ovale (PFO) Closure	Revised	Mar. 1, 2024
Pharmacogenetic Panel Testing	Updated	Mar. 1, 2024
Pharmacogenetic Panel Testing (for Nebraska Only)	Updated	Mar. 1, 2024
Pharmacogenetic Panel Testing (for New Jersey Only)	Updated	Mar. 1, 2024
Plagiocephaly and Craniosynostosis Treatment	Updated	Jan. 1, 2024
Plagiocephaly and Craniosynostosis Treatment (for New Jersey Only)	Updated	Jan. 1, 2024
Private Duty Nursing Services (for Nebraska Only)	Revised	Mar. 1, 2024
Prolotherapy and Platelet Rich Plasma Therapies (for New Jersey Only)	Updated	Jan. 1, 2024
Radiation Therapy: Fractionation, Image-Guidance, and Special Services	Revised	Mar. 1, 2024
Skin and Soft Tissue Substitutes	Revised	Mar. 1, 2024
Skin and Soft Tissue Substitutes (for Nebraska Only)	Revised	Mar. 1, 2024
Surgical Treatment of Lymphedema	Updated	Feb. 1, 2024
Surgical Treatment of Lymphedema (for New Jersey Only)	Updated	Feb. 1, 2024
Total Artificial Disc Replacement for the Spine	Revised	Mar. 1, 2024
Transcranial Magnetic Stimulation	Updated	Mar. 1, 2024
Transcranial Magnetic Stimulation (for New Jersey Only)	Updated	Mar. 1, 2024
Treatment of Temporomandibular Joint Disorders	Revised	Mar. 1, 2024
Treatment of Temporomandibular Joint Disorders (for Nebraska Only)	Revised	Mar. 1, 2024
Vagus and External Trigeminal Nerve Stimulation (for New Jersey Only)	Updated	Jan. 1, 2024
Video Electroencephalographic (vEEG) Monitoring and Recording	Updated	Jan. 1, 2024
Video Electroencephalographic (vEEG) Monitoring and Recording (for New Jersey Only)	Updated	Jan. 1, 2024

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Actemra® (Tocilizumab) Injection for Intravenous Infusion	Updated	Feb. 1, 2024
Benlysta® (Belimumab)	Updated	Jan. 1, 2024
Briumvi® (Ublituximab-Xiiy)	Updated	Jan. 1, 2024
Denosumab (Prolia® & Xgeva®)	Updated	Jan. 1, 2024
Evenity® (Romosozumab-Aqqg)	Updated	Jan. 1, 2024
Intravenous Iron Replacement Therapy (Feraheme®, Injectafer®, & Monoferric®)	Updated	Feb. 1, 2024
Ketalar® (Ketamine) and Spravato® (Esketamine)	Updated	Jan. 1, 2024
Ketalar® (Ketamine) and Spravato® (Esketamine)	Revised	Feb. 1, 2024
Ketalar® (Ketamine) and Spravato® (Esketamine) (for New Jersey Only)	Revised	Feb. 1, 2024
Leqvio® (Inclisiran)	Updated	Jan. 1, 2024
Neonatal Fc Receptor Blockers (Vyvgart®, Vyvgart® Hytrulo, & Rystiggo®)	Revised	Feb. 1, 2024
Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors	Updated	Jan. 1, 2024
Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors	Revised	Feb. 1, 2024
Qalsody® (Tofersen)	Updated	Jan. 1, 2024
Reblozyl® (Luspatercept-Aamt)	Revised	Feb. 1, 2024
Rebyota™ (Fecal Microbiota, Live-Jslm)	Revised	Jan. 1, 2024
Spevigo® (Spesolimab-Sbzo)	Updated	Jan. 1, 2024
Testosterone Replacement or Supplementation Therapy	Revised	Feb. 1, 2024
Zolgensma® (Onasemnogene Apeparvovec-Xioi)	Updated	Jan. 1, 2024

Coverage Determination Guideline Updates

Policy Title	Status	Effective Date
Speech Language Pathology Services (for New Jersey Only)	Replaced	Feb. 1, 2024

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 and Medical Benefit Drug Policy 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 and Medical Benefit Drug Policies is available at [UHCprovider.com](https://uhcprovider.com) > Policies and Protocols > Community Plan Policies > [Medical & Drug Policies](#).