

# UnitedHealthcare Community Plan of Indiana 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
Airway Clearance Devices (for Indiana Only)	Retired	Jan. 1, 2024
Elective Inpatient Services (for Indiana Only)	Revised	Mar. 1, 2024
Electric Tumor Treatment Field Therapy (for Indiana Only)	Updated	Mar. 1, 2024
Implanted Electrical Stimulator for Spinal Cord (for Indiana Only)	Retired	Jan. 1, 2024
Neurophysiologic Testing and Monitoring (for Indiana Only)	Revised	Mar. 1, 2024
Obstructive and Central Sleep Apnea Treatment (for Indiana Only)	Revised	Mar. 1, 2024
Surgical Treatment of Lymphedema (for Indiana Only)	Updated	Feb. 1, 2024
Treatment of Temporomandibular Joint Disorders (for Indiana Only)	Revised	Mar. 1, 2024

## Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Intravenous Iron Replacement Therapy (Feraheme®, Injectafer®, & Monoferric®) (for Indiana Only)	Updated	Feb. 1, 2024
Leqvio® (Inclisiran) (for Indiana Only)	Retired	Jan. 1, 2024
Neonatal Fc Receptor Blockers (Vyvgart®, Vyvgart® Hytrulo, & Rystiggo®) (for Indiana Only)	Revised	Feb. 1, 2024
Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors (for Indiana Only)	Revised	Feb. 1, 2024
Testosterone Replacement or Supplementation Therapy (for Indiana Only)	Revised	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 Community Plan of Indiana 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 Medical Policies and Medical Benefit Drug Policies for UnitedHealthcare Community Plan of Indiana is available at [UHCprovider.com/IN](https://UHCprovider.com/IN) > Medicaid (Community Plan) > Current Policies and Clinical Guidelines > [UnitedHealthcare Community Plan of Indiana Medical & Drug Policies](#).