

## *UnitedHealthcare Commercial* **Medical Policy Update Bulletin: August 2022**

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="#">Diagnostic Dynamic Spinal Visualization and Vertebral Motion Analysis</a>	Revised	Oct. 1, 2022
<a href="#">Left Atrial Appendage Closure (Occlusion)</a>	Revised	Oct. 1, 2022
<a href="#">Noncontact Warming Therapy, Ultrasound Therapy and Fluorescence Imaging for Wounds</a>	Revised	Oct. 1, 2022
<a href="#">Omnibus Codes</a>	Revised	Oct. 1, 2022
<a href="#">Rhinoplasty and Other Nasal Surgeries</a>	Revised	Oct. 1, 2022
<a href="#">Skin and Soft Tissue Substitutes</a>	Revised	Oct. 1, 2022

### **Medical Benefit Drug Policy Updates**

Policy Title	Status	Effective Date
<a href="#">Complement Inhibitors (Soliris® &amp; Ultomiris®)</a>	Revised	Sep. 1, 2022
<a href="#">Drug Coverage Criteria - New and Therapeutic Equivalent Medications (for Oxford Only)</a>	Revised	Sep. 1, 2022
<a href="#">Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors</a>	Revised	Sep. 1, 2022
<a href="#">Radicava® (Edaravone)</a>	Revised	Sep. 1, 2022
<a href="#">Respiratory Interleukins (Cinqair®, Fasenra®, &amp; Nucala®)</a>	Updated	Aug. 1, 2022
<a href="#">RNA-Targeted Therapies (Amvuttra™ and Onpattro®)</a>	Revised	Sep. 1, 2022
<a href="#">Tepezza® (Teprotumumab-Trbw)</a>	Revised	Sep. 1, 2022
<a href="#">Vyvgart™ (Efgartigimod Alfa-Fcab)</a>	Revised	Sep. 1, 2022

## 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://UHCprovider.com) > Policies and Protocols > Commercial Policies > [Medical & Drug Policies and Coverage Determination Guidelines](#).