

UnitedHealthcare Community Plan Medical Policy Update Bulletin: September 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

Annual ICD-10 Code and Quarterly CPT/HCPCS Code Updates

Effective Oct. 1, 2021, 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 and quarterly CPT/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 \(CMS\) 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](#)
- [Centers for Medicare & Medicaid Services. Healthcare Common Procedure Coding System: HCPCS Level II](#)

Complete details on impacted policies and corresponding code edits will be provided in the October 2021 edition of the Medical Policy Update Bulletin.

InterQual® Clinical Criteria Release: July 2021

Effective Sep. 1, 2021, the following Medical Policies and Coverage Determination Guidelines have been updated to reflect the applicable InterQual® clinical criteria reference(s) associated with the July 2021 Release:

- Catheter Ablation for Atrial Fibrillation
- Catheter Ablation for Atrial Fibrillation (for Nebraska Only)
- Catheter Ablation for Atrial Fibrillation (for New Jersey Only)
- Power Mobility Devices
- Surgical Treatment for Spine Pain
- Surgical Treatment for Spine Pain (for Nebraska Only)
- Surgical Treatment for Spine Pain (for New Jersey Only)
- Wheelchair Options and Accessories
- Wheelchair Seating

Policy Implementation Delay

The following Medical Policies will not be effective on the dates listed below as previously announced; implementation of these new policies has been postponed until further notice:

- *Sacroiliac Joint Interventions* (Oct. 1, 2021)
- *Surgery of the Ankle* (Nov. 1, 2021)

Medical Policy Updates

Policy Title	Status	Effective Date
Articular Cartilage Defect Repairs (for Nebraska Only)	Revised	Nov. 1, 2021

Policy Title	Status	Effective Date
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation (for Nebraska Only)	Revised	Nov. 1, 2021
Epidural Steroid Injections for Spinal Pain (for Nebraska Only)	Revised	Nov. 1, 2021
Facet Joint Injections for Spinal Pain (for Nebraska Only)	Revised	Nov. 1, 2021
Functional Endoscopic Sinus Surgery (FESS) (for Nebraska Only)	Revised	Nov. 1, 2021
Total Artificial Heart and Ventricular Assist Devices (for Nebraska Only)	Revised	Nov. 1, 2021
Transcatheter Heart Valve Procedures (for Nebraska Only)	Revised	Nov. 1, 2021
Visual Information Processing Evaluation and Orthoptic and Vision Therapy (for Nebraska Only)	Revised	Nov. 1, 2021

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Crysvita® (Burosumab-Twza)	Revised	Oct. 1, 2021
Gonadotropin Releasing Hormone Analogs	Updated	Oct. 1, 2021
Maximum Dosage and Frequency	Revised	Nov. 1, 2021
Onpattro® (Patisiran)	Updated	Sep. 1, 2021
Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors	Revised	Nov. 1, 2021
Respiratory Interleukins (Cinqair®, Fasentra®, & Nucala®)	Revised	Oct. 1, 2021

Coverage Determination Guideline Updates

Policy Title	Status	Effective Date
Beds and Mattresses (for Nebraska Only)	Revised	Nov. 1, 2021
Manual Wheelchairs (for Nebraska Only)	Revised	Nov. 1, 2021
Panniculectomy and Body Contouring Procedures (for Nebraska Only)	Revised	Nov. 1, 2021
Patient Lifts (for Nebraska Only)	Revised	Nov. 1, 2021
Power Mobility Devices (for Nebraska Only)	Revised	Nov. 1, 2021
Prosthetic Devices, Specialized, Microprocessor or Myoelectric Limbs (for Nebraska Only)	Revised	Nov. 1, 2021
Speech Generating Devices (for Nebraska Only)	Revised	Nov. 1, 2021
Therapeutic Shoes and Inserts for Diabetes (for Nebraska Only)	Revised	Nov. 1, 2021
Transcutaneous Electrical Nerve/Joint Stimulators (for Nebraska Only)	Revised	Nov. 1, 2021
Wheelchair Options and Accessories (for Nebraska Only)	Revised	Nov. 1, 2021
Wheelchair Seating (for Nebraska Only)	Revised	Nov. 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](#).