UnitedHealthcare Commercial

Medical Policy Update Bulletin: April 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

Policy Implementation Delay

The following policies will not be effective on May 1, 2021, as previously announced; implementation of these new policies has been postponed until further notice:

- Home Oxygen
- Lung Volume Reduction Surgery
- Prostate Surgery
- Sacroiliac Joint Injections

Quarterly CPT® and HCPCS Code Updates

All applicable Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, and Utilization Review Guidelines have been modified to reflect the 2021 Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (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. 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
Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes	Revised	May 1, 2021
Deep Brain and Cortical Stimulation	Revised	May 1, 2021
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation	Updated	May 1, 2021
Facet Joint Injections for Spinal Pain	Revised	May 1, 2021
Gender Dysphoria Treatment	Updated	Apr. 1, 2021
Genetic Testing for Neuromuscular Disorders	Updated	May 1, 2021
Hysterectomy	Revised	May 1, 2021
Implanted Electrical Stimulator for Spinal Cord	Revised	May 1, 2021
Proton Beam Radiation Therapy	Updated	May 1, 2021
Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins	Revised	May 1, 2021
Surgical Treatment for Spine Pain	Revised	May 1, 2021
Total Artificial Disc Replacement for the Spine	Revised	May 1, 2021

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Actemra® (Tocilizumab) Injection for Intravenous Infusion	Updated	Apr. 1, 2021
Adakveo® (Crizanlizumab-Tmca)	Updated	Apr. 1, 2021
Amondys 45™ (Casimersen)	New	Apr. 1, 2021
Antiemetics for Oncology	New	Jul. 1, 2021
Entyvio® (Vedolizumab)	Updated	Apr. 1, 2021
Exondys 51® (Eteplirsen)	Updated	Apr. 1, 2021
Givlaari® (Givosiran)	Updated	Apr. 1, 2021
Hereditary Angioedema (HAE), Treatment and Prophylaxis	Revised	May 1, 2021
Infliximab (Avsola™, Inflectra®, Remicade®, & Renflexis®)	Revised	Apr. 1, 2021
Lemtrada (Alemtuzumab)	Revised	May 1, 2021
Oncology Medication Clinical Coverage	Revised	May 1, 2021
Orencia® (Abatacept) Injection for Intravenous Infusion	Updated	Apr. 1, 2021
Respiratory Interleukins (Cinqair®, Fasenra®, & Nucala®)	Revised	May 1, 2021
Stelara® (Ustekinumab)	Updated	Apr. 1, 2021
Tepezza® (Teprotumumab-Trbw)	Revised	May 1, 2021
Trogarzo® (Ibalizumab-Uiyk)	Updated	Apr. 1, 2021
Tysabri® (Natalizumab)	Revised	May 1, 2021
Vyondys 53™ (Golodirsen)	Updated	Apr. 1, 2021

Coverage Determination Guideline Updates

Policy Title	Status	Effective Date
Cosmetic and Reconstructive Procedures	Revised	May 1, 2021
Orthognathic (Jaw) Surgery	Revised	May 1, 2021
Pectus Deformity Repair	Revised	May 1, 2021

Utilization Review Guideline Updates

Policy Title	Status	Effective Date
Elective Inpatient Services	New	May 1, 2021
Observation Services	New	May 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 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 Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, and Utilization Review Guidelines is available at UHCprovider.com > Policies and Protocols > Commercial Policies > Medical & Drug Policies and Coverage Determination Guidelines.