United Healthcare Community Plan

UnitedHealthcare Community Plan of Kentucky
Medical Policy Update Bulletin: April 2022

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Quarterly CPT® and HCPCS Code Updates

Effective Apr. 1, 2022, the following 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

Policy Title	Policy Type	Summary of Changes
Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes (for Kentucky Only)	Medical Policy	• Added A4238 and E2102
Gastrointestinal Pathogen Nucleic Acid Detection Panel Testing for Infectious Diarrhea (for Kentucky Only)	Medical Policy	• Removed 0097U
Medical Therapies for Enzyme Deficiencies	Medical Benefit Drug Policy	Nexviazyme • Replaced C9085, J3490, and J3590 with J0219
Molecular Oncology Testing for Cancer Diagnosis, Prognosis, and Treatment Decisions (for Kentucky Only)	Medical Policy	• Added 0306U, 0307U, 0313U, 0314U, and 0315U • Revised description for 0022U
Omnibus Codes (for Kentucky Only)	Medical Policy	Cardiac Contractility Modulation using an Implantable Device • Added K1030
Ryplazim® (Plasminogen, Human-Tvmh)	Medical Benefit Drug Policy	• Replaced C9399 with C9090
Saphnelo™ (Anifrolumab-Fnia)	Medical Benefit Drug Policy	• Replaced C9086, J3490, and J3590 with J0491

Medical Policy Updates

Updated

Policy Title	Effective Date	Summary of Changes
Cognitive Rehabilitation (for Kentucky Only)	Apr. 1, 2022	Coverage Rationale • Replaced reference to "InterQual® *2021*, *Apr. 2021* Release, LOC: Outpatient Rehabilitation & Chiropractic, *Cerebrovascular Accident (CVA): Rehabilitation (Adult) and Traumatic Brain Injury (TBI): Rehabilitation (Adult)*" with "InterQual® *2022*, *Mar. 2022* Release, LOC: Outpatient Rehabilitation & Chiropractic"
Deep Brain and Cortical Stimulation (for Kentucky Only)	Apr. 1, 2022	Coverage Rationale • Updated language to clarify responsive cortical stimulation is proven and medically necessary for treating *refractory* partial or focal seizure disorder Supporting Information • Updated *Clinical Evidence* and *References* sections to reflect the most current information
Manipulative Therapy (for Kentucky Only)	Apr. 1, 2022	Coverage Rationale • Replaced reference to "InterQual® *2021*, *Apr. 2021* Release, LOC: Outpatient Rehabilitation & Chiropractic, *Cervicogenic Headache: Chiropractic (Adult), Spinal Disorders, Cervical: Chiropractic (Adult), Spinal Disorders, Lumbar: Chiropractic (Adult), Strain, Low Back: Chiropractic (Adult/Adolescent), and Strain, Neck: Chiropractic (Adult/Adolescent)*" with "InterQual® *2022*, *Mar. 2022 Release*, LOC: Outpatient Rehabilitation & Chiropractic"

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Plagiocephaly and Craniosynostosis Treatment (for Kentucky Only)	May 1, 2022	Coverage Rationale *Documentation Requirements* • Added language to indicate medical notes documenting the following are required, when applicable: Surgical Treatment (CPT code 21175) ○ History of medical conditions requiring treatment or surgical invention which includes all of the following: ▪ To prove medical necessity, a well-defined physical/physiologic abnormality resulting in a	Cranial Orthotic Devices are proven and medically necessary for treating infants following craniosynostosis surgery or for nonsynostotic (nonfusion) deformational or positional plagiocephaly. For medical necessity clinical coverage criteria, refer to the InterQual® 2021, Apr. 2021 Release, CP: Durable Medical Equipment, Orthoses, Cranial Remodeling. Click here to view the InterQual® criteria. **Documentation Requirements** ***Surgical Treatment (CPT 21175)*** Medical notes documenting the following, when applicable: • History of medical conditions requiring treatment or surgical invention which includes all of the following: ○ To prove medical necessity, a well-defined physical/physiologic abnormality resulting in a medical condition that requires treatment

