

# UnitedHealthcare Community Plan of Louisiana Medical Policy Update Bulletin Quick View: June 2024



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: June 2024](#).**

## Medical Policy Updates

Policy Title	Status	Effective Date
Augmentative and Alternative Communication Devices (for Louisiana Only)	Updated	Jun. 1, 2024
Beds and Mattresses (for Louisiana Only)	Updated	Aug. 1, 2024
Breast Reduction Surgery (for Louisiana Only)	Updated	Jul. 1, 2024
Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes (for Louisiana Only)	Retired	Jun. 1, 2024
Electrical Stimulation for Wounds (for Louisiana Only)	Revised	Jul. 1, 2024
Electromagnetic Therapy for Wounds (for Louisiana Only)	Revised	Jul. 1, 2024
Intraocular Pressure Measurement (for Louisiana Only)	Retired	Jun. 1, 2024
Lower Extremity Prosthetics (for Louisiana Only)	Revised	Jul. 1, 2024
Pneumatic Compression Devices (for Louisiana Only)	Revised	Jul. 1, 2024
Upper Extremity Prosthetic Devices (for Louisiana Only)	Revised	Jul. 1, 2024

## Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Korsuva® (Difelikefalin) (for Louisiana Only)	Revised	Jul. 1, 2024
Neonatal Fc Receptor Blockers (Vyvgart®, Vyvgart® Hytrulo, & Rystiggo®) (for Louisiana Only)	Revised	Jul. 1, 2024
Ryplazim® (Plasminogen, Human-Tvmh) (for Louisiana Only)	Revised	Jul. 1, 2024
Scenesse® (Afamelanotide) (for Louisiana Only)	Revised	Jul. 1, 2024
Testosterone Replacement or Supplementation Therapy (for Louisiana Only)	Revised	Jul. 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 Louisiana 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 Louisiana is available at [UHCprovider.com/LA](https://UHCprovider.com/LA) > Medicaid (Community Plan) > Current Policies and Clinical Guidelines > [Medical & Drug Policies](#).