

# UnitedHealthcare Community Plan of Kentucky Medical Policy Update Bulletin: October 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

### Annual ICD-10 Diagnosis Code and Quarterly CPT® and HCPCS Code Updates

Effective Oct. 1, 2021, all applicable Medical Policies, Medical Benefit Drug Policies, and Coverage Determination Guidelines have been updated to reflect the annual ICD-10 diagnosis code and quarterly CPT/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 \(CMS\) International Classification of Diseases, Tenth Revision \(ICD-10\) Clinical Modification \(CM\) \(Diagnosis\) Codes](#)
- [Centers for Medicare & Medicaid Services \(CMS\) International Classification of Diseases, Tenth Revision \(ICD-10\) Procedure Coding System \(PCS\) Codes](#)
- [Centers for Medicare & Medicaid Services. Healthcare Common Procedure Coding System: HCPCS Level II](#)

For the list of impacted policies and corresponding details, click [here](#).

## Medical Policy Updates

Policy Title	Status	Effective Date
Autologous Cellular Therapy (for Kentucky Only)	Updated	Nov. 1, 2021
Cesarean-Section (for Kentucky Only)	Retired	Oct. 1, 2021
Helicobacter Pylori Serology Testing (for Kentucky Only)	Retired	Oct. 1, 2021
Intensity-Modulated Radiation Therapy (for Kentucky Only)	Revised	Nov. 1, 2021
Obstructive and Central Sleep Apnea Treatment (for Kentucky Only)	Revised	Nov. 1, 2021
Occipital Nerve Injections and Ablation (Including Occipital Neuralgia and Headache Treatment (for Kentucky Only)	Revised	Nov. 1, 2021
Prostate Surgeries and Interventions (for Kentucky Only)	Revised	Nov. 1, 2021
Surgery of the Foot (for Kentucky Only)	Revised	Nov. 1, 2021
Surgery of the Shoulder (for Kentucky Only)	Revised	Nov. 1, 2021
Surgical Treatment for Spine Pain (for Kentucky Only)	Revised	Nov. 1, 2021

## Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Antiemetics for Oncology (for Kentucky Only)	Revised	Nov. 1, 2021
Botulinum Toxins A and B	Revised	Nov. 1, 2021
Denosumab (Prolia® & Xgeva®)	Revised	Nov. 1, 2021
Entyvio® (Vedolizumab)	Revised	Nov. 1, 2021

Policy Title	Status	Effective Date
Intravenous Iron Replacement Therapy (Feraheme®, Injectafer®, & Monoferric®) (for Kentucky Only)	Revised	Nov. 1, 2021
Medical Therapies for Enzyme Deficiencies (for Kentucky Only)	Revised	Nov. 1, 2021
Ocrevus® (Ocrelizumab)	Revised	Nov. 1, 2021
Oncology Medication Clinical Coverage (for Kentucky Only)	Revised	Nov. 1, 2021
Orencia® (Abatacept) Injection for Intravenous Infusion	Revised	Nov. 1, 2021
Respiratory Interleukins (Cinqair®, Fasentra®, & Nucala®)	Revised	Nov. 1, 2021
Ryplazim® (for Kentucky Only)	New	Nov. 1, 2021
Saphnelo™ (for Kentucky Only)	New	Nov. 1, 2021
Sodium Hyaluronate	Revised	Nov. 1, 2021
Synagis® (Palivizumab) (for Kentucky Only)	Revised	Nov. 1, 2021
Xolair® (Omalizumab)	Revised	Nov. 1, 2021

## Coverage Determination Guideline Updates

Policy Title	Status	Effective Date
Oral and Enteral Nutrition (for Kentucky Only)	Revised	Nov. 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](https://UHCprovider.com/Kentucky) > Medicaid (Community Plan) > Current Policies and Clinical Guidelines > [UnitedHealthcare Community Plan of Kentucky Medical & Drug Policies and Coverage Determination Guidelines](#).