United Healthcare Community Plan

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Medical Policy Update Bulletin: May 2023

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

Community Plan of Nebraska to Use National Policy Versions

Effective **May 1, 2023**, Community Plan of Nebraska will no longer maintain state-specific Medical Policies for the following services; coverage guidelines for the state of Nebraska will now be provided in the Community Plan National policy versions listed below:

- Articular Cartilage Defect Repairs
- Implanted Electrical Stimulator for Spinal Cord
- Proton Beam Radiation Therapy

Medical Policy Updates

Policy Title	Status	Effective Date
Ablative Treatment for Spinal Pain	Revised	Jul. 1, 2023
Ablative Treatment for Spinal Pain (for Nebraska Only)	Revised	Jul. 1, 2023
Ablative Treatment for Spinal Pain (for New Jersey Only)	Revised	Jul. 1, 2023
Athletic Pubalgia Surgery	Revised	Jul. 1, 2023
Brow Ptosis and Eyelid Repair	Revised	Jul. 1, 2023
Brow Ptosis and Eyelid Repair (for New Jersey Only)	Revised	Jul. 1, 2023
Cardiovascular Disease Risk Tests	Updated	Jul. 1, 2023
Cardiovascular Disease Risk Tests (for New Jersey Only)	Updated	Jul. 1, 2023
Chemotherapy Observation or Inpatient Hospitalization	Revised	Jul. 1, 2023
Discogenic Pain Treatment	Revised	Jul. 1, 2023
Discogenic Pain Treatment (for New Jersey Only)	Revised	Jul. 1, 2023
Durable Medical Equipment, Orthotics, Medical Supplies and Repairs/Replacements (for Nebraska Only)	Revised	Jul. 1, 2023
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation (for Nebraska Only)	Revised	Jul. 1, 2023
Electrical Stimulation and Electromagnetic Therapy for Wounds (for New Jersey Only)	Updated	Jul. 1, 2023
Embolization of the Ovarian and Iliac Veins for Pelvic Congestion Syndrome	Updated	Jul. 1, 2023
Habilitation and Rehabilitation Therapy (Occupational, Physical and Speech) (for Nebraska Only)	Revised	Jul. 1, 2023
Hepatitis Screening	Updated	May 1, 2023
Hepatitis Screening (for New Jersey Only)	Updated	May 1, 2023
Home Hemodialysis (for New Jersey Only)	Updated	Jul. 1, 2023

Policy Title	Status	Effective Date
Interspinous Fusion and Decompression Devices	Revised	Jul. 1, 2023
Interspinous Fusion and Decompression Devices (for New Jersey Only)	Revised	Jul. 1, 2023
Liposuction for Lipedema (for Nebraska Only)	Updated	Jul. 1, 2023
Lower Extremity Prosthetics	Revised	Jul. 1, 2023
Lower Extremity Prosthetics (for New Jersey Only)	Revised	Jul. 1, 2023
Macular Degeneration Treatment Procedures (for New Jersey Only)	Updated	Jul. 1, 2023
Manipulation Under Anesthesia (for New Jersey Only)	Revised	Jul. 1, 2023
Minimally Invasive Spine Surgery Procedures	Revised	Jul. 1, 2023
Minimally Invasive Spine Surgery Procedures (for New Jersey Only)	Revised	Jul. 1, 2023
Omnibus Codes (for Nebraska Only)	Updated	May 1, 2023
Omnibus Codes (for Nebraska Only)	Revised	Jul. 1, 2023
Pneumatic Compression Devices (for Nebraska Only)	Revised	Jul. 1, 2023
Prostate Surgeries and Interventions	Revised	Jul. 1, 2023
Provider Administered Drugs – Site of Care (for Nebraska Only)	Replaced	Jun. 1, 2023
Provider Administered Drugs – Site of Care (for New Jersey Only)	Replaced	Jun. 1, 2023
Rhinoplasty and Other Nasal Procedures	Revised	Jul. 1, 2023
Skin and Soft Tissue Substitutes	Revised	Jul. 1, 2023
Skin and Soft Tissue Substitutes (for New Jersey Only)	Revised	Jul. 1, 2023
Spinal Fusion and Decompression	Revised	Jul. 1, 2023
Spinal Fusion and Decompression (for New Jersey Only)	Revised	Jul. 1, 2023
Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins	Revised	Jul. 1, 2023
Surgical Treatment for Spine Pain	Replaced	Jul. 1, 2023
Surgical Treatment for Spine Pain (for Nebraska Only)	Replaced	Jul. 1, 2023
Surgical Treatment for Spine Pain (for New Jersey Only)	Replaced	Jul. 1, 2023
Surgical Treatment of Lymphedema	Updated	Jul. 1, 2023
Transanal Endoscopic Microsurgery	New	Jul. 1, 2023
Transanal Endoscopic Microsurgery (for New Jersey Only)	New	Jul. 1, 2023
Transcatheter Heart Valve Procedures (for Nebraska Only)	Revised	Jul. 1, 2023
Transcatheter Heart Valve Procedures (for New Jersey Only)	Revised	Jun. 1, 2023
Upper Extremity Myoelectric Prosthetic Devices	Revised	Jul. 1, 2023
Upper Extremity Myoelectric Prosthetic Devices (for New Jersey Only)	Revised	Jul. 1, 2023
Whole Exome and Whole Genome Sequencing (for New Jersey Only)	Revised	Jun. 1, 2023

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Crysvita® (Burosumab-Twza)	Revised	Jun. 1, 2023
Evkeeza™ (Evinacumab-Dgnb)	Updated	May 1, 2023
Immune Globulin (IVIG and SCIG)	Revised	Jun. 1, 2023
Medical Therapies for Enzyme Deficiencies	Revised	Jun. 1, 2023
Provider Administered Drugs – Site of Care	Revised	Jun. 1, 2023
Rituximab (Riabni™, Rituxan®, Ruxience®, & Truxima®)	Revised	Jun. 1, 2023
Syfovre™ (Pegcetacoplan Injection)	New	Jun. 1, 2023
Tzield™ (Teplizumab-Mzwv)	Revised	May 1, 2023

Coverage Determination Guideline Updates

Policy Title	Status	Effective Date
Prosthetic Devices, Specialized, Microprocessor or Myoelectric Limbs	Replaced	Jul. 1, 2023
Prosthetic Devices, Specialized, Microprocessor or Myoelectric Limbs (for Nebraska Only)	Replaced	Jul. 1, 2023
Prosthetic Devices, Specialized, Microprocessor or Myoelectric Limbs (for New Jersey Only)	Replaced	Jul. 1, 2023
Speech Language Pathology Services (for Nebraska Only)	Replaced	Jul. 1, 2023

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 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 Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, and Utilization Review Guidelines is available at **UHCprovider.com** > Policies and Protocols > Community Plan Policies > Medical & Drug Policies and Coverage Determination Guidelines for Community Plan.