United Healthcare Community Plan

UnitedHealthcare Community Plan of Indiana
Medical Policy Update Bulletin: May 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

InterQual® 2022 Clinical Criteria: Apr. 2022 Release

Effective May 1, 2022, all applicable Medical Policies, Coverage Determination Guidelines, and Utilization Review Guidelines have been updated to reflect the InterQual® clinical criteria reference(s) associated with the Apr. 2022 Release. For the list of impacted policies and corresponding details, click here.

Policy Retirements

The following policies have been retired effective May 1, 2022, as the state of Indiana does not require clinical review for these services:

Policy Title	Policy Type
Abnormal Uterine Bleeding and Uterine Fibroids (for Indiana Only)	Medical Policy
Athletic Pubalgia Surgery (for Indiana Only)	Medical Policy
Attended Polysomnography for Evaluation of Sleep Disorders (for Indiana Only)	Medical Policy
Autologous Cellular Therapy for Certain Indications (for Indiana Only)	Medical Policy
Bronchial Thermoplasty (for Indiana Only)	Medical Policy
Cardiac Event Monitoring (for Indiana Only)	Medical Policy
Cardiovascular Disease Risk Tests (for Indiana Only)	Medical Policy
Carrier Testing for Genetic Diseases (for Indiana Only)	Medical Policy
Catheter Ablation for Atrial Fibrillation (for Indiana Only)	Medical Policy
Cell-Free Fetal DNA Testing (for Indiana Only)	Medical Policy
Collagen Crosslinks and Biochemical Markers of Bone Turnover (for Indiana Only)	Medical Policy
Computerized Dynamic Posturography (for Indiana Only)	Medical Policy
Corneal Collagen Crosslinking (for Indiana Only)	Medical Policy
Corneal Hysteresis and Intraocular Pressure Measurement (for Indiana Only)	Medical Policy
Cytological Examination of Breast Fluids for Cancer Screening or Diagnosis (for Indiana Only)	Medical Policy
Diagnostic Spinal Ultrasonography (for Indiana Only)	Medical Policy
Electrical Bioimpedance for Cardiac Output Measurement (for Indiana Only)	Medical Policy
Embolization of the Ovarian and Iliac Veins for Pelvic Congestion Syndrome (for Indiana Only)	Medical Policy
Emergency Services (for Indiana Only)	Coverage Determination Guideline
Epidural Steroid Injections for Spinal Pain (for Indiana Only)	Medical Policy
Epiduroscopy, Epidural Lysis of Adhesions, and Discography (for Indiana Only)	Medical Policy
Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions and Soft Tissue Wounds (for Indiana Only)	Medical Policy

Policy Title	Policy Type
Facet Joint Injections for Spinal Pain (for Indiana Only)	Medical Policy
Fecal Calprotectin Testing (for Indiana Only)	Medical Policy
Genetic Testing for Neuromuscular Disorders (for Indiana Only)	Medical Policy
Genitourinary Pathogen Nucleic Acid Detection Panel Testing (for Indiana Only)	Medical Policy
Gynecomastia Treatment (for Indiana Only)	Coverage Determination Guideline
Hepatitis Screening (for Indiana Only)	Medical Policy
Home Hemodialysis (for Indiana Only)	Medical Policy
Home Traction Therapy (for Indiana Only)	Medical Policy
Implantable Beta-Emitting Microspheres for Treatment of Malignant Tumors (for Indiana Only)	Medical Policy
Inhaled Nitric Oxide Therapy (for Indiana Only)	Medical Policy
Intraoperative Hyperthermic Intraperitoneal Chemotherapy (HIPEC) (for Indiana Only)	Medical Policy
Intrauterine Fetal Surgery (for Indiana Only)	Medical Policy
Laser Interstitial Thermal Therapy (for Indiana Only)	Medical Policy
Lithotripsy for Salivary Stones (for Indiana Only)	Medical Policy
Macular Degeneration Treatment Procedures (for Indiana Only)	Medical Policy
Manipulation Under Anesthesia (for Indiana Only)	Medical Policy
Manipulative Therapy (for Indiana Only)	Medical Policy
Minimally Invasive Procedures for Gastroesophageal Reflux Disease (GERD) and Achalasia (for Indiana Only)	Medical Policy
Motorized Spinal Traction (for Indiana Only)	Medical Policy
Nerve Graft to Restore Erectile Function During Radical Prostatectomy (for Indiana Only)	Medical Policy
Otoacoustic Emissions Testing (for Indiana Only)	Medical Policy
Percutaneous Patent Foramen Ovale (PFO) Closure (for Indiana Only)	Medical Policy
Percutaneous Vertebroplasty and Kyphoplasty (for Indiana Only)	Medical Policy
Prolotherapy and Platelet Rich Plasma Therapies (for Indiana Only)	Medical Policy
Skin and Soft Tissue Substitutes (for Indiana Only)	Medical Policy
Transcranial Magnetic Stimulation (for Indiana Only)	Medical Policy
Transpupillary Thermotherapy (for Indiana Only)	Medical Policy
Umbilical Cord Blood Harvesting and Storage for Future Use (for Indiana Only)	Medical Policy
Unicondylar Spacer Devices for Treatment of Pain or Disability (for Indiana Only)	Medical Policy
Visual Information Processing Evaluation and Orthoptic and Vision Therapy (for Indiana Only)	Medical Policy

Medical Policy Updates

Policy Title	Status	Effective Date
Prostate Surgeries and Interventions (for Indiana Only)	New	Jun. 1, 2022

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Enjaymo (for Indiana Only)	New	Jun. 1, 2022
Vyvgart™ (Efgartigimod Alfa-Fcab) (for Indiana Only)	Revised	Jun. 1, 2022

Utilization Review Guideline Updates

Policy Title	Status	Effective Date
Propranolol Treatment for Infantile Hemangiomas: Inpatient Protocol (for Indiana Only)	Retired	May 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 Community Plan of Indiana 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 of Indiana Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, and Utilization Review Guidelines is available at UHCprovider.com/Indiana > Medicaid (Community Plan) > Current Policies and Clinical Guidelines > UnitedHealthcare Community Plan of Indiana Medical & Drug Policies and Coverage Determination Guidelines.