United Healthcare Community Plan

UnitedHealthcare Community Plan of Kentucky
Medical Policy Update Bulletin: January 2023

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, 2023, all applicable Medical Policies and Medical Benefit Drug Policies will be updated to reflect the 2023 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 Level II

For the list of impacted policies and corresponding details, click here.

Medical Benefit Drug Policies Retired

Effective Jan. 1, 2023, the following Medical Benefit Drug Policies will be retired for Community Plan of Kentucky. The state of Kentucky no longer requires medical necessity review for coverage provided under the medical benefit for these medications.

- Antithrombin III (ATryn®, Thrombate III®) (for Kentucky Only)
- Anti-Thymocyte Globulin (Lymphocyte Immune Globulin) (for Kentucky Only)
- Apokyn® (Apomorphine) (for Kentucky Only)
- Azathioprine Sodium Injection (for Kentucky Only)
- Baclofen Injection (for Kentucky Only)
- BAL in Oil (Dimercaprol) Injection (for Kentucky Only)
- Boniva® (Ibandronate) (for Kentucky Only)
- Carnitor® (Levocarnitine) Solution for Injection (for Kentucky Only)
- Ceprotin® (Protein C Concentrate) (for Kentucky Only)
- Cytogam® (Cytomegalovirus Immune Globulin) (for Kentucky Only)
- Deferoxamine Mesylate (for Kentucky Only)
- Desmopressin Acetate Solution for Injection (for Kentucky Only)
- Dexrazoxane Hydrochloride Injection (for Kentucky Only)
- Duopa™ (Carbidopa and Levodopa) Enteral Suspension (for Kentucky Only)
- Ethamolin® (Ethanolamine Oleate) Injection (for Kentucky Only)
- Ethyol® (Amifostine) (for Kentucky Only)
- GamaSTAN®, GamaSTAN S/D® (Intramuscular Immune Globulin) (for Kentucky Only)
- Human Chorionic Gonadotropin (for Kentucky Only)
- Injectable Anticoagulants (for Kentucky Only)
- Injectable Atypical Antipsychotic Agents (for Kentucky Only)
- Intravenous Anti-Infective Agents (for Kentucky Only)
- Intravenous Bisphosphonates/Bone Resorption Inhibitors (Zoledronic Acid & Pamidronate Disodium) (for Kentucky Only)
- Kepivance® (Palifermin) (for Kentucky Only)
- Levetiracetam Solution for Injection (for Kentucky Only)
- Levulan® Kerastick® (Aminolevulinic Acid Hydrochloride) Topical Solution (for Kentucky Only)
- Milrinone Lactate Solution for Injection (for Kentucky Only)
- Morphine Injection for Epidural or Intrathecal (for Kentucky Only)
- Mozobil® (Plerixafor) (for Kentucky Only)

- Nulojix® (Belatacept) (for Kentucky Only)
- Panhematin® (Hemin) (for Kentucky Only)
- Pentamidine Isethionate Inhalant (for Kentucky Only)
- Prialt® (Ziconotide) (for Kentucky Only)
- Prograf® (Tacrolimus) Injection (for Kentucky Only)
- Pulmonary Arterial Hypertension Agents (for Kentucky Only)
- Rhophylac® (Rho[D] Immune Globulin) (for Kentucky Only)
- Rimso-50® (Dimethyl Sulfoxide) Irrigant (for Kentucky Only)
- Simulect® (Basiliximab) (for Kentucky Only)
- Thyrogen® (Thyrotropin Alfa) (for Kentucky Only)
- Vibativ® (Telavancin) (for Kentucky Only)
- Visudyne® (Verteporfin for Injection) (for Kentucky Only)
- Voraxaze® (Glucarpidase) (for Kentucky Only)
- Zinplava™ (Bezlotoxumab) (for Kentucky Only)

Medical Policy Updates

Policy Title	Status	Effective Date
Abnormal Uterine Bleeding and Uterine Fibroids (for Kentucky Only)	Revised	Mar. 1, 2023
Airway Clearance Devices (for Kentucky Only)	Revised	Mar. 1, 2023
Apheresis (for Kentucky Only)	Updated	Mar. 1, 2023
Electrical and Ultrasound Bone Growth Stimulators (for Kentucky Only)	Updated	Mar. 1, 2023
Epiduroscopy, Epidural Lysis of Adhesions and Discography (for Kentucky Only)	Updated	Mar. 1, 2023
Genetic Testing for Neuromuscular Disorders (for Kentucky Only)	Revised	Mar. 1, 2023
Home Health Care Services (for Kentucky Only)	Revised	Mar. 1, 2023
Light and Laser Therapy (for Kentucky Only)	Updated	Mar. 1, 2023
Lithotripsy for Salivary Stones (for Kentucky Only)	Updated	Mar. 1, 2023
Minimally Invasive Procedures for Gastroesophageal Reflux Disease (GERD) and Achalasia (for Kentucky Only)	Revised	Mar. 1, 2023
Obstructive and Central Sleep Apnea Treatment (for Kentucky Only)	Revised	Mar. 1, 2023
Oral and Enteral Nutrition (for Kentucky Only)	Revised	Feb. 1, 2023
Pediatric Gait Trainers and Standing Systems (for Kentucky Only)	Revised	Mar. 1, 2023
Prostate Surgeries and Interventions (for Kentucky Only)	Revised	Mar. 1, 2023
Spinal Fusion and Bone Healing Enhancement Products (for Kentucky Only)	Revised	Mar. 1, 2023
Surgery of the Elbow (for Kentucky Only)	Revised	Mar. 1, 2023
Surgery of the Hip (for Kentucky Only)	Revised	Mar. 1, 2023
Surgery of the Knee (for Kentucky Only)	Revised	Mar. 1, 2023
Surgery of the Shoulder (for Kentucky Only)	Revised	Mar. 1, 2023
Total Artificial Heart and Ventricular Assist Devices (for Kentucky Only)	Revised	Mar. 1, 2023
Walkers (for Kentucky Only)	Updated	Mar. 1, 2023

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Cimzia® (Certolizumab Pegol)	Revised	Feb. 1, 2023
Intravenous Iron Replacement Therapy (Feraheme®, Injectafer®, & Monoferric®)	Updated	Jan. 1, 2023
Ketalar® (Ketamine) and Spravato® (Esketamine)	Revised	Feb. 1, 2023
Long-Acting Injectable Antiretroviral Agents for HIV	Revised	Feb. 1, 2023
Reblozyl® (Luspatercept-Aamt)	Revised	Feb. 1, 2023

Policy Title	Status	Effective Date
Simponi Aria® (Golimumab) Injection for Intravenous Infusion	Revised	Feb. 1, 2023
Stelara® (Ustekinumab)	Updated	Feb. 1, 2023
Testosterone Replacement or Supplementation Therapy	Updated	Jan. 1, 2023

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 Kentucky Medical Policy, Medical Benefit Drug Policy, Coverage Determination Guideline, and Utilization Review Guideline 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 of Kentucky Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, and Utilization Review Guidelines is available at UHCprovider.com/Kentucky > Medicaid (Community Plan) > Current Policies and Clinical Guidelines > UnitedHealthcare Community Plan of Kentucky Medical & Drug Policies and Coverage Determination Guidelines.