United Healthcare Community Plan

UnitedHealthcare Community Plan of Tennessee
Medical Policy Update Bulletin: May 2022

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

InterQual® 2022 Clinical Criteria: Apr. 2022 Release

Effective May 1, 2022, all applicable Medical Policies, Coverage Determination Guidelines, and Utilization Review Guidelines have been updated to reflect the InterQual® clinical criteria reference(s) associated with the Apr. 2022 Release. For the list of impacted policies and corresponding details, click here.

Medical Policy Updates

Policy Title	Status	Effective Date
Airway Clearance Devices (for Tennessee Only)	Revised	Jun. 1, 2022
Apheresis (for Tennessee Only)	Revised	Jun. 1, 2022
Bariatric Surgery (for Tennessee Only)	Revised	Jun. 1, 2022
Computer Assisted Surgical Navigation for Musculoskeletal Procedures (for Tennessee Only)	Updated	Jun. 1, 2022
Core Decompression for Avascular Necrosis (for Tennessee Only)	Updated	May 1, 2022
Deep Brain and Cortical Stimulation (for Tennessee Only)	Revised	Jun. 1, 2022
Diagnostic Spinal Ultrasonography (for Tennessee Only)	Revised	Jun. 1, 2022
Electric Tumor Treatment Field Therapy (for Tennessee Only)	Revised	Jun. 1, 2022
Electrical and Ultrasound Bone Growth Stimulators (for Tennessee Only)	Revised	Jun. 1, 2022
Electrical Bioimpedance for Cardiac Output Measurement (for Tennessee Only)	Updated	May 1, 2022
Facet Joint Injections for Spinal Pain (for Tennessee Only)	Revised	Jun. 1, 2022
Functional Endoscopic Sinus Surgery (FESS) (for Tennessee Only)	Revised	Jun. 1, 2022
Genetic Testing for Hereditary Cancer (for Tennessee Only)	Revised	Jun. 1, 2022
Hepatitis Screening (for Tennessee Only)	Revised	Jun. 1, 2022
Light and Laser Therapy (for Tennessee Only)	Updated	May 1, 2022
Lithotripsy for Salivary Stones (for Tennessee Only)	Updated	May 1, 2022
Meniscus Implant and Allograft (for Tennessee Only)	Updated	May 1, 2022
Nerve Graft to Restore Erectile Function During Radical Prostatectomy (for Tennessee Only)	Updated	May 1, 2022
Neurophysiologic Testing and Monitoring (for Tennessee Only)	Updated	May 1, 2022
Neuropsychological Testing Under the Medical Benefit (for Tennessee Only)	Updated	May 1, 2022
Percutaneous Vertebroplasty and Kyphoplasty (for Tennessee Only)	Updated	May 1, 2022
Pharmacogenetic Testing (for Tennessee Only)	Revised	Jun. 1, 2022
Prolotherapy and Platelet Rich Plasma Therapies (for Tennessee Only)	Updated	May 1, 2022

Policy Title	Status	Effective Date
Sensory Integration Therapy and Auditory Integration Training (for Tennessee Only)	Updated	May 1, 2022
Skin and Soft Tissue Substitutes (for Tennessee Only)	Revised	Jun. 1, 2022
Total Artificial Heart and Ventricular Assist Devices (for Tennessee)	Updated	May 1, 2022
Virtual Upper Gastrointestinal Endoscopy (for Tennessee Only)	Updated	May 1, 2022

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Actemra® (Tocilizumab) Injection for Intravenous Infusion	Revised	Jun. 1, 2022
Denosumab (Prolia® & Xgeva®)	Revised	Jun. 1, 2022
Enjaymo™ (Sutimlimab-Jome)	New	Jun. 1, 2022
Rituximab (Riabni™, Rituxan®, Ruxience®, & Truxima®)	Updated	Jun. 1, 2022
Vyvgart™ (Efgartigimod Alfa-Fcab)	Revised	Jun. 1, 2022
Zolgensma® (Onasemnogene Abeparvovec-Xioi)	Updated	Jun. 1, 2022

Coverage Determination Guideline Updates

Policy Title	Status	Effective Date
Beds and Mattress (for Tennessee Only)	Revised	Jun. 1, 2022

Utilization Review Guideline Updates

Policy Title	Status	Effective Date
Elective Inpatient Services (for Tennessee Only)	Updated	May 1, 2022

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 Tennessee 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 Tennessee Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, and Utilization Review Guidelines is available at UHCprovider.com/Tennessee > Medicaid (Community Plan) > Current Policies and Clinical Guidelines > UnitedHealthcare Community Plan of Tennessee Medical & Drug Policies and Coverage Determination Guidelines.