

## *UnitedHealthcare Commercial* **Medical Policy Update Bulletin: November 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](#).

### **Take Note**

#### **Leqvio® (Inclisiran): Policy Revisions Delayed**

The Medical Benefit Drug Policy titled *Leqvio® (Inclisiran)* will not be revised on Nov. 1, 2022, as previously announced; details on upcoming changes to this policy will be provided in a future edition of the Medical Policy Update Bulletin.

### **Medical Policy Updates**

Policy Title	Status	Effective Date
Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes	Updated	Nov. 1, 2022
Environmental Allergen Immunotherapy	Revised	Jan. 1, 2023
Hepatitis Screening	Revised	Dec. 1, 2022
Immune Globulin – Site of Care	Updated	Jan. 1, 2023
Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Scan – Site of Service	Revised	Feb. 1, 2023
Percutaneous Neuroablation for Pancreatic Cancer Pain, Severe Cancer Pain, and Trigeminal Neuralgia	Revised	Jan. 1, 2023

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

Policy Title	Status	Effective Date
Drug Coverage Criteria - New and Therapeutic Equivalent Medications (for Oxford Only)	Revised	Dec. 1, 2022
Maximum Dosage and Frequency	Revised	Nov. 1, 2022
Medical Therapies for Enzyme Deficiencies	Revised	Dec. 1, 2022
Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors	Revised	Dec. 1, 2022
Tezspire® (Tezepelumab-Ekko)	Revised	Dec. 1, 2022
White Blood Cell Colony Stimulating Factors	Revised	Nov. 1, 2022

### **Utilization Review Guideline Updates**

Policy Title	Status	Effective Date
Office Based Procedures – Site of Service	Revised	Dec. 1, 2022
Outpatient Surgical Procedures – Site of Service	Revised	Dec. 1, 2022
Screening Colonoscopy Procedures – Site of Service	Revised	Dec. 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](#).