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Plagiocephaly and Craniosynostosis Treatment (for Kentucky Only) (continued)	May 1, 2022	medical condition that requires treatment ▪ Recurrent or persistent functional impairment caused by the abnormality ○ Clinical studies/tests addressing the physical/physiologic abnormality confirming its presence and degree to which it causes impairment ○ Physician plan of care with proposed procedures and whether this request is part of a staged procedure; indicate how the procedure will improve and/or restore function Cranial Orthosis (HCPCS codes L0112 and S1040) ○ Initial Request ▪ Current prescription from physician ▪ Reason for the orthotic ▪ Diagnosis ▪ Physical exam related to support the need of the orthotic; include the neurological, circulatory, skin, and musculoskeletal examination that supports the request, as well as presence or absence of torticollis	○ Recurrent or persistent functional impairment caused by the abnormality • Clinical studies/tests addressing the physical/physiologic abnormality confirming its presence and degree to which it causes impairment • Physician plan of care with proposed procedures and whether this request is part of a staged procedure; indicate how the procedure will improve and/or restore function ***Cranial Orthosis (HCPCS L0112 and S1040)*** Initial Request Medical notes documenting the following, when applicable: • Current prescription from physician • Reason for the orthotic • Diagnosis • Physical exam related to support the need of the orthotic; include the neurological, circulatory, skin, and musculoskeletal examination that supports the request, as well as presence or absence of torticollis • At least one of the following: ○ Cranial vault asymmetry index (CVAI) ○ Cephalic index (CI) ○ Transcranial diameter difference (TDD) ○ Cranial vault asymmetry (CVA) ○ Children's Healthcare of Atlanta (CHOA) level • For more details about the definition of these measurements, see InterQual criteria informational notes • Documentation of treatments tried, failed, contraindicated. Include the dates and reason for discontinuation, including: ○ Repositioning ○ Physical or occupational therapy • Orthotist notes to include the following: ○ Equipment quote with billing codes and cost ○ Reason for the orthotic ○ Anthropometric Measurements

Medical Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Plagiocephaly and Craniosynostosis Treatment (for Kentucky Only) (continued)	May 1, 2022	▪ At least one of the following: – Cranial vault asymmetry index (CVAI) – Cephalic index (CI) – Transcranial diameter difference (TDD) – Cranial vault asymmetry (CVA) – Children's Healthcare of Atlanta (CHOA) level ▪ For more details about the definition of these measurements, see InterQual criteria informational notes ▪ Documentation of treatments tried, failed, contraindicated; include the dates and reason for discontinuation, including: – Repositioning – Physical or occupational therapy ▪ Orthotist notes to include the following: – Equipment quote with billing codes and cost – Reason for the orthotic – Anthropometric	● Date and type of injury/surgery, if applicable ○ Plan to treat torticollis with cranial orthosis **Replacement Request** Medical notes documenting the following, when applicable: ● Age of current orthotic ● Reason for replacement ● Adjustments/modifications to current cranial helmet if applicable ● Compliance with wear

Medical Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Plagiocephaly and Craniosynostosis Treatment (for Kentucky Only) (continued)	May 1, 2022	Measurements ▪ Date and type of injury/surgery, if applicable – Plan to treat torticollis with cranial orthosis ○ Replacement Request ▪ Age of current orthotic ▪ Reason for replacement ▪ Adjustments/modifications to current cranial helmet if applicable ▪ Compliance with wear	

Retired

Policy Title	Effective Date	Summary of Changes
Home Oxygen (for Kentucky Only)	Apr. 1, 2022	• Policy retired; home oxygen services no longer require clinical review

Medical Benefit Drug Policy Updates

Updated

Policy Title	Effective Date	Summary of Changes
Adakveo® (Crizanlizumab-Tmca)	May 1, 2022	**Applicable Codes** • Added ICD-10 diagnosis codes D57.0, D57.2, D57.21, D57.3, D57.4, D57.41, D57.43, D57.45, D57.8, D57.81, D57.813, and D57.818 • Revised description for ICD-10 diagnosis code D57.819 **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale

