United Healthcare Community Plan

UnitedHealthcare Community Plan
Medical Policy Update Bulletin: April 2024

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

Quarterly CPT® and HCPCS Code Updates

Beginning **Apr. 1, 2024**, all applicable Medical Policies and Medical Benefit Drug Policies will be updated to reflect the quarterly 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) Quarterly Update

For the list of impacted policies and corresponding details, click here.

Medical Policy Updates

Policy Title	Status	Effective Date
Bariatric Surgery (for Nebraska Only)	Revised	Jun. 1, 2024
Cardiovascular Disease Risk Tests	Revised	Jun. 1, 2024
Deep Brain and Cortical Stimulation	Revised	Apr. 1, 2024
Deep Brain and Cortical Stimulation (for New Jersey Only)	Revised	Apr. 1, 2024
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation (for Nebraska Only)	Revised	Apr. 1, 2024
Electrical Stimulation for Wounds	Revised	Jun. 1, 2024
Electrical Stimulation for Wounds (for New Jersey Only)	Revised	Jun. 1, 2024
Electromagnetic Therapy for Wounds	Revised	Jun. 1, 2024
Electromagnetic Therapy for Wounds (for New Jersey Only)	Revised	Jun. 1, 2024
Embolization of the Ovarian and Iliac Veins for Pelvic Congestion Syndrome	Updated	Apr. 1, 2024
Embolization of the Ovarian and Iliac Veins for Pelvic Congestion Syndrome (for New Jersey Only)	Updated	Apr. 1, 2024
Gastrointestinal Motility Disorders, Diagnosis and Treatment	Updated	Apr. 1, 2024
Gastrointestinal Motility Disorders, Diagnosis and Treatment (for New Jersey Only)	Updated	Apr. 1, 2024
Gastrointestinal Pathogen Nucleic Acid Detection Panel Testing for Infectious Diarrhea (for Nebraska Only)	Revised	Jun. 1, 2024
Gender Dysphoria Treatment (for New Jersey Only)	Updated	May 1, 2024
Genetic Testing for Neuromuscular Disorders	Revised	Jun. 1, 2024
Genetic Testing for Neuromuscular Disorders (for Nebraska Only)	Revised	Jun. 1, 2024
Home Traction Therapy (for Nebraska Only)	Updated	Apr. 1, 2024
Implanted Electrical Stimulator for Spinal Cord	Updated	Apr. 1, 2024

Policy Title	Status	Effective Date
Implanted Electrical Stimulator for Spinal Cord (for New Jersey Only)	Updated	Apr. 1, 2024
Lower Extremity Prosthetics	Revised	Jun. 1, 2024
Lower Extremity Prosthetics (for New Jersey Only)	Revised	Jun. 1, 2024
Neurophysiologic Testing and Monitoring	Updated	Apr. 1, 2024
Neurophysiologic Testing and Monitoring (for New Jersey Only)	Updated	Apr. 1, 2024
Obstructive and Central Sleep Apnea Treatment (for Nebraska Only)	Updated	Apr. 1, 2024
Occipital Nerve Injections and Ablation (Including Occipital Neuralgia and Headache)	Updated	Apr. 1, 2024
Occipital Nerve Injections and Ablation (Including Occipital Neuralgia and Headache) (for New Jersey Only)	Updated	Apr. 1, 2024
Pharmacogenetic Panel Testing (for Nebraska Only)	Updated	Apr. 1, 2024
Pneumatic Compression Devices	Revised	Jun. 1, 2024
Pneumatic Compression Devices (for Nebraska Only)	Revised	Jun. 1, 2024
Pneumatic Compression Devices (for New Jersey Only)	Revised	Jun. 1, 2024
Sacral Nerve Stimulation for Urinary and Fecal Indications	Revised	Apr. 1, 2024
Sacral Nerve Stimulation for Urinary and Fecal Indications (for New Jersey Only)	Revised	Apr. 1, 2024
Skin and Soft Tissue Substitutes	Revised	Jun. 1, 2024
Skin and Soft Tissue Substitutes (for Nebraska Only)	Revised	Jun. 1, 2024
Spinal Fusion and Bone Healing Enhancement Products	Updated	Apr. 1, 2024
Spinal Fusion and Bone Healing Enhancement Products (for New Jersey Only)	Updated	Apr. 1, 2024
Spinal Fusion and Decompression	Revised	Jun. 1, 2024
Spinal Fusion and Decompression (for New Jersey Only)	Revised	Jun. 1, 2024
Transanal Minimally Invasive Surgical Procedures	Revised	Jun. 1, 2024
Transcatheter Heart Valve Procedures (for Nebraska Only)	Revised	Jun. 1, 2024
Upper Extremity Prosthetic Devices	Revised	Jun. 1, 2024
Upper Extremity Prosthetic Devices (for New Jersey Only)	Revised	Jun. 1, 2024
Vagus and External Trigeminal Nerve Stimulation	Updated	Apr. 1, 2024
Vagus and External Trigeminal Nerve Stimulation (for New Jersey Only)	Updated	Apr. 1, 2024
Vertebral Body Tethering for Scoliosis	Updated	Apr. 1, 2024
Vertebral Body Tethering for Scoliosis (for New Jersey Only)	Updated	Apr. 1, 2024
Whole Exome and Whole Genome Sequencing (Non-Oncology Conditions) (for Nebraska Only)	Revised	Jun. 1, 2024

