

UnitedHealthcare Community Plan of Ohio 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](#).

Medical Policy Updates

Policy Title	Status	Effective Date
Apheresis (for Ohio Only)	Revised	Mar. 1, 2024
Bariatric Surgery (for Ohio Only)	Revised	Feb. 1, 2024
Computed Tomographic Colonography (for Ohio Only)	Revised	Feb. 1, 2024
Electrical and Ultrasound Bone Growth Stimulators (for Ohio Only)	Updated	Feb. 1, 2024
Embolization of the Ovarian and Iliac Veins for Pelvic Congestion Syndrome (for Ohio Only)	Updated	Feb. 1, 2024
Epiduroscopy, Epidural Lysis of Adhesions and Discography (for Ohio Only)	Revised	Feb. 1, 2024
Gender Dysphoria Treatment (for Ohio Only)	Revised	Feb. 1, 2024
Hearing Aids and Devices Including Wearable, Bone-Anchored and Semi-Implantable (for Ohio Only)	Revised	Feb. 1, 2024
Hospital Services: Observation and Inpatient (for Ohio Only)	New	Feb. 1, 2024
Manipulation Under Anesthesia (for Ohio Only)	Revised	Feb. 1, 2024
Molecular Oncology Companion Diagnostic Testing (for Ohio Only)	Revised	Mar. 1, 2024
Molecular Oncology Testing for Hematologic Cancer Diagnosis, Prognosis, and Treatment Decisions (for Ohio Only)	Revised	Mar. 1, 2024
Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions (for Ohio Only)	Revised	Mar. 1, 2024
Neurophysiologic Testing and Monitoring (for Ohio Only)	Revised	Mar. 1, 2024
Percutaneous Patent Foramen Ovale (PFO) Closure (for Ohio Only)	New	Feb. 1, 2024
Pharmacogenetic Panel Testing (for Ohio Only)	Revised	Mar. 1, 2024
Pneumatic Compression Devices (for Ohio Only)	Revised	Feb. 1, 2024
Preimplantation Genetic Testing and Related Services (for Ohio Only)	Revised	Feb. 1, 2024
Proton Beam Radiation Therapy (for Ohio Only)	Revised	Feb. 1, 2024
Radiation Therapy: Fractionation, Image-Guidance, and Special Services (for Ohio Only)	Revised	Mar. 1, 2024
Sacral Nerve Stimulation for Urinary and Fecal Indications (for Ohio Only)	New	Feb. 1, 2024
Total Artificial Disc Replacement for the Spine (for Ohio Only)	Revised	Mar. 1, 2024
Transcatheter Heart Valve Procedures (for Ohio Only)	Revised	Feb. 1, 2024
Transcranial Magnetic Stimulation (for Ohio Only)	Revised	Mar. 1, 2024
Treatment of Temporomandibular Joint Disorders (for Ohio Only)	Revised	Mar. 1, 2024
Unicondylar Spacer Devices for Treatment of Pain or Disability (for Ohio Only)	Updated	Feb. 1, 2024
Vagus and External Trigeminal Nerve Stimulation (for Ohio Only)	Revised	Feb. 1, 2024

Policy Title	Status	Effective Date
Vertebral Body Tethering for Scoliosis (for Ohio Only)	Updated	Feb. 1, 2024
Video Electroencephalographic (vEEG) Monitoring and Recording (for Ohio Only)	Revised	Feb. 1, 2024
Visual Information Processing Evaluation and Orthoptic and Vision Therapy (for Ohio Only)	Revised	Feb. 1, 2024

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Adakveo® (Crizanlizumab-Tmca) (for Ohio Only)	Updated	Feb. 1, 2024
Gamifant® (Emapalumab-Lzsg) (for Ohio Only)	Updated	Feb. 1, 2024
Ilaris® (Canakinumab) (for Ohio Only)	Revised	Feb. 1, 2024
Krystexxa® (Pegloticase) (for Ohio Only)	Revised	Feb. 1, 2024
Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease (for Ohio Only)	New	Feb. 1, 2024
Neonatal Fc Receptor Blockers (Vyvgart®, Vyvgart® Hytrulo, & Rystiggo®) (for Ohio Only)	Revised	Feb. 1, 2024
Parsabiv® (Etelcalcetide) (for Ohio Only)	Updated	Feb. 1, 2024
Reblozyl® (Luspatercept-Aamt) (for Ohio Only)	Revised	Feb. 1, 2024
Review at Launch for New to Market Medications (for Ohio Only)	Revised	Feb. 1, 2024
Roctavian™ (Valoctocogene Roxaparovec-Rvox) (for Ohio Only)	New	Feb. 1, 2024
Saphnelo® (Anifrolumab-Fnia) (for Ohio Only)	Revised	Feb. 1, 2024
Self-Administered Medications (for Ohio Only)	New	Feb. 1, 2024
Skyrizi® (Risankizumab-Rzaa) (for Ohio Only)	Revised	Feb. 1, 2024
Subcutaneous Implantable Naltrexone Pellets (for Ohio Only)	Updated	Feb. 1, 2024
Xiaflex® (Collagenase Clostridium Histolyticum) (for Ohio Only)	Updated	Feb. 1, 2024

Utilization Review Guideline Updates

Policy Title	Status	Effective Date
Observation Services (for Ohio 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 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 Ohio is available at UHCprovider.com/OH > Medicaid (Community Plan) > Current Policies and Clinical Guidelines > [UnitedHealthcare Community Plan of Ohio Medical & Drug Policies](#).