Lemtrada® (Alemtuzumab)	May 1, 2022	**Coverage Rationale**
		• Revised list of drug products (at least two required) the patient has a history of failure following a trial for at least 4 weeks or history of intolerance; added cladribine (Mavenclad)
		Supporting Information
		• Updated *References* section to reflect the most current information
			Lemtrada (alemtuzumab) is proven and medically necessary for treatment of relapsing forms of multiple sclerosis when all of the following criteria are met:
			• Diagnosis of relapsing forms of multiple sclerosis (MS) (e.g., relapsing-remitting MS, active secondary-progressive MS); and
			• One of the following:
			  ○ Treatment-naïve to alemtuzumab:
			  ▪ Patient has history of failure following a trial for at least 4 weeks or history of intolerance to at least two of the following:
			  – Interferon β-1a (Avonex® or Rebif®)
			  – Interferon β-1b (Betaseron® or Extavia®)
			  – Glatiramer acetate (Copaxone® or Glatopa®)
			  – Dimethyl fumarate (Tecfidera®)
			  – Teriflunomide (Aubagio®)
			  – Fingolimod (Gilenya®)
			  – Peginterferon beta-1a (Plegridy™)
			  – Natalizumab (Tysabri®)
			  – Ocrelizumab (Ocrevus®)
			  – Rituximab (Rituxan®, Riabni™, Truxima®, Ruxience™)
			  – Siponimod (Mayzent®)
			  – Ozanimod (Zeposia®)
			  – Ofatumumab (Kesimpta®)
			  – Monomethyl fumarate (Bafiertam)
			  – Cladribine (Mavenclad)

Medical Benefit Drug Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Lemtrada® (Alemtuzumab) (continued)	May 1, 2022		and ▪ Patient has not been previously treated with alemtuzumab; and ▪ Patient is not receiving alemtuzumab in combination with another disease modifying agent for multiple sclerosis (e.g., interferon beta preparations, glatiramer acetate, natalizumab, fingolimod, teriflunomide, ocrelizumab, etc.); and ▪ Initial dosing is administered: 12 mg intravenously daily for 5 consecutive days; and ▪ Regimen is administered only once within 12 months; and ▪ Initial authorization is for no more than 12 months or ○ Treatment-experienced with alemtuzumab: ▪ Patient has previously received treatment with alemtuzumab; and ▪ Documentation of positive clinical response to alemtuzumab therapy; and ▪ Patient is not receiving alemtuzumab in combination with another disease modifying agent for multiple sclerosis (e.g., interferon beta preparations, glatiramer acetate, natalizumab, fingolimod, teriflunomide, ocrelizumab, etc.); and ▪ Retreatment dosing is administered: 12 mg intravenously daily for 3 consecutive days; and ▪ Regimen is administered only once within 12 months; and ▪ Authorization is for no more than 12 months Alemtuzumab is unproven and not medically necessary for the treatment of: • Rheumatoid arthritis • Autoimmune neutropenia • Autoimmune hemolytic anemia • Pure red cell aplasia • Immune thrombocytopenic purpura • Evans syndrome • Autoimmune pancytopenia

Medical Benefit Drug Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Long-Acting Injectable Antiretroviral Agents for HIV	May 1, 2022	Coverage Rationale • Revised list of applicable long-acting injectable antiretroviral products; added Apretude (cabotegravir) • Added language to indicate: ○ Apretude (cabotegravir) has been added to the Review at Launch program and some members may not be eligible for coverage of this medication at this time; refer to the Medical Benefit Drug Policy titled *Review at Launch for New to Market Medications* for additional details ○ Apretude (cabotegravir) is proven to reduce the risk of sexually acquired HIV-1 infection in at-risk adults and adolescents weighing at least 35kg ○ Apretude is medically necessary when the following additional criteria are met: *Initial Therapy* ▪ Used for HIV-1 pre-exposure prophylaxis (PrEP) ▪ Patient has a negative HIV-1 test ▪ Provider confirms that the patient will be tested for	This policy refers to the following long-acting injectable antiretroviral products: • Apretude (cabotegravir) • Cabenuva (cabotegravir/rilpivirine) Apretude (cabotegravir) is proven to reduce the risk of sexually acquired HIV-1 infection in at-risk adults and adolescents weighing at least 35kg. Apretude is medically necessary when the following additional criteria are met: • For initial therapy, all of the following: ○ Used for HIV-1 pre-exposure prophylaxis (PrEP); and ○ Patient has a negative HIV-1 test; and ○ Provider confirms that the patient will be tested for HIV-1 infection with each subsequent injection; and ○ Patient is not an appropriate candidate for oral PrEP (e.g., difficulty with adherence to prior oral PrEP, significant renal disease); and ○ Provider attests that patient demonstrates treatment readiness by both of the following: ▪ Patient understands the risks of missed doses of Apretude ▪ Patient has the ability to adhere to the required every 2 months injection and testing appointments and ○ Dosing is in accordance with the United States Food and Drug Administration approved labeling; and ○ Initial authorization is for no more than 12 months. • For continuation therapy, all of the following: ○ Patient has previously received treatment with Apretude; and ○ Patient has a negative HIV-1 test; and ○ Provider confirms that the patient will be tested for HIV-1 infection with each subsequent injection; and ○ Dosing is in accordance with the United States Food and Drug Administration approved labeling; and ○ Authorization is for no more than 12 months.

