

UnitedHealthcare Community Plan of Kentucky Medical Policy Update Bulletin: March 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](#).

Medical Policy Updates

Policy Title	Status	Effective Date
Ablative Treatment for Spinal Pain (for Kentucky Only)	Revised	Apr. 1, 2024
Airway Clearance Devices (for Kentucky Only)	Revised	Apr. 1, 2024
Collagen Crosslinks and Biochemical Markers of Bone Turnover (for Kentucky Only)	Revised	Apr. 1, 2024
Deep Brain and Cortical Stimulation (for Kentucky Only)	Revised	Apr. 1, 2024
Elective Inpatient Services (for Kentucky Only)	Revised	Apr. 1, 2024
Electroretinography (for Kentucky Only)	Revised	Apr. 1, 2024
Gastrointestinal Pathogen Nucleic Acid Detection Panel Testing for Infectious Diarrhea (for Kentucky Only)	Revised	May 1, 2024
Genetic Testing for Hereditary Cancer (for Kentucky Only)	Revised	Apr. 1, 2024
Injectables for Reconstructive Procedures (for Kentucky Only)	Revised	Apr. 1, 2024
Intensity-Modulated Radiation Therapy (for Kentucky Only)	Revised	Apr. 1, 2024
Light and Laser Therapy (for Kentucky Only)	Revised	Apr. 1, 2024
Liposuction for Lipedema (for Kentucky Only)	Revised	Apr. 1, 2024
Obstructive and Central Sleep Apnea Treatment (for Kentucky Only)	Revised	Apr. 1, 2024
Omnibus Codes (for Kentucky Only)	Revised	Apr. 1, 2024
Proton Beam Radiation Therapy (for Kentucky Only)	Revised	Apr. 1, 2024
Sacral Nerve Stimulation for Urinary and Fecal Indications (for Kentucky Only)	Revised	Apr. 1, 2024
Stereotactic Body Radiation Therapy and Stereotactic Radiosurgery (for Kentucky Only)	Revised	Apr. 1, 2024
Surgery of the Foot (for Kentucky Only)	Updated	Mar. 1, 2024
Total Artificial Disc Replacement for the Spine (for Kentucky Only)	Revised	Apr. 1, 2024
Vagus and External Trigeminal Nerve Stimulation (for Kentucky Only)	Revised	Apr. 1, 2024

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Adzynma (ADAMTS13, Recombinant-KrhN)	New	Apr. 1, 2024
Complement Inhibitors (Soliris® & Ultomiris®)	Revised	Apr. 1, 2024
Denosumab (Prolia® & Xgeva®)	Updated	Apr. 1, 2024
Evkeeza® (Evinacumab-Dgnb)	Revised	Apr. 1, 2024
Leqvio® (Inclisiran)	Revised	Apr. 1, 2024

Policy Title	Status	Effective Date
Maximum Dosage and Frequency	Revised	Apr. 1, 2024
Omvo [™] (Mirikizumab-Mrkz)	New	Apr. 1, 2024
Ryplazim [®] (Plasminogen, Human-Tvmh)	Revised	Apr. 1, 2024
Veopoz [™] (Pozelimab-Bbfg)	Updated	Apr. 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 > [UnitedHealthcare Community Plan of Kentucky Medical & Drug Policies](#).