United Healthcare Community Plan

UnitedHealthcare Community Plan of Kentucky
Medical Policy Update Bulletin: June 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® Release Dates Removed

Effective Jun. 1, 2022, all references to specific InterQual® release dates will be removed from the Medical Policies, Coverage Determination Guidelines, and Utilization Review Guidelines which contain language pertaining to InterQual® criteria; refer to the most current version of the InterQual® criteria, when applicable.

Medical Policy Updates

Policy Title	Status	Effective Date
Genetic Testing for Hereditary Cancer (for Kentucky Only)	Updated	Jul. 1, 2022
Genitourinary Pathogen Nucleic Acid Detection Panel Testing (for Kentucky Only)	Revised	Jul. 1, 2022
Implanted Electrical Stimulator for Spinal Cord (for Kentucky Only)	Revised	Jul. 1, 2022
Manipulation Under Anesthesia (for Kentucky Only)	Revised	Jul. 1, 2022
Prescribed Pediatric Extended Care (for Kentucky Only)	Revised	Jul. 1, 2022
Proton Beam Radiation Therapy (for Kentucky Only)	Updated	Jul. 1, 2022
Spinal Fusion Enhancement Products (for Kentucky Only)	Revised	Jul. 1, 2022
Surgical Treatment for Spine Pain (for Kentucky Only)	Revised	Jul. 1, 2022
Transcranial Magnetic Stimulation (for Kentucky Only)	Revised	Jul. 1, 2022

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Apokyn® (Apomorphine) (for Kentucky Only)	Revised	Jul. 1, 2022
Botulinum Toxins A and B	Revised	Aug. 1, 2022
Complement Inhibitors (Soliris® & Ultomiris®)	Revised	Jul. 1, 2022
Entyvio® (Vedolizumab)	Revised	Aug. 1, 2022
Erythropoiesis-Stimulating Agents	Revised	Aug. 1, 2022
Immune Globulin (IVIG and SCIG)	Revised	Aug. 1, 2022
Infliximab (Avsola™, Inflectra®, Remicade®, & Renflexis®)	Revised	Aug. 1, 2022
Intravenous Iron Replacement Therapy (for Kentucky Only)	Revised	Aug. 1, 2022
Ocrevus® (Ocrelizumab)	Revised	Aug. 1, 2022
Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors	Revised	Jul. 1, 2022
Orencia® (Abatacept) Injection for Intravenous Infusion	Revised	Aug. 1, 2022
Respiratory Interleukins (Cinqair®, Fasenra®, & Nucala®)	Revised	Aug. 1, 2022

Policy Title	Status	Effective Date
Sodium Hyaluronate	Revised	Aug. 1, 2022
White Blood Cell Colony Stimulating Factors	Revised	Jul. 1, 2022
Xolair® (Omalizumab)	Revised	Aug. 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 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 > Medicaid (Community Plan) > Current Policies and Clinical Guidelines > UnitedHealthcare Community Plan of Kentucky Medical & Drug Policies and Coverage Determination Guidelines.