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Long-Acting Injectable Antiretroviral Agents for HIV (continued)	May 1, 2022	HIV-1 infection with each subsequent injection ▪ Patient is not an appropriate candidate for oral PrEP (e.g., difficulty with adherence to prior oral PrEP, significant renal disease) ▪ Provider attests that patient demonstrates treatment readiness by both of the following: – Patient understands the risks of missed doses of Apretude – Patient has the ability to adhere to the required every 2 months injection and testing appointments ▪ Dosing is in accordance with the United States Food and Drug Administration approved labeling ▪ Initial authorization is for no more than 12 months *Continuation Therapy* ▪ Patient has previously received treatment with Apretude ▪ Patient has a negative HIV-1 test	Apretude is unproven and not medically necessary for the treatment of human immunodeficiency virus type-1 (HIV-1). Cabenuva (cabotegravir/rilpivirine) is proven for the treatment of a human immunodeficiency virus type-1 (HIV-1) in patients who are virologically suppressed (HIV-1 RNA less than 50 copies per mL). Cabenuva is medically necessary when the following additional criteria are met: • For initial therapy, all of the following: ○ Diagnosis of HIV-1 infection; and ○ Patient has no prior virologic failures or baseline resistance to either cabotegravir or rilpivirine; and ○ Patient is currently on a stable antiretroviral regimen; and ○ Submission of medical records (e.g., chart notes, laboratory results) showing viral suppression (HIV-1 RNA less than 50 copies per mL) for at least 6 months prior to initiation of Cabenuva; and ○ Provider attests that patient demonstrates treatment readiness by both of the following: ▪ Patient understands the risks of missed doses of Cabenuva ▪ Patient has the ability to adhere to the required monthly or every 2 months injection appointments and ○ Provider confirms that tolerability will be assessed using a 28-day oral lead-in of Vocabria (cabotegravir) and Edurant® (rilpivirine) tablets prior to the first injection of Cabenuva; and ○ Dosing is in accordance with the United States Food and Drug Administration approved labeling; and ○ Initial authorization is for no more than 12 months • For continuation therapy, all of the following: ○ Patient has previously received treatment with Cabenuva; and ○ Provider confirms that the patient has achieved and maintained viral suppression (HIV-1 RNA less than 50 copies per mL) while on Cabenuva therapy; and

Medical Benefit Drug Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Long-Acting Injectable Antiretroviral Agents for HIV (continued)	May 1, 2022	▪ Provider confirms that the patient will be tested for HIV-1 infection with each subsequent injection ▪ Dosing is in accordance with the United States Food and Drug Administration approved labeling ▪ Authorization is for no more than 12 months ○ Apretude is unproven and not medically necessary for the treatment of human immunodeficiency virus type-1 (HIV-1) **Applicable Codes** • Added HCPCS codes C9399 and J3490 • Added ICD-10 diagnosis codes Z11.3, Z11.4, Z20, Z20.2, Z20.6, Z72.5, Z72.51, Z72.52, and Z72.53 **Supporting Information** • Updated *Background*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	○ Dosing is in accordance with the United States Food and Drug Administration approved labeling; and ○ Authorization is for no more than 12 months Cabenuva is unproven and not medically necessary for the treatment of: • Human immunodeficiency virus type-1 (HIV-1) in patients who are not currently virally suppressed (HIV-1 RNA less than 50 copies per mL)
Repository Corticotropin Injections	May 1, 2022	**Title Change** • Previously titled *Repository Corticotropin Injection (Acthar® Gel)* **Coverage Rationale** • Revised list of applicable drug products; added “Purified	This policy refers to the following drug products: • Acthar® Gel (repository corticotropin injection) • Purified Cortrophin Gel™ (repository corticotropin injection USP) Acthar Gel (repository corticotropin injection) and Purified Cortrophin Gel (repository corticotropin injection USP) are proven and medically necessary

