

# UnitedHealthcare Community Plan Medical Policy Update Bulletin: August 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

### Community Plan of Nebraska to Use National Policy Versions

Effective Aug. 1, 2022, Community Plan of Nebraska will no longer maintain a state-specific version of the Coverage Determination Guideline titled *Clinical Trials (for Nebraska Only)*; coverage guidelines for the state of Nebraska will now be provided in the Community Plan National policy version titled Clinical Trials.

## Medical Policy Updates

Policy Title	Status	Effective Date
Articular Cartilage Defect Repairs (for Nebraska Only)	Revised	Oct. 1, 2022
Cardiovascular Disease Risk Tests (for Nebraska Only)	Revised	Oct. 1, 2022
Catheter Ablation for Atrial Fibrillation (for Nebraska Only)	Updated	Aug. 1, 2022
Collagen Crosslinks and Biochemical Markers of Bone Turnover (for Nebraska Only)	Revised	Oct. 1, 2022
Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes (for Nebraska Only)	Revised	Oct. 1, 2022
Deep Brain and Cortical Stimulation (for Nebraska Only)	Updated	Aug. 1, 2022
Diagnostic Dynamic Spinal Visualization and Vertebral Motion Analysis	Revised	Oct. 1, 2022
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation (for Nebraska Only)	Revised	Oct. 1, 2022
Epidural Steroid Injections for Spinal Pain (for Nebraska Only)	Revised	Oct. 1, 2022
Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions and Soft Tissue Wounds (for Nebraska Only)	Updated	Aug. 1, 2022
Facet Joint and Medial Branch Block Injections for Spinal Pain (for Nebraska Only)	Revised	Oct. 1, 2022
Functional Endoscopic Sinus Surgery (FESS) (for Nebraska Only)	Revised	Oct. 1, 2022
Glaucoma Surgical Treatments (for Nebraska Only)	Updated	Aug. 1, 2022
Hearing Aids and Devices Including Wearable, Bone-Anchored and Semi-Implantable (for Nebraska Only)	Updated	Aug. 1, 2022
Home Hemodialysis	Updated	Aug. 1, 2022
Hysterectomy (for Nebraska Only)	Revised	Oct. 1, 2022
Intrauterine Fetal Surgery (for Nebraska Only)	Revised	Oct. 1, 2022
Laser Interstitial Thermal Therapy (for Nebraska Only)	Updated	Aug. 1, 2022
Left Atrial Appendage Closure (Occlusion)	Revised	Oct. 1, 2022

Policy Title	Status	Effective Date
Mandatory Medicaid Coverage of Routine Patient Costs in Qualifying Clinical Trials	Revised	Aug. 1, 2022
Manipulation Under Anesthesia (for Nebraska Only)	Revised	Oct. 1, 2022
Minimally Invasive Procedures for Gastroesophageal Reflux Disease (GERD) and Achalasia (for Nebraska Only)	Revised	Aug. 1, 2022
Negative Pressure Wound Therapy (for Nebraska Only)	Revised	Oct. 1, 2022
Noncontact Warming Therapy, Ultrasound Therapy and Fluorescence Imaging for Wounds	Revised	Oct. 1, 2022
Occipital Nerve Injections and Ablation (Including Occipital Neuralgia and Headache) (for Nebraska Only)	Updated	Aug. 1, 2022
Omnibus Codes	Revised	Oct. 1, 2022
Percutaneous Vertebroplasty and Kyphoplasty (for New Jersey Only)	Updated	Sep. 1, 2022
Pneumatic Compression Devices (for Nebraska Only)	Revised	Oct. 1, 2022
Skin and Soft Tissue Substitutes	Revised	Oct. 1, 2022
Spinal Fusion Enhancement Products (for Nebraska Only)	Revised	Oct. 1, 2022
Surgery of the Elbow (for Nebraska Only)	Updated	Aug. 1, 2022
Surgery of the Knee (for Nebraska Only)	Revised	Oct. 1, 2022
Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins (for Nebraska Only)	Revised	Oct. 1, 2022
Temporomandibular Joint Disorders (for Nebraska Only)	Revised	Oct. 1, 2022
Transcatheter Heart Valve Procedures (for Nebraska Only)	Revised	Oct. 1, 2022
Vertebral Body Tethering for Scoliosis (for Nebraska Only)	Updated	Aug. 1, 2022
Video Electroencephalographic (vEEG) Monitoring and Recording (for Nebraska Only)	Revised	Oct. 1, 2022

## Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Brineura® (Cerliponase Alfa)	Updated	Aug. 1, 2022
Complement Inhibitors (Soliris® & Ultomiris®)	Revised	Sep. 1, 2022
Enjaymo™ (Sutimlimab-Jome)	Updated	Aug. 1, 2022
Intravenous Iron Replacement Therapy (Feraheme®, Injectafer®, & Monoferric®)	Updated	Sep. 1, 2022
Leqvio® (Inclisiran)	Revised	Sep. 1, 2022
Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors	Revised	Sep. 1, 2022
Respiratory Interleukins (Cinqair®, Fasentra®, & Nucala®)	Revised	Aug. 1, 2022
RNA-Targeted Therapies (Amvuttra™ and Onpattro®)	Revised	Sep. 1, 2022
Tepezza® (Teprotumumab-Trbw)	Revised	Sep. 1, 2022
Uplizna® (Inebilizumab-Cdon)	Updated	Aug. 1, 2022
Viltepso® (Viltolarsen)	Updated	Aug. 1, 2022
Vyvgart® (Efgartigimod Alfa-Fcab)	Revised	Sep. 1, 2022
Xiaflex® (Collagenase Clostridium Histolyticum)	Updated	Aug. 1, 2022

## Coverage Determination Guideline Updates

Policy Title	Status	Effective Date
Clinical Trials	Updated	Aug. 1, 2022

Policy Title	Status	Effective Date
Outpatient Physical and Occupational Therapy (for Nebraska Only)	Revised	Oct. 1, 2022
Speech Language Pathology Services (for Nebraska Only)	Revised	Oct. 1, 2022

## Utilization Review Guideline Updates

Policy Title	Status	Effective Date
Elective Inpatient Services (for Nebraska Only)	Updated	Aug. 1, 2022
Provider Administered Drugs – Site of Care (for Nebraska Only)	Revised	Oct. 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](https://UHCprovider.com) > Policies and Protocols > Community Plan Policies > [Medical & Drug Policies and Coverage Determination Guidelines for Community Plan](#).