



## UnitedHealthcare Commercial Medical Policy Update Bulletin: November 2020

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](#).

### Medical Policy Updates

Policy Title	Status	Effective Date
<a href="#">Airway Clearance Devices</a>	Revised	Jan. 1, 2021
<a href="#">Electrical and Ultrasound Bone Growth Stimulators</a>	Revised	Jan. 1, 2021
<a href="#">Fecal Calprotectin Testing</a>	Updated	Dec. 1, 2020
<a href="#">Genetic Testing for Hereditary Cancer</a>	Revised	Dec. 1, 2020
<a href="#">Hepatitis Screening</a>	Updated	Oct. 14, 2020
<a href="#">Hip Resurfacing and Replacement Surgery (Arthroplasty)</a>	Updated	Nov. 1, 2020
<a href="#">Knee Replacement Surgery (Arthroplasty), Total and Partial</a>	Updated	Nov. 1, 2020
<a href="#">Molecular Oncology Testing for Cancer Diagnosis, Prognosis, and Treatment Decisions</a>	Revised	Jan. 1, 2021
<a href="#">Percutaneous Vertebroplasty and Kyphoplasty</a>	Updated	Nov. 1, 2020
<a href="#">Radiation Therapy: Fractionation, Image-Guidance, and Special Services</a>	New	Feb. 1, 2021
<a href="#">Shoulder Replacement Surgery (Arthroplasty)</a>	Updated	Nov. 1, 2020
<a href="#">Skin and Soft Tissue Substitutes</a>	Revised	Dec. 1, 2020
<a href="#">Stereotactic Body Radiation Therapy and Stereotactic Radiosurgery</a>	New	Feb. 1, 2021
<a href="#">Surgical Treatment for Spine Pain</a>	Updated	Nov. 1, 2020
<a href="#">Total Artificial Disc Replacement for the Spine</a>	Updated	Nov. 1, 2020
<a href="#">Total Artificial Heart</a>	Updated	Nov. 1, 2020

### Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
<a href="#">Buprenorphine (Probuphine® &amp; Sublocade®)</a>	Updated	Nov. 1, 2020
<a href="#">Cimzia® (Certolizumab Pegol)</a>	Updated	Nov. 1, 2020
<a href="#">Intravenous Enzyme Replacement Therapy (ERT) for Gaucher Disease</a>	Revised	Dec. 1, 2020
<a href="#">Krystexxa® (Pegloticase)</a>	Updated	Nov. 1, 2020
<a href="#">White Blood Cell Colony Stimulating Factors</a>	Revised	Jan. 1, 2021

### Coverage Determination Guideline Updates

Policy Title	Status	Effective Date
<a href="#">Panniculectomy and Body Contouring Procedures</a>	Updated	Nov. 1, 2020

## Utilization Review Guideline Updates

Policy Title	Status	Effective Date
Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Scan – Site of Service	Revised	Jan. 1, 2021
Outpatient Surgical Procedures – Site of Service	Revised	Jan. 1, 2021
Provider Administered Drugs – Site of Care	Revised	Jan. 1, 2021

## 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, and Utilization Review 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 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 UnitedHealthcare Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, and Utilization Review Guidelines is available at [UHCprovider.com](https://www.uhcprovider.com) > Policies and Protocols > Commercial Policies > [Medical & Drug Policies and Coverage Determination Guidelines](#).