United Healthcare Community Plan

UnitedHealthcare Community Plan of Kentucky 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
Cardiovascular Disease Risk Tests (for Kentucky Only)	Revised	Jul. 1, 2024
Chemotherapy Observation or Inpatient Hospitalization (for Kentucky Only)	Revised	Jul. 1, 2024
Corneal Hysteresis and Intraocular Pressure Measurement (for Kentucky Only)	Retired	Jun. 1, 2024
Mobility Devices, Options, and Accessories (for Kentucky Only)	Revised	Aug. 1, 2024
Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions (for Kentucky Only)	Revised	Jul. 1, 2024
Pneumatic Compression Devices (for Kentucky Only)	Revised	Jul. 1, 2024
Prostate Surgeries and Interventions (for Kentucky Only)	Revised	Jul. 1, 2024
Rhinoplasty and Other Nasal Procedures (for Kentucky Only)	Revised	Jul. 1, 2024
Skin and Soft Tissue Substitutes (for Kentucky Only)	Revised	Jul. 1, 2024
Transanal Minimally Invasive Surgical Procedures (for Kentucky Only)	Revised	Jul. 1, 2024

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Actemra® (Tocilizumab) Injection for Intravenous Infusion	Revised	Jul. 1, 2024
Complement Inhibitors (Soliris® & Ultomiris®)	Revised	Jul. 1, 2024
Immune Globulin (IVIG and SCIG)	Revised	Jul. 1, 2024
Korsuva® (Difelikefalin)	Revised	Jul. 1, 2024
Long-Acting Injectable Antiretroviral Agents for HIV	Updated	Jul. 1, 2024
Nplate® (Romiplostim)	Revised	Jul. 1, 2024
Oncology Medication Clinical Coverage	Revised	Jul. 1, 2024
Oxlumo® (Lumasiran) and Rivfloza™ (Nedosiran)	Revised	Jul. 1, 2024
Review at Launch for New to Market Medications	Revised	Jul. 1, 2024
Saphnelo® (Anifrolumab-Fnia)	Revised	Jul. 1, 2024
Scenesse® (Afamelanotide)	Revised	Jul. 1, 2024
Sodium Hyaluronate	Revised	Jul. 1, 2024
Spevigo® (Spesolimab-Sbzo)	Revised	Jul. 1, 2024
Testosterone Replacement or Supplementation Therapy	Revised	Jul. 1, 2024
Trogarzo® (Ibalizumab-Uiyk)	Updated	Jul. 1, 2024
Vyjuvek® (Beramagene Geperpavec-Svdt)	Revised	Jul. 1, 2024

Policy Title	Status	Effective Date
White Blood Cell Colony Stimulating Factors	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 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 Medical Policies and Medical Benefit Drug Policies for UnitedHealthcare Community Plan of Kentucky is available at **UHCprovider.com/KY** > Medicaid (Community Plan) > Current Policies and Clinical Guidelines > Medical & Drug Policies.