

UnitedHealthcare Community Plan of Kentucky 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 and 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
Abnormal Uterine Bleeding and Uterine Fibroids (for Kentucky Only)	Revised	Mar. 1, 2024
Apheresis (for Kentucky Only)	Revised	Mar. 1, 2024
Computer-Assisted Surgical Navigation for Musculoskeletal Procedures (for Kentucky Only)	Updated	Jan. 1, 2024
Enteral Nutrition (Oral and Tube Feeding) (for Kentucky Only)	Revised	Feb. 1, 2024
Implanted Electrical Stimulator for Spinal Cord (for Kentucky Only)	Updated	Mar. 1, 2024
Mechanical Stretching Devices (for Kentucky Only)	Revised	Feb. 1, 2024
Minimally Invasive Procedures for Gastric and Esophageal Diseases (for Kentucky Only)	Revised	Mar. 1, 2024
Molecular Oncology Companion Diagnostic Testing (for Kentucky Only)	Revised	Mar. 1, 2024
Molecular Oncology Testing for Hematologic Cancer Diagnosis, Prognosis, and Treatment Decisions (for Kentucky Only)	Revised	Mar. 1, 2024
Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions (for Kentucky Only)	Revised	Mar. 1, 2024
Neurophysiologic Testing and Monitoring (for Kentucky Only)	Revised	Mar. 1, 2024
Percutaneous Patent Foramen Ovale (PFO) Closure (for Kentucky Only)	Revised	Mar. 1, 2024
Pharmacogenetic Panel Testing (for Kentucky Only)	Updated	Mar. 1, 2024
Plagiocephaly and Craniosynostosis Treatment (for Kentucky Only)	Updated	Jan. 1, 2024
Radiation Therapy: Fractionation, Image-Guidance, and Special Services (for Kentucky Only)	Revised	Mar. 1, 2024
Sacroiliac Joint Interventions (for Kentucky Only)	Revised	Feb. 1, 2024
Skin and Soft Tissue Substitutes (for Kentucky Only)	Revised	Mar. 1, 2024
Surgical Treatment of Lymphedema (for Kentucky Only)	Updated	Feb. 1, 2024

Policy Title	Status	Effective Date
Treatment of Temporomandibular Joint Disorders (for Kentucky Only)	Revised	Mar. 1, 2024
Video Electroencephalographic (vEEG) Monitoring and Recording (for Kentucky 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
Intravenous Iron Replacement Therapy (Feraheme®, Injectafer®, & Monoferric®)	Updated	Feb. 1, 2024
Ketalar® (Ketamine) and Spravato® (Esketamine)	Revised	Feb. 1, 2024
Neonatal Fc Receptor Blockers (Vyvgart®, Vyvgart® Hytrulo, & Rystiggo®)	Revised	Feb. 1, 2024
Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors	Revised	Feb. 1, 2024
Reblozyl® (Luspatercept-Aamt)	Revised	Feb. 1, 2024
Testosterone Replacement or Supplementation Therapy	Revised	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 Community Plan of Kentucky 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 Medical Policies and Medical Benefit Drug Policies for UnitedHealthcare Community Plan of Kentucky is available at UHCprovider.com/KY > Medicaid (Community Plan) > Current Policies and Clinical Guidelines > [UnitedHealthcare Community Plan of Kentucky Medical & Drug Policies](#).