

UnitedHealthcare Community Plan of Tennessee 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 Tennessee Only) | Updated | Apr. 1, 2025 |
| Athletic Pubalgia Surgery (for Tennessee Only) | Retired | Apr. 1, 2025 |
| Deep Brain and Cortical Stimulation (for Tennessee Only) | Updated | Apr. 1, 2025 |
| Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/Replacements (for Tennessee Only) | Updated | Apr. 1, 2025 |
| Fecal Microbiota Transplantation (for Tennessee Only) | Retired | Apr. 1, 2025 |
| Genetic Testing for Hereditary Cancer (for Tennessee Only) | Revised | Jun. 1, 2025 |
| Hearing Aids and Devices Including Wearable, Bone-Anchored, and Semi-Implantable (for Tennessee Only) | Updated | Apr. 1, 2025 |
| Intensity-Modulated Radiation Therapy (for Tennessee Only) | Revised | Jun. 1, 2025 |
| Interspinous Fusion and Decompression Devices (for Tennessee Only) | Revised | Jun. 1, 2025 |
| Minimally Invasive Spine Surgery Procedures (for Tennessee Only) | Updated | May 1, 2025 |
| Neurophysiologic Testing and Monitoring (for Tennessee Only) | Updated | Apr. 1, 2025 |
| Proton Beam Radiation Therapy (for Tennessee Only) | Revised | Jun. 1, 2025 |
| Sacral Nerve Stimulation for Urinary and Fecal Indications (for Tennessee Only) | Updated | Jun. 1, 2025 |
| Skin and Soft Tissue Substitutes (for Tennessee Only) | Revised | May 1, 2025 |
| Total Artificial Disc Replacement for the Spine (for Tennessee Only) | Revised | Jun. 1, 2025 |
| Transanal Minimally Invasive Surgical Procedures (for Tennessee Only) | Retired | Apr. 1, 2025 |
| Transcranial Magnetic Stimulation (for Tennessee Only) | Revised | Jun. 1, 2025 |
| Transpupillary Thermotherapy (for Tennessee Only) | Retired | Apr. 1, 2025 |
| Upper Extremity Prosthetic Devices (for Tennessee Only) | Revised | Jun. 1, 2025 |

| Policy Title | Status | Effective Date |
|---|---------|----------------|
| Whole Exome and Whole Genome Sequencing (Non-Oncology Conditions) (for Tennessee 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 |
| Omvoh® (Mirikizumab-Mrkz) | Revised | May 1, 2025 |
| Parsabiv® (Etelcalcetide) | Updated | May 1, 2025 |
| Provider Administered Drugs – Site of Care | Revised | 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 Tennessee 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 Tennessee Medical Policies and Medical Benefit Drug Policies is available at UHCprovider.com/TN > Community Plan (Medicaid) > Current Policies and Clinical Guidelines > [Medical & Drug Policies](#).