UnitedHealthcare Community Plan

September 2020

medical policy update bulletin

Medical Policy, Medical Benefit Drug Policy & Coverage Determination Guideline Updates

Take Note

CHANGE IN POLICY APPLICATION GUIDELINES FOR STATE OF FLORIDA

The state of Florida will **not** be excluded from the following policies on Oct. 1, 2020 as previously announced. These policies will continue to apply to the state of Florida; refer to the policies for complete details on applicable coverage guidelines.

- Blepharoplasty, Blepharoptosis, and Brow Ptosis Repair
- Breast Reduction Surgery
- Cosmetic and Reconstructive Procedures
- Epidural Steroid and Facet Injections for Spinal Pain
- Hepatitis Screening
- Obstructive Sleep Apnea Treatment
- Orthognathic (Jaw) Surgery
- Panniculectomy and Body Contouring Procedures
- Surgical Treatment for Spine Pain
- Total Artificial Disc Replacement for the Spine

NEW LOOK FOR UNITEDHEALTHCARE COMMUNITY PLAN POLICIES

Beginning Sep. 1, 2020 and continuing over the next several months, we will be refreshing the look of the UnitedHealthcare Community Plan Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, and Utilization Review Guidelines. Unless otherwise announced, there will be no change to policy content/guidelines as a result of the new look.

ANNUAL ICD-10 CODE UPDATES

Effective Oct. 1, 2020, all applicable Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, and Utilization Review Guidelines will be modified to reflect the annual ICD-10 code additions, revisions, and deletions. Refer to the following sources for information on the code updates:

- Centers for Medicare & Medicaid Services (CMS) International Classification of Diseases, Tenth Revision (ICD-10) Clinical Modification (CM) (Diagnosis) Codes
- Centers for Medicare & Medicaid Services (CMS) International Classification of Diseases, Tenth Revision (ICD-10) Procedure Coding System (PCS) Codes

Complete details on impacted policies and corresponding code edits will be provided in the October 2020 edition of the Medical Policy Update Bulletin.

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.

Policy Title	Status	Effective Date
MEDICAL POLICY		
Autologous Cellular Therapy for Certain Indications (for Florida Only)	Revised	Oct. 1, 2020
Balloon Sinus Ostial Dilation (for Tennessee Only)	Revised	Oct. 1, 2020
Cardiac Event Monitoring (for Louisiana Only)	Updated	Sep. 1, 2020

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Policy Title	Status	Effective Date
Carrier Testing for Genetic Diseases (for Nebraska Only)	Retired	Sep. 1, 2020
Chelation Therapy for Non-Overload Conditions (for Louisiana Only)	Updated	Oct. 1, 2020
Chromosome Microarray Testing (Non-Oncology Conditions) (for Louisiana Only)	Retired	Sep. 1, 2020
Chromosome Microarray Testing (Non-Oncology Conditions) (for Nebraska Only)	Retired	Sep. 1, 2020
Collagen Crosslinks and Biochemical Markers of Bone Turnover (for Louisiana Only)	Revised	Oct. 1, 2020
Electrical and Ultrasound Bone Growth Stimulators (for Louisiana Only)	Updated	Sep. 1, 2020
Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions and Soft Tissue Wounds (for Tennessee Only)	Updated	Oct. 1, 2020
Facet Injections for Spinal Pain (for Louisiana Only)	Revised	Oct. 1, 2020
Fetal Aneuploidy Testing Using Cell-Free Fetal Nucleic Acids in Maternal Blood (for Nebraska Only)	Retired	Sep. 1, 2020
Functional Endoscopic Sinus Surgery (FESS) (for Tennessee Only)	Revised	Oct. 1, 2020
Gastrointestinal Motility Disorders, Diagnosis and Treatment (for Louisiana Only)	Revised	Oct. 1, 2020
Gastrointestinal Pathogen Nucleic Acid Detection Panel Testing for Infectious Diarrhea	Updated	Sep. 1, 2020
Genetic Testing for Cardiac Disease (for Nebraska Only)	Retired	Sep. 1, 2020
Genetic Testing for Hereditary Cancer (for Louisiana Only)	Updated	Sep. 1, 2020
Genitourinary Pathogen Nucleic Acid Detection Panel Testing	Updated	Sep. 1, 2020
Glaucoma Surgical Treatments (for Louisiana Only)	Revised	Oct. 1, 2020
High Frequency Chest Wall Compression Devices (for Louisiana Only)	Retired	Sep. 1, 2020
Hip Resurfacing and Replacement Surgery (Arthroplasty) (for Florida Only)	Revised	Oct. 1, 2020
Hip Resurfacing and Replacement Surgery (Arthroplasty) (for Tennessee Only)	Revised	Oct. 1, 2020
Inhaled Nitric Oxide for Infants	Updated	Oct. 1, 2020
Intrauterine Fetal Surgery (for Louisiana Only)	Revised	Oct. 1, 2020
Knee Replacement Surgery (Arthroplasty), Total and Partial (for Florida Only)	Revised	Oct. 1, 2020
Knee Replacement Surgery (Arthroplasty), Total and Partial (for Tennessee Only)	Revised	Oct. 1, 2020
Manipulation Under Anesthesia (for Louisiana Only)	Revised	Oct. 1, 2020
Minimally Invasive Procedures for Gastroesophageal Reflux Disease (GERD) and Achalasia	Revised	Nov. 1, 2020
Molecular Oncology Testing for Cancer Diagnosis, Prognosis, and Treatment Decisions (for Louisiana Only)	Updated	Sep. 1, 2020
Molecular Oncology Testing for Cancer Diagnosis, Prognosis, and Treatment Decisions (for Nebraska Only)	Retired	Sep. 1, 2020
Omnibus Codes (for Florida Only)	Revised	Oct. 1, 2020
Pharmacogenetic Testing (for Nebraska Only)	Retired	Sep. 1, 2020
Preimplantation Genetic Testing (for Nebraska Only)	Retired	Sep. 1, 2020
Shoulder Replacement Surgery (Arthroplasty) (for Florida Only)	Revised	Oct. 1, 2020
Shoulder Replacement Surgery (Arthroplasty) (for Tennessee Only)	Revised	Oct. 1, 2020
Spinal Ultrasonography	Revised	Nov. 1, 2020
Standing Systems and Gait Trainers (for Tennessee Only)	Revised	Oct. 1, 2020
Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins (for Tennessee Only)	Revised	Oct. 1, 2020
Surgical Treatment for Spine Pain (for Louisiana Only)	Revised	Oct. 1, 2020
Surgical Treatment for Spine Pain (for Tennessee Only)	Revised	Oct. 1, 2020
Surgical Treatment for Spine Pain (for Tennessee Only)	Revised	Nov. 1, 2020