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Repository Corticotropin Injections (continued)	May 1, 2022	Cortrophin Gel™ (repository corticotropin injection USP)" • Added language to indicate: ○ Purified Cortrophin Gel is proven and medically necessary for the treatment of infantile spasm (i.e., West Syndrome) and opsoclonus-myoclonus syndrome (i.e., OMS, Kinsbourne Syndrome) when all of the criteria [listed in the policy] are met ○ Purified Cortrophin Gel is not medically necessary for treatment of acute exacerbations of multiple sclerosis ○ Purified Cortrophin Gel is unproven and not medically necessary for treatment of the following disorders and diseases: ▪ Allergic States: Serum sickness ▪ Collagen Diseases: Systemic lupus erythematosus, systemic dermatomyositis (polymyositis) ▪ Dermatologic Diseases: Severe erythema multiforme, Stevens-Johnson syndrome	for the treatment of: • Infantile spasm (i.e., West Syndrome) for up to 4 weeks when all of the following criteria are met: ○ Diagnosis of infantile spasms (i.e., West Syndrome); and ○ Patient is less than 2 years old; and ○ Physician attestation that the caregiver is not able to be trained or are physically unable to administer the drug. Physician must submit explanation; and ○ Dosing for infantile spasm is as follows: ▪ Initial dose: 75 U/m^2 intramuscular (IM) twice daily for 2 weeks ▪ After 2 weeks, dose should be tapered according to the following schedule: 30 U/m^2 IM in the morning for 3 days; 15 U/m^2 IM in the morning for 3 days; 10 U/m^2 IM in the morning for 3 days; and 10 U/m^2 IM every other morning for 6 days (3 doses) • Opsoclonus-myoclonus syndrome (i.e., OMS, Kinsbourne Syndrome) when both of the following criteria are met: ○ Diagnosis of Opsoclonus-myoclonus syndrome (i.e., OMS, Kinsbourne Syndrome); and ○ Physician attestation that the caregiver is not able to be trained or are physically unable to administer the drug; physician must submit explanation. Acthar Gel and Purified Cortrophin Gel are not medically necessary for treatment of acute exacerbations of multiple sclerosis. Acthar Gel and Purified Cortrophin Gel are unproven and not medically necessary for treatment of the following disorders and diseases: • Allergic States: Serum sickness • Collagen Diseases: Systemic lupus erythematosus, systemic dermatomyositis (polymyositis) • Dermatologic Diseases: Severe erythema multiforme, Stevens-Johnson syndrome • Edematous State: To induce a diuresis or a remission of proteinuria in the

Medical Benefit Drug Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Repository Corticotropin Injections (continued)	May 1, 2022	▪ Edematous State: To induce a diuresis or a remission of proteinuria in the nephrotic syndrome without uremia of the idiopathic type or that due to lupus erythematosus ▪ Ophthalmic Diseases: Severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa such as: keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation ▪ Respiratory Diseases: Symptomatic sarcoidosis ▪ Rheumatic Disorders: Psoriatic arthritis, rheumatoid arthritis, including juvenile rheumatoid arthritis, ankylosing spondylitis ▪ Any indication outside of the proven indications [listed in the policy] • Revised coverage criteria for: *Infantile Spasm* ○ Added criterion requiring physician attestation that the	nephrotic syndrome without uremia of the idiopathic type or that due to lupus erythematosus • Ophthalmic Diseases: Severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa such as keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation • Respiratory Diseases: Symptomatic sarcoidosis • Rheumatic Disorders: Psoriatic arthritis, rheumatoid arthritis, including juvenile rheumatoid arthritis, ankylosing spondylitis • Any indication outside of the proven indications above

