United Healthcare Community Plan

UnitedHealthcare Community Plan of Kentucky
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 Kentucky Only)	Revised	May 1, 2024
Deep Brain and Cortical Stimulation (for Kentucky Only)	Updated	Apr. 1, 2024
Electrical Stimulation for Wounds (for Kentucky Only)	Revised	Jun. 1, 2024
Electromagnetic Therapy for Wounds (for Kentucky Only)	Revised	Jun. 1, 2024
Embolization of the Ovarian and Iliac Veins for Pelvic Congestion Syndrome (for Kentucky Only)	Updated	Apr. 1, 2024
Gastrointestinal Motility Disorders, Diagnosis and Treatment (for Kentucky Only)	Updated	Apr. 1, 2024
Genetic Testing for Neuromuscular Disorders (for Kentucky Only)	Revised	Jun. 1, 2024
Hearing Instruments and Devices Including Wearable, Bone-Anchored, and Semi-Implantable (for Kentucky Only)	Updated	May 1, 2024
Implanted Electrical Stimulator for Spinal Cord (for Kentucky Only)	Updated	Apr. 1, 2024
Interspinous Fusion and Decompression Devices (for Kentucky Only)	Revised	May 1, 2024
Lower Extremity Prosthetics (for Kentucky Only)	Revised	Jun. 1, 2024
Minimally Invasive Spine Surgery Procedures (for Kentucky Only)	Revised	May 1, 2024
Neurophysiologic Testing and Monitoring (for Kentucky Only)	Updated	Apr. 1, 2024
Occipital Nerve Injections and Ablation (Including Occipital Neuralgia and Headache) (for Kentucky Only)	Revised	Apr. 1, 2024
Sacral Nerve Stimulation for Urinary and Fecal Indications (for Kentucky Only)	Updated	Apr. 1, 2024
Spinal Fusion and Bone Healing Enhancement Products (for Kentucky Only)	Revised	Apr. 1, 2024
Spinal Fusion and Decompression (for Kentucky Only)	Revised	Jun. 1, 2024
Transcatheter Heart Valve Procedures (for Kentucky Only)	Revised	May 1, 2024
Upper Extremity Prosthetic Devices (for Kentucky Only)	Revised	Jun. 1, 2024

Policy Title	Status	Effective Date
Urine Drug Testing (for Kentucky Only)	New	May 1, 2024
Vagus and External Trigeminal Nerve Stimulation (for Kentucky Only)	Revised	Apr. 1, 2024
Vertebral Body Tethering for Scoliosis (for Kentucky Only)	Updated	Apr. 1, 2024
Whole Exome and Whole Genome Sequencing (Non-Oncology Conditions) (for Kentucky Only)	Revised	May 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
Amondys 45® (Casimersen)	Revised	May 1, 2024
Briumvi® (Ublituximab-Xiiy)	Revised	May 1, 2024
Enjaymo® (Sutimlimab-Jome)	Revised	May 1, 2024
Erythropoiesis-Stimulating Agents	Revised	May 1, 2024
Exondys 51® (Eteplirsen)	Revised	May 1, 2024
Givlaari® (Givosiran)	Revised	May 1, 2024
Lemtrada® (Alemtuzumab)	Revised	May 1, 2024
Ocrevus® (Ocrelizumab)	Revised	May 1, 2024
Omvoh™ (Mirikizumab-Mrkz)	New	Apr. 1, 2024
Oncology Medication Clinical Coverage	Revised	May 1, 2024
Radicava® (Edaravone)	Revised	May 1, 2024
Reblozyl® (Luspatercept-Aamt)	Revised	May 1, 2024
Tysabri® (Natalizumab)	Revised	May 1, 2024
Vyjuvek™ (Beramagene Geperpavec-Svdt)	Revised	May 1, 2024
Vyondys 53® (Golodirsen)	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 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.