United Healthcare Community Plan

UnitedHealthcare Community Plan of Kentucky

Medical Policy Update Bulletin: August 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

Implementation of Revisions Delayed: Maximum Dosage and Frequency

Implementation of the revisions to the Medical Benefit Drug Policy titled Maximum Dosage and Frequency (for Kentucky Only), previously announced for an effective date of Aug. 1, 2021, has been postponed until Sep. 1, 2021.

Medical Policy Updates

Policy Title	Status	Effective Date
Airway Clearance Devices (for Kentucky Only)	Revised	Sep. 1, 2021
Cell-Free Fetal DNA (for Kentucky Only)	Updated	Aug. 1, 2021
Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions and Soft Tissue Wounds (for Kentucky Only)	Updated	Aug. 1, 2021
Gastrointestinal Motility Disorders, Diagnosis and Treatment (for Kentucky Only)	Revised	Sep. 1, 2021
Hearing Aids and Devices Including Wearable, Bone-Anchored and Semi-Implantable (for Kentucky Only)	Updated	Aug. 1, 2021
Lower Extremity Invasive Diagnostic and Endovascular Procedures (for Kentucky Only)	Revised	Sep. 1, 2021
Prolotherapy and Platelet Rich Plasma Therapies (for Kentucky Only)	Updated	Aug. 1, 2021
Sacroiliac Joint Interventions (for Kentucky Only)	Revised	Sep. 1, 2021
Total Artificial Disc Replacement for the Spine (for Kentucky Only)	Revised	Sep. 1, 2021
Transcatheter Heart Valve Procedures (for Kentucky Only)	Revised	Sep. 1, 2021

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Actemra® (Tocilizumab) Injection for Intravenous Infusion (for Kentucky Only)*	Revised	Sep. 1, 2021
Adakveo® (Crizanlizumab-Tmca) (for Kentucky Only)	Updated	Aug. 1, 2021
Alpha$_1$-Proteinase Inhibitors (for Kentucky Only)	Updated	Aug. 1, 2021
Azathioprine Sodium Injection (for Kentucky Only)	New	Sep. 1, 2021
Baclofen Injection (for Kentucky Only)	New	Sep. 1, 2021
BAL in Oil (Dimercaprol) Injection (for Kentucky Only)	New	Sep. 1, 2021
Brineura™ (Cerliponase Alfa) (for Kentucky Only)	Updated	Aug. 1, 2021
Buprenorphine (Probuphine® & Sublocade™) (for Kentucky Only)	Updated	Aug. 1, 2021
Carnitor® (Levocarnitine) Solution for Injection (for Kentucky Only)	New	Sep. 1, 2021
Cimzia® (Certolizumab Pegol) (for Kentucky Only)*	Revised	Sep. 1, 2021

