

UnitedHealthcare Community Plan of Kentucky Medical Policy Update Bulletin Quick View: April 2025



A list of recently approved, revised, and/or retired Medical Policies and/or Medical Benefit Drug Policies is provided below for your reference. **For a comprehensive summary of the latest updates, refer to the [Medical Policy Update Bulletin: April 2025](#).**

Take Note

Quarterly CPT/HCPCS Code Updates

Effective **Apr. 1, 2025**, 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 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 \(HCPCS\) Quarterly Update](#)

Refer to the [Medical Policy Update Bulletin: April 2025](#) for a list of impacted policies and corresponding details.

Medical Policy Updates

Policy Title	Status	Effective Date
Ablative Treatment for Spinal Pain (for Kentucky Only)	Revised	May 1, 2025
Airway Clearance Devices (for Kentucky Only)	Revised	Jun. 1, 2025
Ambulance Services (for Kentucky Only)	Updated	Jun. 1, 2025
Athletic Pubalgia Surgery (for Kentucky Only)	Retired	Apr. 1, 2025
Bariatric Surgery (for Kentucky Only)	Revised	May 1, 2025
Cardiovascular Disease Risk Tests (for Kentucky Only)	Revised	Jun. 1, 2025
Deep Brain and Cortical Stimulation (for Kentucky Only)	Revised	May 1, 2025
Electric Tumor Treatment Field Therapy (for Kentucky Only)	Revised	May 1, 2025
Fecal Microbiota Transplantation (for Kentucky Only)	Retired	Apr. 1, 2025
Gastrointestinal Pathogen Nucleic Acid Detection Panel Testing for Infectious Diarrhea (for Kentucky Only)	Revised	May 1, 2025
Genetic Testing for Hereditary Cancer (for Kentucky Only)	Revised	Jun. 1, 2025
Hearing Instruments and Devices Including Wearable, Bone-Anchored, and Semi-Implantable (for Kentucky Only)	Updated	Apr. 1, 2025
Intensity-Modulated Radiation Therapy (for Kentucky Only)	Revised	Jun. 1, 2025
Interspinous Fusion and Decompression Devices (for Kentucky Only)	Updated	Jun. 1, 2025
Neurophysiologic Testing and Monitoring (for Kentucky Only)	Updated	Apr. 1, 2025
Proton Beam Radiation Therapy (for Kentucky Only)	Revised	Jun. 1, 2025
Rhinoplasty and Other Nasal Procedures (for Kentucky Only)	Updated	Jun. 1, 2025
Sacral Nerve Stimulation for Urinary and Fecal Indications (for Kentucky Only)	Updated	Jun. 1, 2025
Skin and Soft Tissue Substitutes (for Kentucky Only)	Revised	May 1, 2025

Policy Title	Status	Effective Date
Transanal Minimally Invasive Surgical Procedures (for Kentucky Only)	Retired	Apr. 1, 2025
Transarterial Radioembolization (TARE)/Selective Internal Radiation Therapy (SIRT) for the Treatment of Malignant Cancers of the Liver (for Kentucky Only)	Revised	May 1, 2025
Transcranial Magnetic Stimulation (for Kentucky Only)	Revised	Jun. 1, 2025
Transpupillary Thermotherapy (for Kentucky Only)	Retired	Apr. 1, 2025
Treatment of Temporomandibular Joint Disorders (for Kentucky Only)	Revised	May 1, 2025
Upper Extremity Prosthetic Devices (for Kentucky Only)	Revised	Jun. 1, 2025
Whole Exome and Whole Genome Sequencing (Non-Oncology Conditions) (for Kentucky Only)	Revised	May 1, 2025

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Amondys 45 [®] (Casimersen)	Revised	May 1, 2025
Elevidys [™] (Delandistrogene Moxparvovec-Rokl)	Revised	May 1, 2025
Enjaymo [®] (Sutimlimab-Jome)	Updated	Apr. 1, 2025
Exondys 51 [®] (Eteplirsen)	Revised	May 1, 2025
Niktimvo [™] (Axatilimab-Csfr)	New	May 1, 2025
Omvo [®] (Mirikizumab-Mrkz)	Revised	May 1, 2025
Parsabiv [®] (Etelcalcetide)	Updated	May 1, 2025
Repository Corticotropin Injections	Revised	May 1, 2025
Tremfya [®] (Guselkumab)	Revised	May 1, 2025
Ustekinumab	Revised	May 1, 2025
Viltepso [®] (Viltolarsen)	Revised	May 1, 2025
Vyondys 53 [®] (Golodirsen)	Revised	May 1, 2025

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 changes to our Community Plan of Kentucky Medical Policies and Medical Benefit Drug Policies. 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 and Medical Benefit Drug Policies is available at UHCprovider.com/KY > Community Plan (Medicaid) > Current Policies and Clinical Guidelines > [Medical & Drug Policies](#).