United Healthcare Community Plan

UnitedHealthcare Community Plan of Ohio
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 Ohio Only)	Revised	Apr. 1, 2024
Airway Clearance Devices (for Ohio Only)	Revised	Apr. 1, 2024
Bariatric Surgery (for Ohio Only)	Revised	May 1, 2024
Catheter Ablation for Atrial Fibrillation (for Ohio Only)	Revised	Apr. 1, 2024
Collagen Crosslinks and Biochemical Markers of Bone Turnover (for Ohio Only)	Updated	Apr. 1, 2024
Computerized Dynamic Posturography (for Ohio Only)	Updated	Apr. 1, 2024
Discogenic Pain Treatment (for Ohio Only)	Updated	Apr. 1, 2024
Elective Inpatient Services (for Ohio Only)	Revised	Apr. 1, 2024
Electroretinography (for Ohio Only)	Revised	Apr. 1, 2024
Gastrointestinal Pathogen Nucleic Acid Detection Panel Testing for Infectious Diarrhea (for Ohio Only)	Revised	May 1, 2024
Hearing Aids and Devices Including Wearable, Bone-Anchored and Semi-Implantable (for Ohio Only)	Updated	Apr. 1, 2024
Hysterectomy (for Ohio Only)	Updated	Apr. 1, 2024
Injectables for Reconstructive Procedures (for Ohio Only)	Revised	Apr. 1, 2024
Intensity-Modulated Radiation Therapy (for Ohio Only)	Revised	Apr. 1, 2024
Interspinous Fusion and Decompression Devices (for Ohio Only)	Revised	Apr. 1, 2024
Light and Laser Therapy (for Ohio Only)	Revised	Apr. 1, 2024
Liposuction for Lipedema (for Ohio Only)	Revised	Apr. 1, 2024
Omnibus Codes (for Ohio Only)	Revised	Apr. 1, 2024
Percutaneous Patent Foramen Ovale (PFO) Closure (for Ohio Only)	Revised	Apr. 1, 2024
Pharmacogenetic Panel Testing (for Ohio Only)	Updated	Apr. 1, 2024
Proton Beam Radiation Therapy (for Ohio Only)	Revised	Apr. 1, 2024
Surgery of the Foot (for Ohio Only)	Updated	Apr. 1, 2024
Thermography (for Ohio Only)	Retired	Apr. 1, 2024
Transcatheter Heart Valve Procedures (for Ohio Only)	Revised	May 1, 2024
Transcranial Magnetic Stimulation (for Ohio Only)	Revised	Apr. 1, 2024

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Actemra® (Tocilizumab) Injection for Intravenous Infusion (for Ohio Only)	Updated	Apr. 1, 2024

Policy Title	Status	Effective Date
Cimzia® (Certolizumab Pegol) (for Ohio Only)	Updated	Apr. 1, 2024
Gamifant® (Emapalumab-Lzsg) (for Ohio Only)	Updated	Apr. 1, 2024
Intracanalicular and Intravitreal Corticosteroid Implants (for Ohio Only)	Revised	Apr. 1, 2024
Intravenous Iron Replacement Therapy (Feraheme®, Injectafer®, & Monoferric®) (for Ohio Only)	Updated	Apr. 1, 2024
Ketalar® (Ketamine) and Spravato® (Esketamine) (for Ohio Only)	Updated	Apr. 1, 2024
Long-Acting Injectable Antiretroviral Agents for HIV (for Ohio Only)	Updated	Apr. 1, 2024
Medical Therapies for Enzyme Deficiencies (for Ohio Only)	Revised	Apr. 1, 2024
Neonatal Fc Receptor Blockers (Vyvgart®, Vyvgart® Hytrulo, & Rystiggo®) (for Ohio Only)	Revised	Apr. 1, 2024
Off-Label/Unproven/New FDA Indication Specialty Drug Treatment (for Ohio Only)	Revised	Apr. 1, 2024
Omvoh™ (Mirikizumab-Mrkz) (for Ohio Only)	New	Apr. 1, 2024
Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors (for Ohio Only)	Revised	Apr. 1, 2024
Oxlumo® (Lumasiran) (for Ohio Only)	Updated	Apr. 1, 2024
Provider Administered Drugs – Site of Care (for Ohio Only)	Updated	Apr. 1, 2024
Qalsody® (Tofersen) (for Ohio Only)	Updated	Apr. 1, 2024
Reblozyl® (Luspatercept-Aamt) (for Ohio Only)	Revised	Apr. 1, 2024
Rebyota™ (Fecal Microbiota, Live-Jslm) (for Ohio Only)	Revised	Apr. 1, 2024
Simponi Aria® (Golimumab) Injection for Intravenous Infusion (for Ohio Only)	Updated	Apr. 1, 2024
Somatostatin Analogs (for Ohio Only)	Updated	Apr. 1, 2024
Subcutaneous Implantable Naltrexone Pellets (for Ohio Only)	Updated	Apr. 1, 2024
Veopoz™ (Pozelimab-Bbfg) (for Ohio Only)	New	Apr. 1, 2024
Vyjuvek™ (Beramagene Geperpavec-Svdt) (for Ohio Only)	Updated	Apr. 1, 2024
Xiaflex® (Collagenase Clostridium Histolyticum) (for Ohio Only)	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 Ohio 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 Ohio is available at **UHCprovider.com/OH** > Medicaid (Community Plan) > Current Policies and Clinical Guidelines > UnitedHealthcare Community Plan of Ohio Medical & Drug Policies.