United Healthcare Community Plan

UnitedHealthcare Community Plan of Kentucky
Medical Policy Update Bulletin: June 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.

Medical Policy Updates

Policy Title	Status	Effective Date
Articular Cartilage Defect Repairs	Revised	Jul. 1, 2021
Cell-Free Fetal DNA Testing	Revised	Jul. 1, 2021
Femoroacetabular Impingement Syndrome	Replaced	Jun. 1, 2021
Implanted Electrical Stimulator for Spinal Cord	Revised	Jul. 1, 2021
Lower Extremity Invasive Diagnostic and Endovascular Procedures	Revised	Jul. 1, 2021
Otoacoustic Emissions Testing	Retired	Jun. 1, 2021
Pharmacogenetic Testing	Updated	Jun. 1, 2021

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Antiemetics for Oncology	Revised	Jul. 1, 2021
Benlysta® (Belimumab)	Revised	Jul. 1, 2021
Complement Inhibitors (Soliris® & Ultomiris®)	Revised	Jul. 1, 2021
Gonadotropin Releasing Hormone Analogs	Revised	Jul. 1, 2021
Infliximab (Remicade®)	Revised	Jul. 1, 2021
Intravenous Bisphosphonates/Bone Resorption Inhibitors (Zoledronic Acid & Pamidronate Disodium)	Revised	Jul. 1, 2021
Long-Acting Injectable Antiretroviral Agents	New	Jul. 1, 2021
Oxlumo™ (Lumasiran)	New	Jul. 1, 2021
Rituximab (Riabni™, Rituxan®, Ruxience®, & Truxima®)	Revised	Jul. 1, 2021
Spinraza® (Nusinersen)	Revised	Jul. 1, 2021
White Blood Cell Colony Stimulating Factors	Revised	Jul. 1, 2021
Xiaflex® (Collagenase, Clostridium, Histolyticum)	Revised	Jul. 1, 2021
Xolair® (Omalizumab)	Revised	Jul. 1, 2021
Zolgensma® (Onasemnogene Abeparvovec-Xioi)	Revised	Jul. 1, 2021

Coverage Determination Guideline Updates

Policy Title	Status	Effective Date
Ambulance Services	Revised	Jul. 1, 2021
Breast Reconstruction Post Mastectomy and Poland Syndrome	Updated	Jun. 1, 2021

Policy Title	Status	Effective Date
Chiropractic Services	Revised	Jul. 1, 2021
Rhinoplasty and Other Nasal Surgeries	Updated	Jun. 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.