United Healthcare Community Plan

UnitedHealthcare Community Plan of Kentucky
Medical Policy Update Bulletin: May 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
Ablative Treatment for Spinal Pain	Revised	May 1, 2021
Attended Polysomnography for Evaluation of Sleep Disorders	Revised	May 1, 2021
Balloon Sinus Ostial Dilation	Revised	May 1, 2021
Bariatric Surgery	Revised	May 1, 2021
Cardiac Event Monitoring	Revised	May 1, 2021
Cochlear Implants	Revised	May 1, 2021
Computed Tomographic Colonography	Revised	May 1, 2021
Deep Brain and Cortical Stimulation	Revised	Jun. 1, 2021
Electrical and Ultrasound Bone Growth Stimulators	Revised	May 1, 2021
Epiduroscopy, Epidural Lysis of Adhesions and Discography	Revised	May 1, 2021
Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions and Soft Tissue Wounds	Revised	May 1, 2021
Functional Endoscopic Sinus Surgery (FESS)	Revised	May 1, 2021
Gastrointestinal Motility Disorders, Diagnosis and Treatment	Revised	May 1, 2021
Genetic Testing for Neuromuscular Disorders	Revised	Jun. 1, 2021
Hysterectomy	Revised	Jun. 1, 2021
Intensity-Modulated Radiation Therapy	Revised	Jun. 1, 2021
Manipulative Therapy	Revised	May 1, 2021
Molecular Oncology Testing for Cancer Diagnosis, Prognosis, and Treatment Decisions	Updated	Jun. 1, 2021
Negative Pressure Wound Therapy	Revised	May 1, 2021
Neurophysiologic Testing and Monitoring	Revised	May 1, 2021
Neuropsychological Testing Under the Medical Benefit	Revised	May 1, 2021
Obstructive Sleep Apnea Treatment	Revised	Jun. 1, 2021
Percutaneous Vertebroplasty and Kyphoplasty	Revised	May 1, 2021
Prostate Surgery	Revised	Jun. 1, 2021
Proton Beam Radiation Therapy	Revised	May 1, 2021
Sacroiliac Joint Injections	New	Jun. 1, 2021
Single-Photon Emission Computed Tomography (SPECT) and Positron Emission Tomography (PET) Scans	Retired	May 1, 2021
Standing Systems	Revised	May 1, 2021
Temporomandibular Joint Disorders	Revised	Jun. 1, 2021

Policy Title	Status	Effective Date
Total Artificial Disc Replacement for the Spine	Revised	Jun. 1, 2021
Total Artificial Heart and Ventricular Assist Devices	Revised	May 1, 2021
Transcatheter Heart Valve Procedures	Revised	May 1, 2021
Vagus and External Trigeminal Nerve Stimulation	Revised	May 1, 2021

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Dexrazoxane Hydrochloride Injection	New	Jun. 1, 2021
Intravenous Iron Replacement Therapy	Revised	Jun. 1, 2021
Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors	Revised	Jun. 1, 2021
Sodium Hyaluronate	Revised	Jun. 1, 2021
Steroidal Ophthalmic Intravitreal Injections/Implants and Sinus Implants	Revised	Jun. 1, 2021

Coverage Determination Guideline Updates

Policy Title	Status	Effective Date
Blepharoplasty, Blepharoptosis, and Brow Ptosis Repair	Revised	May 1, 2021
Breast Reconstruction Post Mastectomy and Poland Syndrome	Revised	May 1, 2021
Breast Reduction Surgery	Revised	May 1, 2021
Breast Repair/Reconstruction Not Following Mastectomy	Revised	May 1, 2021
Clinical Trials	Revised	May 1, 2021
Gastrointestinal Pathogen Nucleic Acid Detection Panel Testing for Infectious Diarrhea	Revised	Jun. 1, 2021
Gynecomastia Treatment	Revised	May 1, 2021
Panniculectomy and Body Contouring Procedures	Revised	May 1, 2021
Prosthetic Devices, Wigs, Specialized, Microprocessor or Myoelectric Limbs	Revised	May 1, 2021
Transcutaneous Electrical Nerve/Joint Stimulators	Revised	May 1, 2021

Utilization Review Guideline Updates

Policy Title	Status	Effective Date
Elective Inpatient Services	New	Jun. 1, 2021
Observation Services	New	Jun. 1, 2021
Pediatric Outpatient Intensive Feeding	Revised	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.