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Policy Title	Status	Effective Date
Total Artificial Disc Replacement for the Spine (for Tennessee Only)	Revised	Oct. 1, 2020
Transcatheter Heart Valve Procedures (for Tennessee Only)	Revised	Oct. 1, 2020
MEDICAL BENEFIT DRUG POLICY		
Botulinum Toxins A and B	Updated	Sep. 1, 2020
Crysvita® (Burosumab-Twza)	Revised	Oct. 1, 2020
Givlaari® (Givosiran) (for Pennsylvania Only)	New	Oct. 1, 2020
Hereditary Angioedema (HAE), Treatment and Prophylaxis	Revised	Oct. 1, 2020
Respiratory Interleukins (Cinqair®, Fasenra®, & Nucala®)	Revised	Oct. 1, 2020
Scenesse® (Afamelanotide)	New	Oct. 1, 2020
Uplizna™ (Inebilizumab-Cdon)	New	Oct. 1, 2020
COVERAGE DETERMINATION GUIDELINE (CDG)		
Blepharoplasty, Blepharoptosis, and Brow Ptosis Repair (for Tennessee Only)	Revised	Oct. 1, 2020
Breast Reconstruction Post Mastectomy (for Louisiana Only)	Revised	Oct. 1, 2020
Breast Reduction Surgery (for Tennessee Only)	Revised	Oct. 1, 2020
Cosmetic and Reconstructive Procedures (for Tennessee Only)	Revised	Oct. 1, 2020
Durable Medical Equipment, Orthotics, Ostomy Supplies, Medical Supplies and Repairs/Replacements (for Louisiana Only)	Revised	Oct. 1, 2020
Oral and Enteral Nutrition (for Tennessee Only)	Revised	Oct. 1, 2020
Orthognathic (Jaw) Surgery (for Tennessee Only)	Revised	Oct. 1, 2020
Panniculectomy and Body Contouring Procedures (for Tennessee Only)	Revised	Oct. 1, 2020
Pectus Deformity Repair (for Tennessee Only)	Revised	Oct. 1, 2020
Prosthetic Devices, Specialized, Microprocessor or Myoelectric Limbs (for Louisiana Only)	Updated	Sep. 1, 2020
Rhinoplasty and Other Nasal Surgeries (for Tennessee Only)	Revised	Oct. 1, 2020

UnitedHealthcare Community Plan

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 Medical Policy, Medical Benefit Drug Policy, Coverage Determination Guideline, Utilization Review Guideline, and Quality of Care 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, CDGs, and URGs is available at **UHCprovider.com** > *Policies and Protocols > Community Plan Policies > Medical & Drug Policies and Coverage Determination Guidelines for Community Plan*.