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Repository Corticotropin Injections (continued)	May 1, 2022	caregiver is not able to be trained or are physically unable to administer the drug; the physician must submit an explanation *Opsoclonus-Myoclonus Syndrome* ○ Added criterion requiring: ▪ Diagnosis of opsoclonus-myoclonus syndrome (i.e., OMS, Kinsbourne Syndrome) ▪ Physician attestation that the caregiver is not able to be trained or are physically unable to administer the drug; the physician must submit an explanation Supporting Information ● Updated *Background*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	
Stelara® (Ustekinumab)	May 1, 2022	Coverage Rationale *Crohn's Disease* ● Revised coverage criteria for initial therapy; added criterion requiring history of failure, contraindication, or intolerance to two biologic DMARDs FDA-approved for the treatment of Crohn's disease (document drug, date, and duration of trial)	Refer to the policy for complete details.

Medical Benefit Drug Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Stelara® (Ustekinumab) (continued)	May 1, 2022	*Plaque Psoriasis* • Revised coverage criteria for initial therapy; added criterion requiring history of failure, contraindication, or intolerance to two biologic or targeted synthetic DMARDs FDA-approved for the treatment of plaque psoriasis (document drug, date, and duration of trial) *Psoriatic Arthritis* • Revised coverage criteria for initial therapy; added criterion requiring one of the following: ○ History of failure, contraindication, or intolerance to two biologic or targeted synthetic DMARDs FDA-approved for the treatment of psoriatic arthritis (document drug, date, and duration of trial); or ○ Patient is currently on Stelara *Ulcerative Colitis* • Revised coverage criteria; added criterion requiring history of failure, contraindication, or intolerance to one biologic or targeted synthetic DMARD FDA-approved for the treatment of ulcerative colitis (document drug, date, and duration of trial)	

Coverage Determination Guidelines

Updated

Policy Title	Effective Date	Summary of Changes
Outpatient Physical, Occupational, and Speech Therapy (for Kentucky Only)	Apr. 1, 2022	Coverage Rationale • Replaced reference to: *Medical Necessity Clinical Coverage Criteria* ○ "InterQual® *2021*, *Apr. 2021* Release, LOC: Outpatient Rehabilitation & Chiropractic" with "InterQual® *2022*, *Mar. 2022 Release*, LOC: Outpatient Rehabilitation & Chiropractic" *Visit Guidelines* ○ "InterQual® *2021*" with "InterQual® *2022*"

Retired

Policy Title	Effective Date	Summary of Changes
Chiropractic Services (for Kentucky Only)	Apr. 1, 2022	• Policy retired; refer to the Kentucky Administrative Regulations 907 KAR 3:125 for applicable guidelines for chiropractic services
Nursing Facility Services and Intermediate Care Facility for Individuals with an Intellectual Disability Services (for Kentucky Only)	Apr. 1, 2022	• Policy retired; refer to the Kentucky Administrative Regulations 907 KAR 1:022 for applicable guidelines for nursing facility services and intermediate care facility for individuals with an intellectual disability services
Orthopedic Shoes and Attachments (for Kentucky Only)	Apr. 1, 2022	• Policy retired; refer to the Kentucky Administrative Regulations 907 KAR 1:479 for applicable guidelines for orthopedic shoes and attachments
Podiatry Program Services (for Kentucky Only)	Apr. 1, 2022	• Policy retired; refer to the Kentucky Administrative Regulations 907 KAR 1:270 for applicable guidelines for podiatry services
Selected Therapies as Ancillary Services in Nursing Facilities (for Kentucky Only)	Apr. 1, 2022	• Policy retired; refer the Kentucky Administrative Regulations 907 KAR 1:023 for applicable guidelines for selected therapies as ancillary services in nursing facilities
Tobacco Cessation (for Kentucky Only)	Apr. 1, 2022	• Policy retired; refer to the Kentucky Administrative Regulations 907 KAR 3:215 for applicable guidelines for tobacco cessation services

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 Kentucky 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 Kentucky Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, and Utilization Review Guidelines is available at UHCprovider.com/Kentucky > Medicaid (Community Plan) > Current Policies and Clinical Guidelines > UnitedHealthcare Community Plan of Kentucky Medical & Drug Policies and Coverage Determination Guidelines.