United Healthcare Community Plan

UnitedHealthcare Community Plan of Ohio
Medical Policy Update Bulletin: April 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
Athletic Pubalgia Surgery (for Ohio Only)	Updated	May 1, 2024
Cardiovascular Disease Risk Tests (for Ohio Only)	Revised	Jun. 1, 2024
Corneal Collagen Cross-Linking (for Ohio Only)	Updated	May 1, 2024
Deep Brain and Cortical Stimulation (for Ohio Only)	Revised	May 1, 2024
Electrical Stimulation for Wounds (for Ohio Only)	Revised	Jun. 1, 2024
Electromagnetic Therapy for Wounds (for Ohio Only)	Revised	Jun. 1, 2024
Embolization of the Ovarian and Iliac Veins for Pelvic Congestion Syndrome (for Ohio Only)	Updated	May 1, 2024
Fecal Microbiota Transplantation (for Ohio Only)	Updated	May 1, 2024
Gastrointestinal Motility Disorders, Diagnosis and Treatment (for Ohio Only)	Updated	May 1, 2024
Genetic Testing for Hereditary Cancer (for Ohio Only)	Revised	May 1, 2024
Home Traction Therapy (for Ohio Only)	Updated	May 1, 2024
Implanted Electrical Stimulator for Spinal Cord (for Ohio Only)	Revised	Jun. 1, 2024
Lower Extremity Prosthetics (for Ohio Only)	Revised	Jun. 1, 2024
Manipulation Under Anesthesia (for Ohio Only)	Updated	May 1, 2024
Minimally Invasive Spine Surgery Procedures (for Ohio Only)	Revised	May 1, 2024
Molecular Oncology Companion Diagnostic Testing (for Ohio Only)	Updated	May 1, 2024
Molecular Oncology Testing for Hematologic Cancer Diagnosis, Prognosis, and Treatment Decisions (for Ohio Only)	Updated	May 1, 2024
Negative Pressure Wound Therapy (for Ohio Only)	Updated	May 1, 2024
Occipital Nerve Injections and Ablation (Including Occipital Neuralgia and Headache) (for Ohio Only)	Updated	May 1, 2024
Pneumatic Compression Devices (for Ohio Only)	Updated	Jun. 1, 2024
Sacral Nerve Stimulation for Urinary and Fecal Indications (for Ohio Only)	Revised	May 1, 2024
Skin and Soft Tissue Substitutes (for Ohio Only)	Updated	Jun. 1, 2024
Spinal Fusion and Bone Healing Enhancement Products (for Ohio Only)	Updated	May 1, 2024
Spinal Fusion and Decompression (for Ohio Only)	Revised	Jun. 1, 2024
Transanal Minimally Invasive Surgical Procedures (for Ohio Only)	Revised	Jun. 1, 2024
Transpupillary Thermotherapy (for Ohio Only)	Updated	May 1, 2024
Upper Extremity Prosthetic Devices (for Ohio Only)	Revised	Jun. 1, 2024
Vagus and External Trigeminal Nerve Stimulation (for Ohio Only)	Updated	May 1, 2024
Vertebral Body Tethering for Scoliosis (for Ohio Only)	Updated	May 1, 2024

Policy Title	Status	Effective Date
Whole Exome and Whole Genome Sequencing (Non-Oncology Conditions) (for Ohio Only)	Updated	May 1, 2024

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Amondys 45® (Casimersen) (for Ohio Only)	Revised	May 1, 2024
Briumvi® (Ublituximab-Xiiy) (for Ohio Only)	Revised	May 1, 2024
Complement Inhibitors (Soliris® & Ultomiris®) (for Ohio Only)	Revised	May 1, 2024
Enjaymo® (Sutimlimab-Jome) (for Ohio Only)	Revised	May 1, 2024
Evkeeza® (Evinacumab-Dgnb) (for Ohio Only)	Revised	May 1, 2024
Exondys 51® (Eteplirsen) (for Ohio Only)	Revised	May 1, 2024
Lemtrada® (Alemtuzumab) (for Ohio Only)	Updated	May 1, 2024
Leqvio® (Inclisiran) (for Ohio Only)	Revised	May 1, 2024
Maximum Dosage and Frequency (for Ohio Only)	Revised	May 1, 2024
Ocrevus® (Ocrelizumab) (for Ohio Only)	Updated	May 1, 2024
Omvoh™ (Mirikizumab-Mrkz) (for Ohio Only)	Revised	May 1, 2024
Orencia® (Abatacept) Injection for Intravenous Infusion (for Ohio Only)	Updated	May 1, 2024
Radicava® (Edaravone) (for Ohio Only)	Revised	May 1, 2024
Repository Corticotropin Injections (for Ohio Only)	Updated	May 1, 2024
Ryplazim® (Plasminogen, Human-Tvmh) (for Ohio Only)	Revised	May 1, 2024
Spevigo® (Spesolimab-Sbzo) (for Ohio Only)	Updated	May 1, 2024
Tysabri® (Natalizumab) (for Ohio Only)	Updated	May 1, 2024
Vyjuvek™ (Beramagene Geperpavec-Svdt) (for Ohio Only)	Revised	May 1, 2024
Vyondys 53® (Golodirsen) (for Ohio Only)	Revised	May 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.