

January 2020

medical policy update **bulletin**

Medical Policy, Medical Benefit Drug Policy & Coverage Determination Guideline Updates

Take Note

ANNUAL CPT® AND HCPCS CODE UPDATES

All applicable Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, and Utilization Review Guidelines have been modified to reflect the 2020 Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) code additions, revisions, and deletions. Refer to the following sources for information on the 2020 code updates:

- [American Medical Association. Current Procedural Terminology: CPT®](#)
- [Centers for Medicare & Medicaid Services. Healthcare Common Procedure Coding System: HCPCS Level II](#)

For the list of impacted policies and corresponding details, click [here](#).

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](#).

Policy Title	Status	Effective Date
MEDICAL POLICY		
Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes	Revised	Apr. 1, 2020
Gastrointestinal Pathogen Nucleic Acid Detection Panel Testing for Infectious Diarrhea	New	Mar. 1, 2020
Intensity-Modulated Radiation Therapy	Revised	Feb. 1, 2020
Magnetic Resonance Spectroscopy (MRS)	Retired	Jan. 1, 2020
Negative Pressure Wound Therapy	Revised	Feb. 1, 2020
Surgical Treatment for Spine Pain	Updated	Jan. 1, 2020
Total Artificial Disc Replacement for the Spine	Revised	Mar. 1, 2020
Transcatheter Heart Valve Procedures	Revised	Mar. 1, 2020
Vertebral Body Tethering for Scoliosis	New	Mar. 1, 2020
MEDICAL BENEFIT DRUG POLICY		
Benlysta® (Belimumab)	Revised	Jan. 1, 2020
Complement Inhibitors (Soliris® & Ultomiris™)	Revised	Jan. 1, 2020
Immune Globulin (IVIG and SCIG)	Revised	Feb. 1, 2020
Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors	Revised	Jan. 1, 2020
Reblozyl® (Luspatercept-Aamt)	New	Feb. 1, 2020
Rituximab (Rituxan®, Ruxience®, & Truxima®)	Revised	Feb. 1, 2020
COVERAGE DETERMINATION GUIDELINE (CDG)		
Breast Reconstruction Post Mastectomy	Revised	Feb. 1, 2020
Breast Reduction Surgery	Revised	Feb. 1, 2020
Cosmetic and Reconstructive Procedures	Revised	Feb. 1, 2020
Infertility Services	Updated	Jan. 1, 2020
Preventive Care Services	Revised	Feb. 1, 2020

Policy Title	Status	Effective Date
UTILIZATION REVIEW GUIDELINE (URG)		
Outpatient Surgical Procedures – Site of Service	Revised	Feb. 1, 2020
Outpatient Surgical Procedures – Site of Service	Revised	Mar. 1, 2020

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 Medical Policy, Medical Benefit Drug Policy, Coverage Determination Guideline, Utilization Review Guideline, and Quality of Care Guideline 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 and/or documentation review requirements 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 or documentation review requirements; 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 and/or documentation review requirements

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 Medical Policies, Medical Benefit Drug Policies, CDGs, URGs, and QOCGs is available at [UHCprovider.com](https://www.uhcprovider.com) > *Policies and Protocols* > *Commercial Policies* > *Medical & Drug Policies and Coverage Determination Guidelines*.