United Healthcare Community Plan

UnitedHealthcare Community Plan
Medical Policy Update Bulletin: July 2021

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

InterQual® 2021 Clinical Criteria Release

Effective July 1, 2021, all applicable Medical Policies, Coverage Determination Guidelines, and Utilization Review Guidelines have been updated to reflect the applicable InterQual® 2021 clinical criteria reference(s). For the list of impacted policies and corresponding details, click here.

Quarterly CPT® and HCPCS Code Updates

Effective July 1, 2021, all applicable Medical Policies and Medical Benefit Drug Policies have been updated to reflect the quarterly 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
Cochlear Implants (for Mississippi Only)	Revised	Aug. 1, 2021
Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes	Revised	Jul. 1, 2021
Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes (for Mississippi Only)	Revised	Aug. 1, 2021
Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes (for Pennsylvania Only)	Revised	Aug. 1, 2021
Home Hemodialysis (for Nebraska Only)	Updated	Jul. 1, 2021
Home Traction Therapy (for Mississippi Only)	Revised	Aug. 1, 2021
Implanted Electrical Stimulator for Spinal Cord (for Nebraska Only)	Revised	Sep. 1, 2021
Lower Extremity Invasive Diagnostic and Endovascular Procedures (for Nebraska Only)	Revised	Sep. 1, 2021
Negative Pressure Wound Therapy (for Nebraska Only)	Updated	Jul. 1, 2021
Nerve Graft to Restore Erectile Function During Radical Prostatectomy (for Nebraska Only)	Revised	Sep. 1, 2021
Obstructive Sleep Apnea Treatment (for Nebraska Only)	Revised	Sep. 1, 2021
Occipital Nerve Injections and Ablation (Including Occipital Neuralgia and Headache)	Revised	Sep. 1, 2021
Pneumatic Compression Devices (for Nebraska Only)	Revised	Sep. 1, 2021
Proton Beam Radiation Therapy (for Nebraska Only)	Updated	Sep. 1, 2021

Policy Title	Status	Effective Date
Radiation Therapy: Fractionation, Image-Guidance, and Special Services	New	Oct. 1, 2021
Radiation Therapy: Fractionation, Image-Guidance, and Special Services (for Mississippi Only)	New	Oct. 1, 2021
Sacroiliac Joint Interventions	New	Oct. 1, 2021
Spinal Ultrasonography (for Nebraska Only)	Revised	Sep. 1, 2021
Standing Systems and Gait Trainers (for Mississippi Only)	Revised	Aug. 1, 2021
Stereotactic Body Radiation Therapy and Stereotactic Radiosurgery	New	Oct. 1, 2021
Stereotactic Body Radiation Therapy and Stereotactic Radiosurgery (for Mississippi Only)	New	Oct. 1, 2021
Surgery of the Elbow (for Nebraska Only)	Revised	Sep. 1, 2021
Surgery of the Foot	New	Sep. 1, 2021
Surgery of the Knee (for Nebraska Only)	Revised	Sep. 1, 2021
Surgery of the Shoulder (for Nebraska Only)	Revised	Sep. 1, 2021
Surgery of the Shoulder (for New Jersey Only)	Revised	Aug. 1, 2021
Surgical Treatment for Spine Pain (for Nebraska Only)	Updated	Sep. 1, 2021
Transcatheter Heart Valve Procedures	Revised	Sep. 1, 2021

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Amondys 45™ (Casimersen) (for Pennsylvania Only)	New	Aug. 1, 2021
Complement Inhibitors (Soliris® & Ultomiris®)	Revised	Jul. 1, 2021
Denosumab (Prolia® & Xgeva®)	Revised	Oct. 1, 2021
Infliximab (Avsola™, Inflectra®, Remicade®, & Renflexis®)	Revised	Jul. 1, 2021
Intravitreal Corticosteroid Implants	New	Aug. 1, 2021
Maximum Dosage and Frequency	Revised	Aug. 1, 2021
Medical Therapies for Enzyme Deficiencies	Revised	Aug. 1, 2021
Off-Label/Unproven Specialty Drug Treatment	Revised	Aug. 1, 2021
Oncology Medication Clinical Coverage	Updated	Aug. 1, 2021
Oncology Medication Clinical Coverage (for Pennsylvania Only)	Revised	Aug. 1, 2021
Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors	Revised	Aug. 1, 2021
Reblozyl® (Luspatercept-Aamt)	Revised	Aug. 1, 2021
Repository Corticotropin Injection (Acthar® Gel) (for Pennsylvania Only)	Updated	Jul. 1, 2021
Sodium Hyaluronate	Revised	Jul. 1, 2021
Spinraza® (Nusinersen) (for Pennsylvania Only)	Revised	Aug. 1, 2021
Xolair® (Omalizumab)	Revised	Aug. 1, 2021
Zolgensma® (Onasemnogene Abeparvovec-Xioi) (for Pennsylvania Only)	Revised	Aug. 1, 2021

Coverage Determination Guideline Updates

Policy Title	Status	Effective Date
Ambulance Services (for Mississippi Only)	Revised	Aug. 1, 2021
Blepharoplasty, Blepharoptosis, and Brow Ptosis Repair (for Mississippi Only)	Revised	Aug. 1, 2021
Breast Reduction Surgery (for Nebraska Only)	Revised	Aug. 1, 2021
Breast Repair/Reconstruction Not Following Mastectomy (for Mississippi Only)	Revised	Aug. 1, 2021

Policy Title	Status	Effective Date
Clinical Trials (for Nebraska Only)	Updated	Jul. 1, 2021
Cosmetic and Reconstructive Procedures (for Mississippi Only)	Revised	Aug. 1, 2021
Durable Medical Equipment, Orthotics, Medical Supplies and Repairs/Replacements (for Mississippi Only)	Revised	Aug. 1, 2021
Home Health Care (for Mississippi Only)	Revised	Aug. 1, 2021
Hospice Care (for Florida Only)	Revised	Sep. 1, 2021
Hospice Care (for Mississippi Only)	Revised	Aug. 1, 2021
Oral and Enteral Nutrition (for Pennsylvania Only)	Revised	Aug. 1, 2021
Orthognathic (Jaw) Surgery (for Nebraska Only)	Revised	Sep. 1, 2021
Pediatric Gait Trainers, Standing Systems, and Walkers (for Nebraska Only)	Revised	Sep. 1, 2021
Private Duty Nursing (PDN) Services	Revised	Sep. 1, 2021
Speech Generating Devices (for Mississippi Only)	Revised	Aug. 1, 2021

Utilization Review Guideline Updates

Policy Title	Status	Effective Date
Pediatric Outpatient Intensive Feeding Programs (for Nebraska Only)	New	Sep. 1, 2021

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.