

UnitedHealthcare Community Plan of Kentucky Medical Policy Update Bulletin Quick View: February 2025



A list of recently approved, revised, and/or retired Medical Policies and/or Medical Benefit Drug Policies is provided below for your reference. **For a comprehensive summary of the latest updates, refer to the [Medical Policy Update Bulletin: February 2025](#).**

Medical Policy Updates

Policy Title	Status	Effective Date
Cardiac Event Monitoring (for Kentucky Only)	Updated	Feb. 1, 2025
Catheter Ablation for Atrial Fibrillation (for Kentucky Only)	Updated	Feb. 1, 2025
Computer-Assisted Surgical Navigation for Musculoskeletal Procedures (for Kentucky Only)	Revised	Mar. 1, 2025
Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes (for Kentucky Only)	Revised	Mar. 1, 2025
Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/Replacements (for Kentucky Only)	Revised	Mar. 1, 2025
Implanted Electrical Stimulator for the Spinal Cord (for Kentucky Only)	Updated	Feb. 1, 2025
Liposuction for Lipedema (for Kentucky Only)	Updated	Feb. 1, 2025
Lower Extremity Endovascular Procedures (for Kentucky Only)	Revised	Mar. 1, 2025
Lower Extremity Prosthetics (for Kentucky Only)	Updated	Feb. 1, 2025
Mechanical Stretching Devices (for Kentucky Only)	Updated	Feb. 1, 2025
Pharmacogenetic Panel Testing (for Kentucky Only)	Revised	Mar. 1, 2025
Sacroiliac Joint Interventions (for Kentucky Only)	Revised	Mar. 1, 2025
Skin and Soft Tissue Substitutes (for Kentucky Only)	Revised	Mar. 1, 2025
Spinal Fusion and Decompression (for Kentucky Only)	Updated	Feb. 1, 2025
Surgery for the Prevention and Treatment of Lymphedema (for Kentucky Only)	Revised	Mar. 1, 2025

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Botulinum Toxins A and B	Revised	Mar. 1, 2025
Intravenous Iron Replacement Therapy (Feraheme®, Injectafer®, & Monoferic®)	Revised	Mar. 1, 2025
Simponi Aria® (Golimumab) Injection for Intravenous Infusion	Revised	Mar. 1, 2025
Tepezza® (Teprotumumab-Trbw)	Revised	Mar. 1, 2025
White Blood Cell Colony Stimulating Factors	Revised	Mar. 1, 2025

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 Kentucky 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 UnitedHealthcare Community Plan of Kentucky Medical Policies and Medical Benefit Drug Policies is available at UHCprovider.com/KY > Community Plan (Medicaid) > Current Policies and Clinical Guidelines > [Medical & Drug Policies](#).