Policy Title	Status	Effective Date
Desmopressin Acetate Solution for Injection (for Kentucky Only)	New	Sep. 1, 2021
Duopa™ (Carbidopa and Levodopa) Enteral Suspension (for Kentucky Only)	New	Sep. 1, 2021
Entyvio® (Vedolizumab) (for Kentucky Only)	Updated	Aug. 1, 2021
Ethamolin® (Ethanolamine Oleate) Injection (for Kentucky Only)	New	Sep. 1, 2021
Evenity™ (Romosozumab-Aqqg) (for Kentucky Only)	Updated	Aug. 1, 2021
Exondys 51® (Eteplirsen) (for Kentucky Only)	Updated	Aug. 1, 2021
Givlaari® (Givosiran) (for Kentucky Only)	Revised	Sep. 1, 2021
Hereditary Angioedema (HAE), Treatment and Prophylaxis (for Kentucky Only)	Revised	Sep. 1, 2021
Human Chorionic Gonadotropin (for Kentucky Only)	New	Sep. 1, 2021
Immune Globulin (IVIG and SCIG) (for Kentucky Only)	Revised	Sep. 1, 2021
Injectable Atypical Antipsychotic Agents (for Kentucky Only)	New	Sep. 1, 2021
Intravenous Anti-Infective Agents (for Kentucky Only)	New	Sep. 1, 2021
Intravenous Enzyme Replacement Therapy (ERT) for Gaucher Disease (for Kentucky Only)	Revised	Sep. 1, 2021
Intravitreal Corticosteroid Implants (for Kentucky Only)	Revised	Sep. 1, 2021
Ketalar® (Ketamine) and Spravato™ (Esketamine) (for Kentucky Only)	Revised	Sep. 1, 2021
Krystexxa® (Pegloticase) (for Kentucky Only)	Updated	Aug. 1, 2021
Lemtrada (Alemtuzumab) (for Kentucky Only)	Revised	Sep. 1, 2021
Levetiracetam Solution for Injection (for Kentucky Only)	New	Sep. 1, 2021
Levulan® Kerastick® (Aminolevulinic Acid Hydrochloride) Topical Solution (for Kentucky Only)	New	Sep. 1, 2021
Milrinone Lactate Solution for Injection (for Kentucky Only)	New	Sep. 1, 2021
Morphine Injection for Epidural or Intrathecal (for Kentucky Only)	New	Sep. 1, 2021
Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors (for Kentucky Only)	Revised	Sep. 1, 2021
Orencia® (Abatacept) Injection for Intravenous Infusion (for Kentucky Only)*	Revised	Sep. 1, 2021
Parsabiv® (Etelcalcetide) (for Kentucky Only)	Revised	Sep. 1, 2021
Pentamidine Isethionate Inhalant (for Kentucky Only)	New	Sep. 1, 2021
Prialt® (Ziconotide) (for Kentucky Only)	New	Sep. 1, 2021
Prograf® (Tacrolimus) Injection (for Kentucky Only)	New	Sep. 1, 2021
Respiratory Interleukins (Cinqair®, Fasenra®, & Nucala®) (for Kentucky Only)	Revised	Sep. 1, 2021
Rhophylac® (Rho[D] Immune Globulin) (for Kentucky Only)	New	Sep. 1, 2021
Rimso-50® (Dimethyl Sulfoxide) Irrigant (for Kentucky Only)	New	Sep. 1, 2021
Simponi Aria® (Golimumab) Injection for Intravenous Infusion (for Kentucky Only)*	Revised	Sep. 1, 2021
Stelara® (Ustekinumab) (for Kentucky Only)*	Revised	Sep. 1, 2021
Tepezza® (Teprotumumab-Trbw) (for Kentucky Only)	Revised	Sep. 1, 2021
Trogarzo® (Ibalizumab-Uiyk) (for Kentucky Only)	Updated	Aug. 1, 2021
Tysabri® (Natalizumab) (for Kentucky Only)	Revised	Sep. 1, 2021
Viltepso® (Viltolarsen) (for Kentucky Only)	New	Sep. 1, 2021
Vyepti™ (Eptinezumab) (for Kentucky Only)	Revised	Sep. 1, 2021
Vyondys 53™ (Golodirsen) (for Kentucky Only)	Updated	Aug. 1, 2021
Zilretta® (Triamcinolone Acetonide Extended-Release Injectable Suspension) (for Kentucky Only)	Revised	Sep. 1, 2021

*Updated Aug. 3, 2021: Corrected summary of changes; refer to the detailed version of the bulletin for complete details

Coverage Determination Guideline Updates

Policy Title	Status	Effective Date
Emergency Health Services and Urgent Care Center Services (for Kentucky Only)	Revised	Sep. 1, 2021
Home Health Care Services (for Kentucky Only)	Updated	Aug. 1, 2021
Speech Generating Devices (for Kentucky Only)	Updated	Sep. 1, 2021

Utilization Review Guideline Updates

Policy Title	Status	Effective Date
Drug Testing (for Kentucky Only)	Revised	Sep. 1, 2021
Inpatient Pediatric Feeding Programs (for Kentucky Only)	Retired	Aug. 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 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.