

UnitedHealthcare Community Plan of Kentucky Medical Policy Update Bulletin Quick View: November 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: November 2024](#).**

Medical Policy Updates

Policy Title	Status	Effective Date
Breast Imaging for Screening and Diagnosing Cancer (for Kentucky Only)	Updated	Jan. 1, 2025
Breast Reconstruction (for Kentucky Only)	Revised	Dec. 1, 2024
Brow Ptosis and Eyelid Repair (for Kentucky Only)	Revised	Dec. 1, 2024
Carrier Testing Panels for Genetic Diseases (for Kentucky Only)	Revised	Dec. 1, 2024
Cognitive Rehabilitation (for Kentucky Only)	Revised	Dec. 1, 2024
Computed Tomographic Colonography (for Kentucky Only)	Retired	Nov. 1, 2024
Corneal Collagen Cross-Linking (for Kentucky Only)	Retired	Nov. 1, 2024
Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions and Soft Tissue Wounds (for Kentucky Only)	Updated	Dec. 1, 2024
Hospital Services: Observation and Inpatient (for Kentucky Only)	Revised	Dec. 1, 2024
Inhaled Nitric Oxide Therapy (for Kentucky Only)	Updated	Nov. 1, 2024
Injectable Dermal Fillers and Bulking Agents (for Kentucky Only)	Revised	Dec. 1, 2024
Left Atrial Appendage Closure (Occlusion) (for Kentucky Only)	Revised	Dec. 1, 2024
Light and Laser Therapy (for Kentucky Only)	Revised	Jan. 1, 2025
Mechanical Stretching Devices (for Kentucky Only)	Revised	Jan. 1, 2025
Molecular Oncology Testing for Hematologic Cancer Diagnosis, Prognosis, and Treatment Decisions (for Kentucky Only)	Revised	Dec. 1, 2024
Obstructive and Central Sleep Apnea Treatment (for Kentucky Only)	Revised	Dec. 1, 2024
Private Duty Nursing Services (for Kentucky Only)	Revised	Jan. 1, 2025
Sacral Nerve Stimulation for Urinary and Fecal Indications (for Kentucky Only)	Updated	Dec. 1, 2024
Surgery of the Hip (for Kentucky Only)	Updated	Nov. 1, 2024
Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins (for Kentucky Only)	Revised	Dec. 1, 2024

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Complement Inhibitors (PiaSky®, Soliris®, & Ultomiris®)	Revised	Dec. 1, 2024
Hereditary Angioedema (HAE), Treatment and Prophylaxis	Revised	Dec. 1, 2024
Ilaris® (Canakinumab)	Revised	Dec. 1, 2024
Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease	Revised	Dec. 1, 2024

Policy Title	Status	Effective Date
Review at Launch for New to Market Medications	Revised	Dec. 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 UnitedHealthcare Community Plan of Kentucky Medical Policies and Medical Benefit Drug Policies is available at UHCprovider.com/KY > Community Plan (Medicaid) > Current Policies and Clinical Guidelines > [Medical & Drug Policies](#).