UnitedHealthcare Community Plan

UnitedHealthcare Community Plan of Mississippi

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.

Community Plan of Mississippi to Use National Policy Versions

Effective Jun. 1, 2022, Community Plan of Mississippi will no longer maintain state-specific Medical Policies, Coverage Determination Guidelines, or Utilization Review Guidelines for the following services; coverage guidelines for the state of Mississippi will now be provided in the Community Plan National policy versions listed below:

Policy Title	Policy Type
Apheresis	Medical Policy
Athletic Pubalgia Surgery	Medical Policy
Autologous Cellular Therapy	Medical Policy
Balloon Sinus Ostial Dilation	Medical Policy
Bariatric Surgery	Medical Policy
Breast Imaging for Screening and Diagnosing Cancer	Medical Policy
Bronchial Thermoplasty	Medical Policy
Cardiac Event Monitoring	Medical Policy
Carrier Testing for Genetic Diseases	Medical Policy
Catheter Ablation for Atrial Fibrillation	Medical Policy
Chromosome Microarray Testing (Non-Oncology Conditions)	Medical Policy
Cognitive Rehabilitation	Medical Policy
Collagen Crosslinks and Biochemical Markers of Bone Turnover	Medical Policy
Computer-Assisted Surgical Navigation for Musculoskeletal Procedures	Medical Policy
Computerized Dynamic Posturography	Medical Policy
Corneal Hysteresis and Intraocular Pressure Measurement	Medical Policy
Cytological Examination of Breast Fluids for Cancer Screening or Diagnosis	Medical Policy
Deep Brain and Cortical Stimulation	Medical Policy
Diagnostic Spinal Ultrasonography	Medical Policy
Electric Tumor Treatment Field Therapy	Medical Policy
Electrical and Ultrasound Bone Growth Stimulators	Medical Policy
Electrical Bioimpedance for Cardiac Output Measurement	Medical Policy
Electrical Stimulation and Electromagnetic Therapy for Wounds	Medical Policy

Policy Title	Policy Type
Epiduroscopy, Epidural Lysis of Adhesions and Discography	Medical Policy
Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions and Soft Tissue Wounds	Medical Policy
Fecal Calprotectin Testing	Medical Policy
Gender Dysphoria Treatment	Medical Policy
Genetic Testing for Cardiac Disease	Medical Policy
Genetic Testing for Hereditary Cancer	Medical Policy
Genetic Testing for Neuromuscular Disorders	Medical Policy
Glaucoma Surgical Treatments	Medical Policy
Hearing Aids and Devices Including Wearable, Bone-Anchored and Semi-Implantable	Medical Policy
Hepatitis Screening	Medical Policy
Hysterectomy	Medical Policy
Implantable Beta-Emitting Microspheres for Treatment of Malignant Tumors	Medical Policy
Intraoperative Hyperthermic Intraperitoneal Chemotherapy (HIPEC)	Medical Policy
Intrauterine Fetal Surgery	Medical Policy
Laser Interstitial Thermal Therapy	Medical Policy
Light and Laser Therapy	Medical Policy
Lithotripsy for Salivary Stones	Medical Policy
Macular Degeneration Treatment Procedures	Medical Policy
Mechanical Stretching Devices	Medical Policy
Meniscus Implant and Allograft	Medical Policy
Minimally Invasive Procedures for Gastroesophageal Reflux Disease (GERD) and Achalasia	Medical Policy
Neuropsychological Testing Under the Medical Benefit	Medical Policy
Occipital Neuralgia and Headache Treatment	Medical Policy
Outpatient Surgical Procedures – Site of Service	Utilization Review Guideline
Percutaneous Patent Foramen Ovale (PFO) Closure	Medical Policy
Pharmacogenetic Testing	Medical Policy
Preimplantation Genetic Testing	Medical Policy
Prolotherapy and Platelet Rich Plasma Therapies	Medical Policy
Prostate Surgeries and Interventions	Medical Policy
Radiation Therapy: Fractionation, Image-Guidance, and Special Services	Medical Policy
Rhinoplasty and Other Nasal Surgeries	Coverage Determination Guideline
Stereotactic Body Radiation Therapy and Stereotactic Radiosurgery	Medical Policy
Surgery of the Foot	Medical Policy
Surgery of the Hand or Wrist	Medical Policy
Thermography	Medical Policy
Total Artificial Disc Replacement for the Spine	Medical Policy
Transcranial Magnetic Stimulation	Medical Policy
Transpupillary Thermotherapy	Medical Policy
Umbilical Cord Blood Harvesting and Storage for Future Use	Medical Policy
Vertebral Body Tethering for Scoliosis	Medical Policy
Warming Therapy and Ultrasound Therapy for Wounds	Medical Policy

Medical Policy Updates

Policy Title	Status	Effective Date
Percutaneous Vertebroplasty and Kyphoplasty (for Mississippi Only)	Updated	Jun. 1, 2022
Proton Beam Radiation Therapy (for Mississippi Only)	Updated	Jul. 1, 2022
Spinal Fusion Enhancement Products (for Mississippi Only)	Revised	Jul. 1, 2022
Surgical Treatment for Spine Pain (for Mississippi Only)	Revised	Jul. 1, 2022

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Botulinum Toxins A and B	Revised	Aug. 1, 2022
Complement Inhibitors (Soliris® & Ultomiris®) (for Mississippi Only)	Revised	Jul. 1, 2022
Entyvio® (Vedolizumab)	Revised	Aug. 1, 2022
Intravenous Iron Replacement Therapy (Feraheme®, Injectafer®, & Monoferric®)	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
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 Mississippi 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 Mississippi Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, and Utilization Review Guidelines is available at UHCprovider.com/Mississippi > Medicaid (Community Plan) > Current Policies and Clinical Guidelines > UnitedHealthcare Community Plan of Mississippi Medical & Drug Policies and Coverage Determination Guidelines.