UnitedHealthcare®

November 2019

medical policy update bulletin

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

Take Note

IMPLEMENTATION DELAYED FOR MEDICAL BENEFIT DRUG POLICY UPDATES

Implementation of the changes associated with the following **Medical Benefit Drug Policies**, previously announced for an **Oct. 1 2019** effective date, has been delayed until further notice:

- Actemra® (Tocilizumab) Injection for Intravenous Infusion
- Benlysta® (Belimumab)
- Cimzia® (Certolizumab Pegol) *(New)*
- Orencia® (Abatacept) Injection for Intravenous Infusion
- Simponi Aria® (Golimumab) Injection for Intravenous Infusion

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		
Articular Cartilage Defect Repairs	Revised	Jan. 1, 2020
Computed Tomographic Colonography	Revised	Jan. 1, 2020
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation	Revised	Jan. 1, 2020
Genetic Testing for Hereditary Cancer	Revised	Dec. 1, 2019
Skin and Soft Tissue Substitutes	Revised	Jan. 1, 2020
Vagus and External Trigeminal Nerve Stimulation	Revised	Dec. 1, 2019
Visual Information Processing Evaluation and Orthoptic and Vision Therapy	Revised	Dec. 1, 2019
MEDICAL BENEFIT DRUG POLICY		
Botulinum Toxins A and B	Revised	Dec. 1, 2019
Clotting Factors, Coagulant Blood Products & Other Hemostatics	Revised	Nov. 1, 2019
Erythropoiesis-Stimulating Agents	Revised	Jan. 1, 2020
COVERAGE DETERMINATION GUIDELINE (CDG)		
Breast Reduction Surgery	Updated	Nov. 1, 2019
Preventive Care Services	Revised	Dec. 1, 2019
UTILIZATION REVIEW GUIDELINE (URG)		
Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Scan – Site of Service	Updated	Nov. 1, 2019
Outpatient Surgical Procedures – Site of Service	Revised	Nov. 1, 2019

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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.*