

UnitedHealthcare Community Plan of Kentucky Medical Policy Update Bulletin Quick View: July 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: July 2024](#).**

Take Note

Quarterly CPT® and HCPCS Code Updates

Effective **Jul. 1, 2024**, all applicable Medical Policies and Medical Benefit Drug Policies have been 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](#)

Refer to the [Medical Policy Update Bulletin: July 2024](#) for a list of impacted policies and corresponding details.

Medical Policy Updates

Policy Title	Status	Effective Date
Ambulance Services (for Kentucky Only)	Updated	Sep. 1, 2024
Beds and Mattresses (for Kentucky Only)	Revised	Aug. 1, 2024
Breast Reduction Surgery (for Kentucky Only)	Updated	Aug. 1, 2024
Cardiac Event Monitoring (for Kentucky Only)	Revised	Aug. 1, 2024
Fecal Calprotectin Testing (for Kentucky Only)	Retired	Jul. 1, 2024
Gastrointestinal Motility Disorders, Diagnosis and Treatment (for Kentucky Only)	Revised	Sep. 1, 2024
Gynecomastia Surgery (for Kentucky Only)	Updated	Sep. 1, 2024
Omnibus Codes (for Kentucky Only)	Revised	Aug. 1, 2024
Panniculectomy and Body Contouring Procedures (for Kentucky Only)	Revised	Sep. 1, 2024
Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins (for Kentucky Only)	Revised	Aug. 1, 2024
Walkers (for Kentucky Only)	Revised	Aug. 1, 2024

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
17-Alpha-Hydroxyprogesterone Caproate (Makena® and 17P)	Retired	Jul. 1, 2024
Antiemetics for Oncology	Updated	Jul. 1, 2024
Brineura® (Cerliponase Alfa)	Revised	Aug. 1, 2024
Gene Therapies for Hemophilia B	Revised	Aug. 1, 2024
Immune Globulin (IVIG and SCIG)	Revised	Aug. 1, 2024

Policy Title	Status	Effective Date
Maximum Dosage and Frequency	Revised	Aug. 1, 2024
Medical Therapies for Enzyme Deficiencies	Revised	Aug. 1, 2024
Oncology Medication Clinical Coverage	Revised	Aug. 1, 2024
Respiratory Interleukins (Cinqair®, Fasenra®, & Nucala®)	Revised	Aug. 1, 2024
Rituximab (Riabni®, Rituxan®, Ruxience®, & Truxima®)	Revised	Aug. 1, 2024
RNA-Targeted Therapies (Amvuttra® and Onpattro®)	Revised	Aug. 1, 2024
Xolair® (Omalizumab)	Revised	Aug. 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 of Kentucky 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 Medical Policies and Medical Benefit Drug Policies for UnitedHealthcare Community Plan of Kentucky is available at UHCprovider.com/KY > Medicaid (Community Plan) > Current Policies and Clinical Guidelines > [Medical & Drug Policies](#).