United Healthcare Community Plan

# *UnitedHealthcare Community Plan*
# Medical Policy Update Bulletin: January 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

### Annual CPT/HCPCS Code Updates

Beginning **Jan. 1, 2024**, all applicable Medical Policies and Medical Benefit Drug Policies will be updated to reflect the 2024 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 |
|---|---|---|
| Ablative Treatment for Spinal Pain | Updated | Jan. 1, 2024 |
| Ablative Treatment for Spinal Pain (for New Jersey Only) | Updated | Jan. 1, 2024 |
| Abnormal Uterine Bleeding and Uterine Fibroids | Revised | Mar. 1, 2024 |
| Ambulance Services (for Nebraska Only) | Updated | Mar. 1, 2024 |
| Apheresis | Revised | Mar. 1, 2024 |
| Autologous Cellular Therapy (for New Jersey Only) | Updated | Jan. 1, 2024 |
| Bariatric Surgery (for Nebraska Only) | Revised | Mar. 1, 2024 |
| Computer-Assisted Surgical Navigation for Musculoskeletal Procedures | Updated | Jan. 1, 2024 |
| Computer-Assisted Surgical Navigation for Musculoskeletal Procedures (for New Jersey Only) | Updated | Jan. 1, 2024 |
| Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/Replacements (for New Jersey Only) | Revised | Feb. 1, 2024 |
| Elective Inpatient Services | Revised | Mar. 1, 2024 |
| Elective Inpatient Services (for New Jersey Only) | Revised | Mar. 1, 2024 |
| Electric Tumor Treatment Field Therapy | Revised | Mar. 1, 2024 |
| Electric Tumor Treatment Field Therapy (for New Jersey Only) | Revised | Mar. 1, 2024 |
| Habilitation and Rehabilitation Therapy (Occupational, Physical, and Speech) (for New Jersey Only) | Revised | Feb. 1, 2024 |
| Hepatitis Screening (for Nebraska Only) | Updated | Jan. 1, 2024 |
| Hepatitis Screening (for New Jersey Only) | Updated | Jan. 1, 2024 |
| Home Health, Skilled, and Custodial Care Services (for Nebraska Only) | Revised | Mar. 1, 2024 |
| Implanted Electrical Stimulator for Spinal Cord | Updated | Mar. 1, 2024 |

