

UnitedHealthcare Community Plan Medical Policy Update Bulletin: January 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

Annual CPT® and HCPCS Code Updates

Effective Jan. 1, 2022, all applicable Medical Policies, Medical Benefit Drug Policies, and Coverage Determination Guidelines have been updated to reflect the 2022 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 Level II](#)

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

Medical Policy Updates

Policy Title	Status	Effective Date
Airway Clearance Devices (for Nebraska Only)	Revised	Mar. 1, 2022
Apheresis	Revised	Mar. 1, 2022
Bariatric Surgery	Revised	Mar. 1, 2022
Cardiac Event Monitoring (for Nebraska Only)	Updated	Jan. 1, 2022
Cochlear Implants (for Nebraska Only)	Revised	Mar. 1, 2022
Deep Brain and Cortical Stimulation (for Nebraska Only)	Revised	Mar. 1, 2022
Diagnostic Spinal Ultrasonography (for Nebraska Only)	Revised	Mar. 1, 2022
Electrical and Ultrasound Bone Growth Stimulators	Revised	Mar. 1, 2022
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation (for Nebraska Only)	Revised	Mar. 1, 2022
Functional Endoscopic Sinus Surgery (FESS) (for Nebraska Only)	Revised	Mar. 1, 2022
Gastrointestinal Motility Disorders, Diagnosis and Treatment (for Nebraska Only)	Revised	Mar. 1, 2022
Glaucoma Surgical Treatments (for Nebraska Only)	Revised	Mar. 1, 2022
Home Traction Therapy (for Nebraska Only)	Revised	Mar. 1, 2022
Hysterectomy (for Nebraska Only)	Updated	Mar. 1, 2022
Implantable Beta-Emitting Microspheres for Treatment of Malignant Tumors (for Nebraska Only)	Revised	Mar. 1, 2022
Implanted Electrical Stimulator for Spinal Cord (for Nebraska Only)	Revised	Mar. 1, 2022
Intensity-Modulated Radiation Therapy (for Nebraska Only)	Revised	Mar. 1, 2022
Intraoperative Hyperthermic Intraperitoneal Chemotherapy (HIPEC) (for Nebraska Only)	Revised	Mar. 1, 2022
Liposuction for Lipedema	New	Apr. 1, 2022

Policy Title	Status	Effective Date
Lower Extremity Invasive Diagnostic and Endovascular Procedures (for Nebraska Only)	Revised	Mar. 1, 2022
Macular Degeneration Treatment Procedures (for Nebraska Only)	Revised	Mar. 1, 2022
Manipulative Therapy (for Nebraska Only)	Updated	Jan. 1, 2022
Meniscus Implant and Allograft (for Nebraska Only)	Updated	Jan. 1, 2022
Percutaneous Patent Foramen Ovale (PFO) Closure	New	Apr. 1, 2022
Percutaneous Patent Foramen Ovale (PFO) Closure (for Nebraska Only)	New	Apr. 1, 2022
Percutaneous Vertebroplasty and Kyphoplasty	New	Apr. 1, 2022
Percutaneous Vertebroplasty and Kyphoplasty (for Nebraska Only)	New	Apr. 1, 2022
Prolotherapy and Platelet Rich Plasma Therapies	Updated	Mar. 1, 2022
Prostate Surgeries and Interventions	New	Apr. 1, 2022
Prostate Surgeries and Interventions (for Nebraska Only)	New	Apr. 1, 2022
Skin and Soft Tissue Substitutes	Revised	Mar. 1, 2022
Spinal Fusion Enhancement Products (for Nebraska Only)	Revised	Mar. 1, 2022
Total Artificial Disc Replacement for the Spine (for Nebraska Only)	Revised	Mar. 1, 2022
Total Artificial Heart and Ventricular Assist Devices (for Nebraska Only)	Updated	Jan. 1, 2022

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Actemra® (Tocilizumab) Injection for Intravenous Infusion	Revised	Feb. 1, 2022
Cimzia® (Certolizumab Pegol)	Revised	Feb. 1, 2022
Denosumab (Prolia® & Xgeva®)	Updated	Feb. 1, 2022
Entyvio® (Vedolizumab)	Revised	Feb. 1, 2022
Gonadotropin Releasing Hormone Analogs	Updated	Feb. 1, 2022
Ilumya™ (Tildrakizumab-Asmn)	Revised	Feb. 1, 2022
Immune Globulin (IVIG and SCIG)	Revised	Jan. 1, 2022
Ketalar® (Ketamine) and Spravato® (Esketamine)	Revised	Feb. 1, 2022
Medical Therapies for Enzyme Deficiencies	Updated	Jan. 1, 2022
Orencia® (Abatacept) Injection for Intravenous Infusion	Revised	Feb. 1, 2022
Simponi Aria® (Golimumab) Injection for Intravenous Infusion	Revised	Feb. 1, 2022
Stelara® (Ustekinumab)	Revised	Feb. 1, 2022
Subcutaneous Implantable Naltrexone Pellets	Updated	Jan. 1, 2022

Coverage Determination Guideline Updates

Policy Title	Status	Effective Date
Ambulance Services	Updated	Mar. 1, 2022
Ambulance Services (for Nebraska Only)	Revised	Mar. 1, 2022
Beds and Mattresses (for Nebraska Only)	Revised	Mar. 1, 2022
Cosmetic and Reconstructive Procedures	Revised	Mar. 1, 2022
Home Health Care (for Nebraska Only)	Updated	Jan. 1, 2022
Private Duty Nursing (PDN) Services (for Nebraska Only)	Revised	Mar. 1, 2022
Prosthetic Devices, Specialized, Microprocessor or Myoelectric Limbs	Updated	Mar. 1, 2022

Utilization Review Guideline Updates

Policy Title	Status	Effective Date
Outpatient Surgical Procedures – Site of Service (for New Jersey Only)	Revised	Feb. 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](#).