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Adakveo® (Crizanlizumab-Tmca)	Revised	May 1, 2024
Adzynma (ADAMTS13, Recombinant-Krhn)	New	Apr. 1, 2024
Alpha1-Proteinase Inhibitors	Updated	Apr. 1, 2024
Amondys 45® (Casimersen)	Revised	May 1, 2024
Amondys 45® (Casimersen) (for New Jersey Only)	Revised	May 1, 2024
Briumvi® (Ublituximab-Xiiy)	Revised	May 1, 2024
Denied Drug Codes – Pharmacy Benefit Drugs (for Arizona Only)	Revised	May 1, 2024
Enjaymo® (Sutimlimab-Jome)	Revised	May 1, 2024
Entyvio® (Vedolizumab)	Updated	Apr. 1, 2024

Policy Title	Status	Effective Date
Erythropoiesis-Stimulating Agents	Revised	May 1, 2024
Exondys 51® (Eteplirsen)	Revised	May 1, 2024
Exondys 51® (Eteplirsen) (for New Jersey Only)	Revised	May 1, 2024
Givlaari® (Givosiran)	Revised	May 1, 2024
Immune Globulin (IVIG and SCIG)	Updated	Apr. 1, 2024
Ketalar® (Ketamine) and Spravato® (Esketamine)	Updated	Apr. 1, 2024
Lemtrada® (Alemtuzumab)	Revised	May 1, 2024
Medical Therapies for Enzyme Deficiencies	Updated	Apr. 1, 2024
Ocrevus® (Ocrelizumab)	Revised	May 1, 2024
Omvoh™ (Mirikizumab-Mrkz)	New	Apr. 1, 2024
Oncology Medication Clinical Coverage	Revised	May 1, 2024
Provider Administered Drugs – Site of Care	Revised	May 1, 2024
Radicava® (Edaravone)	Revised	May 1, 2024
Reblozyl® (Luspatercept-Aamt)	Revised	May 1, 2024
Roctavian™ (Valoctocogene Roxaparvovec-Rvox)	Updated	May 1, 2024
Spevigo® (Spesolimab-Sbzo)	Updated	May 1, 2024
Tysabri® (Natalizumab)	Revised	May 1, 2024
Tzield® (Teplizumab-Mzwv)	Updated	May 1, 2024
Vyjuvek™ (Beramagene Geperpavec-Svdt)	Revised	May 1, 2024
Vyondys 53® (Golodirsen)	Revised	May 1, 2024
Vyondys 53® (Golodirsen) (for New Jersey Only)	Revised	May 1, 2024

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 changes to our Community Plan Medical Policies and Medical Benefit Drug Policies. 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 Medical Policies and Medical Benefit Drug Policies is available at **UHCprovider.com** > Policies and Protocols > Community Plan Policies > Medical & Drug Policies.