| Policy Title | Status | Effective Date |
|---|---|---|
| Implanted Electrical Stimulator for Spinal Cord (for New Jersey Only) | Updated | Mar. 1, 2024 |
| Lithotripsy for Salivary Stones (for New Jersey Only) | Updated | Jan. 1, 2024 |
| Minimally Invasive Procedures for Gastric and Esophageal Diseases | Revised | Mar. 1, 2024 |
| Minimally Invasive Procedures for Gastric and Esophageal Diseases (for New Jersey Only) | Revised | Mar. 1, 2024 |
| Molecular Oncology Companion Diagnostic Testing | Revised | Mar. 1, 2024 |
| Molecular Oncology Companion Diagnostic Testing (for Nebraska Only) | Revised | Mar. 1, 2024 |
| Molecular Oncology Testing for Hematologic Cancer Diagnosis, Prognosis, and Treatment Decisions | Revised | Mar. 1, 2024 |
| Molecular Oncology Testing for Hematologic Cancer Diagnosis, Prognosis, and Treatment Decisions (for Nebraska Only) | Revised | Mar. 1, 2024 |
| Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions | Revised | Mar. 1, 2024 |
| Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions (for Nebraska Only) | Revised | Mar. 1, 2024 |
| Neurophysiologic Testing and Monitoring | Updated | Mar. 1, 2024 |
| Neurophysiologic Testing and Monitoring (for New Jersey Only) | Updated | Mar. 1, 2024 |
| Obstructive and Central Sleep Apnea Treatment | Revised | Mar. 1, 2024 |
| Obstructive and Central Sleep Apnea Treatment (for Nebraska Only) | Revised | Mar. 1, 2024 |
| Obstructive and Central Sleep Apnea Treatment (for New Jersey Only) | Revised | Mar. 1, 2024 |
| Percutaneous Patent Foramen Ovale (PFO) Closure | Revised | Mar. 1, 2024 |
| Pharmacogenetic Panel Testing | Updated | Mar. 1, 2024 |
| Pharmacogenetic Panel Testing (for Nebraska Only) | Updated | Mar. 1, 2024 |
| Pharmacogenetic Panel Testing (for New Jersey Only) | Updated | Mar. 1, 2024 |
| Plagiocephaly and Craniosynostosis Treatment | Updated | Jan. 1, 2024 |
| Plagiocephaly and Craniosynostosis Treatment (for New Jersey Only) | Updated | Jan. 1, 2024 |
| Private Duty Nursing Services (for Nebraska Only) | Revised | Mar. 1, 2024 |
| Prolotherapy and Platelet Rich Plasma Therapies (for New Jersey Only) | Updated | Jan. 1, 2024 |
| Radiation Therapy: Fractionation, Image-Guidance, and Special Services | Revised | Mar. 1, 2024 |
| Skin and Soft Tissue Substitutes | Revised | Mar. 1, 2024 |
| Skin and Soft Tissue Substitutes (for Nebraska Only) | Revised | Mar. 1, 2024 |
| Surgical Treatment of Lymphedema | Updated | Feb. 1, 2024 |
| Surgical Treatment of Lymphedema (for New Jersey Only) | Updated | Feb. 1, 2024 |
| Total Artificial Disc Replacement for the Spine | Revised | Mar. 1, 2024 |
| Transcranial Magnetic Stimulation | Updated | Mar. 1, 2024 |
| Transcranial Magnetic Stimulation (for New Jersey Only) | Updated | Mar. 1, 2024 |
| Treatment of Temporomandibular Joint Disorders | Revised | Mar. 1, 2024 |
| Treatment of Temporomandibular Joint Disorders (for Nebraska Only) | Revised | Mar. 1, 2024 |
| Vagus and External Trigeminal Nerve Stimulation (for New Jersey Only) | Updated | Jan. 1, 2024 |
| Video Electroencephalographic (vEEG) Monitoring and Recording | Updated | Jan. 1, 2024 |
| Video Electroencephalographic (vEEG) Monitoring and Recording (for New Jersey Only) | Updated | Jan. 1, 2024 |

## Medical Benefit Drug Policy Updates

| Policy Title | Status | Effective Date |
|---|---|---|
| Actemra® (Tocilizumab) Injection for Intravenous Infusion | Updated | Feb. 1, 2024 |
| Benlysta® (Belimumab) | Updated | Jan. 1, 2024 |
| Briumvi® (Ublituximab-Xiiy) | Updated | Jan. 1, 2024 |
| Denosumab (Prolia® & Xgeva®) | Updated | Jan. 1, 2024 |
| Evenity® (Romosozumab-Aqqg) | Updated | Jan. 1, 2024 |
| Intravenous Iron Replacement Therapy (Feraheme®, Injectafer®, & Monoferric®) | Updated | Feb. 1, 2024 |
| Ketalar® (Ketamine) and Spravato® (Esketamine) | Updated | Jan. 1, 2024 |
| Ketalar® (Ketamine) and Spravato® (Esketamine) | Revised | Feb. 1, 2024 |
| Ketalar® (Ketamine) and Spravato® (Esketamine) (for New Jersey Only) | Revised | Feb. 1, 2024 |
| Leqvio® (Inclisiran) | Updated | Jan. 1, 2024 |
| Neonatal Fc Receptor Blockers (Vyvgart®, Vyvgart® Hytrulo, & Rystiggo®) | Revised | Feb. 1, 2024 |
| Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors | Updated | Jan. 1, 2024 |
| Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors | Revised | Feb. 1, 2024 |
| Qalsody® (Tofersen) | Updated | Jan. 1, 2024 |
| Reblozyl® (Luspatercept-Aamt) | Revised | Feb. 1, 2024 |
| Rebyota™ (Fecal Microbiota, Live-Jslm) | Revised | Jan. 1, 2024 |
| Spevigo® (Spesolimab-Sbzo) | Updated | Jan. 1, 2024 |
| Testosterone Replacement or Supplementation Therapy | Revised | Feb. 1, 2024 |
| Zolgensma® (Onasemnogene Abeparvovec-Xioi) | Updated | Jan. 1, 2024 |

## Coverage Determination Guideline Updates

| Policy Title | Status | Effective Date |
|---|---|---|
| Speech Language Pathology Services (for New Jersey Only) | Replaced | 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.