UnitedHealthcare Community Plan

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Medical Policy Update Bulletin *Quick View*: August 2024

A list of recently approved, revised, and/or retired Medical Policies and/or Medical Benefit Drug Policies is provided below for your reference. **For a comprehensive summary of the latest updates, refer to the Medical Policy Update Bulletin: August 2024.**

Medical Policy Updates

Policy Title	Status	Effective Date
Ambulance Services (for Nebraska Only)	Updated	Oct. 1, 2024
Cell-Free Fetal DNA Testing (for Nebraska Only)	Revised	Oct. 1, 2024
Cell-Free Fetal DNA Testing (for New Jersey Only)	Revised	Sep. 1, 2024
Chromosome Microarray Testing (Non-Oncology Conditions)	Revised	Oct. 1, 2024
Chromosome Microarray Testing (Non-Oncology Conditions) (for Nebraska Only)	Revised	Oct. 1, 2024
Chromosome Microarray Testing (Non-Oncology Conditions) (for New Jersey Only)	Revised	Oct. 1, 2024
Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes	Revised	Oct. 1, 2024
Cosmetic and Reconstructive Procedures	Revised	Oct. 1, 2024
Epidural Steroid Injections for Spinal Pain	Revised	Oct. 1, 2024
Epidural Steroid Injections for Spinal Pain (for New Jersey Only)	Revised	Oct. 1, 2024
Genetic Testing for Cardiac Disease	Revised	Oct. 1, 2024
Glaucoma Surgical Treatments	Revised	Oct. 1, 2024
Glaucoma Surgical Treatments (for New Jersey Only)	Revised	Oct. 1, 2024
Habilitation and Rehabilitation Therapy (Occupational, Physical, and Speech)	Revised	Oct. 1, 2024
Habilitation and Rehabilitation Therapy (Occupational, Physical, and Speech) (for Florida Only)	Revised	Oct. 1, 2024
Hepatitis Screening	Retired	Aug. 1, 2024
Hepatitis Screening (for Nebraska Only)	Retired	Aug. 1, 2024
Hepatitis Screening (for New Jersey Only)	Retired	Aug. 1, 2024
Intraoperative Hyperthermic Intraperitoneal Chemotherapy (HIPEC)	Retired	Aug. 1, 2024
Intraoperative Hyperthermic Intraperitoneal Chemotherapy (HIPEC) (for New Jersey Only)	Retired	Aug. 1, 2024
Intrauterine Fetal Surgery (for Nebraska Only)	Updated	Oct. 1, 2024
Macular Degeneration Treatment Procedures	Updated	Aug. 1, 2024
Macular Degeneration Treatment Procedures (for New Jersey Only)	Updated	Aug. 1, 2024
Mandatory Medicaid Coverage of Routine Patient Costs in Qualifying Clinical Trials	Updated	Oct. 1, 2024
Manipulative Therapy (for Nebraska Only)	Revised	Oct. 1, 2024
Occipital Nerve Injections and Ablation (Including Occipital Neuralgia and Headache)	Updated	Oct. 1, 2024

Policy Title	Status	Effective Date
Occipital Nerve Injections and Ablation (Including Occipital Neuralgia and Headache) (for New Jersey Only)	Updated	Oct. 1, 2024
Prostate Surgeries and Interventions	Updated	Oct. 1, 2024
Prostate Surgeries and Interventions (for New Jersey Only)	Updated	Oct. 1, 2024
Surgery of the Knee	Revised	Oct. 1, 2024
Surgery of the Knee (for New Jersey Only)	Revised	Oct. 1, 2024
Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins	Revised	Sep. 1, 2024
Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins (for New Jersey Only)	Revised	Sep. 1, 2024
Transarterial Radioembolization (TARE)/Selective Internal Radiation Therapy (SIRT) for the Treatment of Malignant Cancers of the Liver	Revised	Oct. 1, 2024
Transarterial Radioembolization (TARE)/Selective Internal Radiation Therapy (SIRT) for the Treatment of Malignant Cancers of the Liver (for New Jersey Only)	Revised	Oct. 1, 2024

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Adzynma (ADAMTS$_{13}$, Recombinant-Krhn)	Updated	Sep. 1, 2024
Alpha$_{1}$-Proteinase Inhibitors	Updated	Sep. 1, 2024
Buprenorphine (Brixadi™ & Sublocade®)	Updated	Sep. 1, 2024
Cosentyx® (Secukinumab)	Updated	Sep. 1, 2024
Denied Drug Codes – Pharmacy Benefit Drugs (for Arizona Only)	Revised	Sep. 1, 2024
Infliximab	Revised	Sep. 1, 2024
Intracanalicular and Intravitreal Corticosteroid Implants	Updated	Aug. 1, 2024
Intracanalicular and Intravitreal Corticosteroid Implants	Updated	Sep. 1, 2024
Ketalar® (Ketamine) and Spravato® (Esketamine)	Updated	Sep. 1, 2024
Omvoh™ (Mirikizumab-Mrkz)	Updated	Sep. 1, 2024
Oncology Medication Clinical Coverage	Revised	Sep. 1, 2024
Rebyota™ (Fecal Microbiota, Live-Jslm)	Updated	Sep. 1, 2024
Scenesse® (Afamelanotide)	Updated	Sep. 1, 2024
Spinraza® (Nusinersen)	Revised	Sep. 1, 2024
Subcutaneous Implantable Naltrexone Pellets	Updated	Sep. 1, 2024
Tocilizumab (Actemra®, Tofidence™, and Tyenne®)	Revised	Sep. 1, 2024
Vyepti® (Eptinezumab-Jjmr)	Revised	Sep. 1, 2024
Xiaflex® (Collagenase Clostridium Histolyticum)	Updated	Sep. 1, 2024
Zulresso® (Brexanolone)	Updated	Sep. 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.