

June 2019

medical policy update **bulletin**

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

Access a policy from the table below for complete details on the latest updates. A detailed summary of changes is provided at the bottom of every policy document for your reference.

| Policy Title | Status | Effective Date |
|--|---------------|-----------------------|
| MEDICAL POLICY | | |
| Chromosome Microarray Testing (Non-Oncology Conditions) | Revised | Jun. 1, 2019 |
| Hepatitis Screening | Revised | Jul. 1, 2019 |
| Molecular Oncology Testing for Cancer Diagnosis, Prognosis, and Treatment Decisions | Updated | Jul. 1, 2019 |
| MEDICAL BENEFIT DRUG POLICY | | |
| Entyvio® (Vedolizumab) | Revised | Jun. 1, 2019 |
| Infliximab (Remicade®, Inflectra™, Renflexis™) | Revised | Jun. 1, 2019 |
| Ketalar® (Ketamine) and Spravato™ (Esketamine) | Revised | Jun. 1, 2019 |
| Off-Label/Unproven Specialty Drug Treatment | Revised | Jun. 1, 2019 |
| Zolgensma® (Onasemnogene Apeparvovec-Xioi) | New | May 29, 2019 |
| COVERAGE DETERMINATION GUIDELINE (CDG) | | |
| Breast Reduction Surgery | Updated | Jul. 1, 2019 |
| Clinical Trials | Updated | Jul. 1, 2019 |
| Cosmetic and Reconstructive Procedures | Revised | Aug. 1, 2019 |
| Durable Medical Equipment, Orthotics, Ostomy Supplies, Medical Supplies and Repairs/Replacements | Updated | Jun. 1, 2019 |
| Gynecomastia Treatment | Revised | Jul. 1, 2019 |
| Infertility Services | Revised | Jul. 1, 2019 |
| Panniculectomy and Body Contouring Procedures | Revised | Aug. 1, 2019 |
| Preventive Care Services | Revised | Jul. 1, 2019 |
| Private Duty Nursing Services (PDN) | Revised | Aug. 1, 2019 |
| UTILIZATION REVIEW GUIDELINE (URG) | | |
| Musculoskeletal Surgical Procedures – Site of Care | New | Aug. 1, 2019 |
| Provider Administered Drugs – Site of Care | Revised | Jul. 1, 2019 |

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 > *Policies and Protocols* > *Commercial Policies* > *Medical & Drug Policies and Coverage Determination Guidelines*.