

UnitedHealthcare Community Plan of Tennessee 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
Ablative Treatment for Spinal Pain (for Tennessee Only)	Revised	Jul. 1, 2022
Articular Cartilage Defect Repairs (for Tennessee Only)	Revised	Jul. 1, 2022
Catheter Ablation for Atrial Fibrillation (for Tennessee Only)	Updated	Jun. 1, 2022
Computed Tomographic Colonography (for Tennessee Only)	Updated	Jun. 1, 2022
Discogenic Pain Treatment (for Tennessee Only)	Revised	Jul. 1, 2022
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation (for Tennessee Only)	Revised	Jul. 1, 2022
Epiduroscopy, Epidural Lysis of Adhesions and Discography (for Tennessee Only)	Revised	Jul. 1, 2022
Gastrointestinal Pathogen Nucleic Acid Detection Panel Testing for Infectious Diarrhea (for Tennessee Only)	Updated	Jun. 1, 2022
Hearing Aids and Devices Including Wearable, Bone-Anchored and Semi-Implantable (for Tennessee Only)	Updated	Jun. 1, 2022
Mechanical Stretching Devices (for Tennessee Only)	Updated	Jun. 1, 2022
Molecular Oncology Testing for Cancer Diagnosis, Prognosis, and Treatment Decisions (for Tennessee Only)	Revised	Jul. 1, 2022
Plagiocephaly and Craniosynostosis Treatment (for Tennessee Only)	Revised	Jul. 1, 2022
Pneumatic Compression Devices (for Tennessee Only)	Revised	Jul. 1, 2022
Surgery of the Elbow (for Tennessee Only)	Revised	Jul. 1, 2022
Surgery of the Hip (for Tennessee Only)	Revised	Jul. 1, 2022
Surgery of the Knee (for Tennessee Only)	Revised	Jul. 1, 2022
Surgery of the Shoulder (for Tennessee Only)	Revised	Jul. 1, 2022
Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins (for Tennessee Only)	Updated	Jun. 1, 2022
Surgical Treatment for Spine Pain (for Tennessee Only)	Revised	Jul. 1, 2022
Temporomandibular Joint Disorders (for Tennessee Only)	Revised	Jul. 1, 2022

Policy Title	Status	Effective Date
Vagus and External Trigeminal Nerve Stimulation (for Pennsylvania Only)	Revised	Jul. 1, 2022
Video Electroencephalographic (vEEG) Monitoring and Recording (for Tennessee Only)	Revised	Jul. 1, 2022
Visual Information Processing Evaluation and Orthoptic and Vision Therapy (for Tennessee Only)	Updated	Jul. 1, 2022
Warming Therapy and Ultrasound Therapy for Wounds (for Tennessee Only)	Updated	Jun. 1, 2022
Whole Exome and Whole Genome Sequencing (for Tennessee 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®)	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 (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®, Fasentra®, & 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

Coverage Determination Guideline Updates

Policy Title	Status	Effective Date
Speech Generating Devices (for Tennessee Only)	Revised	Jul. 1, 2022

Utilization Review Guideline Updates

Policy Title	Status	Effective Date
Chemotherapy Observation or Inpatient Hospitalization (for Tennessee Only)	Updated	Jun. 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](#).