United Healthcare Community Plan

UnitedHealthcare Community Plan
Medical Policy Update Bulletin: February 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

Implementation Postponed: Habilitation and Rehabilitation Therapy (Occupational, Physical, and Speech) (for New Jersey Only)

The Medical Policy titled Habilitation and Rehabilitation Therapy (Occupational, Physical, and Speech) (for New Jersey Only) will not be implemented on Feb. 1, 2024, as previously announced. Complete details on related policy changes for New Jersey plan members will be provided in a future edition of the Medical Policy Update Bulletin. The Coverage Determination Guidelines titled Outpatient Physical and Occupational Therapy (for New Jersey Only) and Speech Language Pathology Services (for New Jersey Only) will remain in effect until further notice.

Medical Policy Updates

Policy Title	Status	Effective Date
Abnormal Uterine Bleeding and Uterine Fibroids (for New Jersey Only)	Revised	Mar. 1, 2024
Airway Clearance Devices	Revised	Apr. 1, 2024
Airway Clearance Devices (for New Jersey Only)	Revised	Apr. 1, 2024
Apheresis (for New Jersey Only)	Revised	Mar. 1, 2024
Collagen Crosslinks and Biochemical Markers of Bone Turnover (for New Jersey Only)	Updated	Feb. 1, 2024
Deep Brain and Cortical Stimulation	Revised	Apr. 1, 2024
Deep Brain and Cortical Stimulation (for New Jersey Only)	Revised	Apr. 1, 2024
Discogenic Pain Treatment (for New Jersey Only)	Updated	Feb. 1, 2024
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation	Updated	Apr. 1, 2024
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation (for Nebraska Only)	Revised	Apr. 1, 2024
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation (for New Jersey Only)	Updated	Apr. 1, 2024
Electroretinography	Revised	Apr. 1, 2024
Electroretinography (for Nebraska Only)	Revised	Apr. 1, 2024
Electroretinography (for New Jersey Only)	Revised	Apr. 1, 2024
Genetic Testing for Hereditary Cancer	Revised	Apr. 1, 2024
Genetic Testing for Hereditary Cancer (for Nebraska Only)	Revised	Apr. 1, 2024
Genetic Testing for Hereditary Cancer (for New Jersey Only)	Revised	Apr. 1, 2024
Hearing Aids and Devices Including Wearable, Bone-Anchored and Semi-Implantable	Updated	Apr. 1, 2024

Policy Title	Status	Effective Date
Hearing Aids and Devices Including Wearable, Bone-Anchored and Semi-Implantable (for New Jersey Only)	Updated	Apr. 1, 2024
Injectables for Reconstructive Procedures	Revised	Apr. 1, 2024
Injectables for Reconstructive Procedures (for Nebraska Only)	Revised	Apr. 1, 2024
Injectables for Reconstructive Procedures (for New Jersey Only)	Revised	Apr. 1, 2024
Intensity-Modulated Radiation Therapy	Revised	Apr. 1, 2024
Intensity-Modulated Radiation Therapy (for New Jersey Only)	Revised	Apr. 1, 2024
Interspinous Fusion and Decompression Devices	Revised	Apr. 1, 2024
Light and Laser Therapy	Revised	Apr. 1, 2024
Light and Laser Therapy (for New Jersey Only)	Revised	Apr. 1, 2024
Liposuction for Lipedema	Revised	Apr. 1, 2024
Liposuction for Lipedema (for Nebraska Only)	Revised	Apr. 1, 2024
Molecular Oncology Companion Diagnostic Testing (for New Jersey Only)	Revised	Mar. 1, 2024
Molecular Oncology Testing for Hematologic Cancer Diagnosis, Prognosis, and Treatment Decisions (for New Jersey Only)	Revised	Mar. 1, 2024
Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions (for New Jersey Only)	Revised	Mar. 1, 2024
Omnibus Codes	Revised	Apr. 1, 2024
Omnibus Codes (for Nebraska Only)	Revised	Apr. 1, 2024
Omnibus Codes (for New Jersey Only)	Revised	Apr. 1, 2024
Percutaneous Patent Foramen Ovale (PFO) Closure (for New Jersey Only)	Revised	Mar. 1, 2024
Proton Beam Radiation Therapy	Revised	Apr. 1, 2024
Proton Beam Radiation Therapy (for New Jersey Only)	Revised	Apr. 1, 2024
Radiation Therapy: Fractionation, Image-Guidance, and Special Services (for New Jersey Only)	Revised	Mar. 1, 2024
Sacral Nerve Stimulation for Urinary and Fecal Indications	Revised	Apr. 1, 2024
Sacral Nerve Stimulation for Urinary and Fecal Indications (for New Jersey Only)	Revised	Apr. 1, 2024
Skin and Soft Tissue Substitutes (for New Jersey Only)	Revised	Mar. 1, 2024
Stereotactic Body Radiation Therapy and Stereotactic Radiosurgery	Revised	Apr. 1, 2024
Stereotactic Body Radiation Therapy and Stereotactic Radiosurgery (for New Jersey Only)	Revised	Apr. 1, 2024
Thermography	Retired	Feb. 1, 2024
Thermography (for New Jersey Only)	Retired	Feb. 1, 2024
Total Artificial Disc Replacement for the Spine (for New Jersey Only)	Revised	Mar. 1, 2024
Treatment of Temporomandibular Joint Disorders (for New Jersey Only)	Revised	Mar. 1, 2024

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Botulinum Toxins A and B	Updated	Mar. 1, 2024
Complement Inhibitors (Soliris® & Ultomiris®)	Revised	Mar. 1, 2024
Elevidys™ (Delandistrogene Moxparvovec-Rokl)	Updated	Feb. 1, 2024
Infliximab (Avsola®, Inflectra®, Remicade®, & Renflexis®)	Revised	Mar. 1, 2024
Intravenous Iron Replacement Therapy (Feraheme®, Injectafer®, & Monoferric®)	Revised	Mar. 1, 2024
Leqvio® (Inclisiran)	Updated	Feb. 1, 2024

Policy Title	Status	Effective Date
Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease	Updated	Feb. 1, 2024
Neonatal Fc Receptor Blockers (Vyvgart®, Vyvgart® Hytrulo, & Rystiggo®)	Revised	Feb. 1, 2024
Neonatal Fc Receptor Blockers (Vyvgart®, Vyvgart® Hytrulo, & Rystiggo®)	Revised	Mar. 1, 2024
Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors	Revised	Mar. 1, 2024
Roctavian™ (Valoctocogene Roxaparvovec-Rvox)	Updated	Feb. 1, 2024
Self-Administered Medications	Updated	Feb. 1, 2024
Stelara® (Ustekinumab)	Revised	Mar. 1, 2024
Vyjuvek™ (Beramagene Geperpavec-Svdt)	Updated	Feb. 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 UnitedHealthcare Medical Policy and Medical Benefit Drug Policy 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 and Medical Benefit Drug Policies is available at **UHCprovider.com** > Policies and Protocols > Community Plan Policies > Medical & Drug Policies.