United Healthcare®

UnitedHealthcare Commercial
Medical Policy Update Bulletin: December 2020

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 CDT®, CPT®, and HCPCS Code Updates

Beginning Jan. 1, 2021, all applicable Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, and Utilization Review Guidelines will be modified to reflect the 2021 Current Dental Terminology (CDT®), 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 Dental Association®. Current Dental Terminology: CDT®
- American Medical Association. Current Procedural Terminology: CPT®
- Centers for Medicare & Medicaid Services. Healthcare Common Procedure Coding System: HCPCS Level II

Complete details on impacted policies and corresponding code edits will be provided in the January 2021 edition of the Medical Policy Update Bulletin.

Medical Policy Updates

Policy Title	Status	Effective Date
Ablative Treatment for Spinal Pain	Revised	Feb. 1, 2021
Airway Clearance Devices	Revised	Jan. 1, 2021
Apheresis	Revised	Feb. 1, 2021
Balloon Sinus Ostial Dilation	Revised	Feb. 1, 2021
Bariatric Surgery	Updated	Dec. 1, 2020
Cell-Free Fetal DNA Testing	Revised	Jan. 1, 2021
Electrical and Ultrasound Bone Growth Stimulators	Revised	Jan. 1, 2021
Functional Endoscopic Sinus Surgery (FESS)	Revised	Feb. 1, 2021
Hip Resurfacing and Replacement Surgery (Arthroplasty)	Updated	Dec. 1, 2020
Infertility Diagnosis and Treatment	Updated	Jan. 1, 2021
Nerve Graft to Restore Erectile Function During Radical Prostatectomy	Revised	Jan. 1, 2021
Neurophysiologic Testing and Monitoring	Revised	Jan. 1, 2021
Neuropsychological Testing Under the Medical Benefit	Revised	Jan. 1, 2021
Omnibus Codes	Revised	Feb. 1, 2021
Prolotherapy and Platelet Rich Plasma Therapies	Updated	Jan. 1, 2021
Skin and Soft Tissue Substitutes	Revised	Dec. 1, 2020
Whole Exome and Whole Genome Sequencing	Revised	Jan. 1, 2021

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Alpha1-Proteinase Inhibitors	Updated	Dec. 1, 2020
Evenity® (Romosozumab-Aqqg)	Updated	Dec. 1, 2020
Gonadotropin Releasing Hormone Analogs	Revised	Jan. 1, 2021
Immune Globulin (IVIG and SCIG)	Revised	Jan. 1, 2021
Oncology Medication Clinical Coverage	Revised	Feb. 1, 2021
Vyepti™ (Eptinezumab-Jjmr)	Revised	Jan. 1, 2021
White Blood Cell Colony Stimulating Factors	Revised	Jan. 1, 2021

Coverage Determination Guideline Updates

Policy Title	Status	Effective Date
Blepharoplasty, Blepharoptosis, and Brow Ptosis Repair	Revised	Jan. 1, 2021
Breast Reconstruction Post Mastectomy and Poland Syndrome	Revised	Jan. 1, 2021
Breast Repair/Reconstruction Not Following Mastectomy	Revised	Jan. 1, 2021
Cosmetic and Reconstructive Procedures	Updated	Jan. 1, 2021
Durable Medical Equipment, Orthotics, Ostomy Supplies, Medical Supplies and Repairs/Replacements	Revised	Jan. 1, 2021
Gynecomastia Treatment	Revised	Jan. 1, 2021
Preventive Care Services	Revised	Jan. 1, 2021
Prosthetic Devices, Wigs, Specialized, Microprocessor or Myoelectric Limbs	Updated	Jan. 1, 2021

Utilization Review Guideline Updates

Policy Title	Status	Effective Date
Outpatient Surgical Procedures – Site of Service	Revised	Jan. 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.