United Healthcare®

UnitedHealthcare Commercial
Medical Policy Update Bulletin: July 2026

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Take Note

Quarterly CPT/HCPCS Code Updates

Effective **Jul. 1, 2026**, the following Medical Policies and Medical Benefit Drug Policies have been updated to reflect the quarterly Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) code additions, revisions, and deletions. Refer to the following sources for information on the code updates:

- American Medical Association: Current Procedural Terminology: CPT®
- Centers for Medicare & Medicaid Services: Healthcare Common Procedure Coding System (HCPCS) Quarterly Update

Policy Title	Policy Type	Summary of Changes
Category III Codes	Medical Policy	• Added CPT codes 1026T, 1036T, 1038T, 1039T, 1040T, 1041T, 1042T, 1043T, 1044T, 1045T, 1046T, 1047T, 1048T, 1049T, 1050T, 1051T, 1052T, and 1053T
Cell-Free Fetal DNA Testing	Medical Policy	• Added CPT codes 0632U and 0633U
Denosumab	Medical Benefit Drug Policy	• Added HCPCS code Q5167
FDA Cleared or Approved Companion Diagnostic Testing	Medical Policy	• Added CPT code 0648U
Genetic Testing for Hereditary Cancer	Medical Policy	**Multigene Panel** • Added CPT code 0651U
Immune Globulin (IVIG and SCIG)	Medical Benefit Drug Policy	• Added HCPCS code J1577 • Revised description for HCPCS code J1569
Itvisma® (Onasemnogene Abeparvovec-Brve)	Medical Benefit Drug Policy	• Replaced HCPCS code C9309 with J3405
Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions	Medical Policy	• Added CPT codes 0631U, 0641U, 0642U, 0643U, 0644U, 0645U, 0646U, and 0647U
Ophthalmologic Vascular Endothelial Growth Factor (VEGF) Inhibitors	Medical Benefit Drug Policy	• Added HCPCS codes Q5149, Q5150, Q5153, Q5155, Q5168, and Q5170
Pharmacogenetic Panel Testing	Medical Policy	• Added CPT codes 0650U and 0652U • Removed CPT codes 0029U and 0423U
Provider Administered Drugs – Site of Care	Medical Benefit Drug Policy	• Added Q5164 • Revised description for J1569
Respiratory Interleukins (Cinqair®, Fasenra®, & Nucala®)	Medical Benefit Drug Policy	• Added HCPCS code J2361
Transcatheter Procedures for Heart Valve Conditions	Medical Policy	• Revised description for HCPCS codes 0805T and 0806T

Take Note

Policy Title	Policy Type	Summary of Changes
Ustekinumab	Medical Benefit Drug Policy	• Added HCPCS code Q5164
Whole Exome and Whole Genome Sequencing (Non-Oncology Conditions)	Medical Policy	• Added CPT codes 0657U, 0658U, and 0659U

Medical Policy Updates

Updated		
Policy Title	**Effective Date**	**Summary of Changes**

Cognitive Rehabilitation and Coma Stimulation	Jul. 1, 2026	**Definitions**
		• Updated definition of:
		  ○ Cognitive Rehabilitation
		  ○ Coma Stimulation
		Supporting Information
		• Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect the most current information

Gender Dysphoria Treatment	Jul. 1, 2026	**Coverage Rationale**
		• Added instruction for fully insured group policies in Washington D.C. to refer to the *Benefit Considerations* section [of the policy] for additional information
		Benefits Considerations
		Fully Insured Group Policies in Washington D.C.
		• Added language to indicate:
		  ○ In accordance with the requirements of the District of Columbia Department of Insurance (DISB) February 27, 2014 Bulletin titled *Prohibition of Discrimination in Health Insurance Based on Gender Identity or Expression*, coverage for medically necessary treatment of Gender Dysphoria is based on the most recent version of the WPATH Standards of Care for the Health of Transgender and Gender Diverse People
		  ○ The criteria in the *Coverage Rationale* section [of the policy] is applicable only to the degree that it does not conflict with the WPATH Standards of Care and DISB's Bulletin
		Fully-Insured Group Policies in New York
		• Added language to clarify coverage for medically necessary treatment of Gender Dysphoria is based on version 8 of the WPATH Standards of Care for the Health of Transgender and Gender Diverse People for fully-insured plans in New York, *including the NY Essential Plan*

Outpatient Surgical Procedures – Site of Service	Aug. 1, 2026	**Related Policies**
		• Added reference link to the Medical Policy titled *Surgery of the Wrist or Thumb*
		Definitions
		• Updated definition of:
		  ○ ASA Physical Status Classification System Risk Scoring Tool
		  ○ Poorly Controlled Hypertension
		Applicable Codes
		Commercial Plans
		• Removed CPT codes 26530, 26535, 29800, 29804, 29805, 29830, 29840, and 29860
		Supporting Information
		• Updated *References* section to reflect the most current information

Updated		
Policy Title	**Effective Date**	**Summary of Changes**

Screening Colonoscopy Procedures – Site of Service	Jul. 1, 2026	**Definitions**
		• Updated definition of:
		  ○ ASA Physical Status Classification System Risk Scoring Tool
		  ○ New York Heart Association Heart Failure Classification
		  ○ Poorly Controlled Hypertension
		Supporting Information
		• Updated *References* section to reflect the most current information

Sinus Surgeries and Interventions	Jul. 1, 2026	**Medical Records Documentation Used for Reviews**
		• Updated list of Medical Records Documentation Used for Reviews:
		  ○ Added:
		  ▪ Relevant medical history, including dates
		  ▪ Procedure being requested
		  ○ Removed:
		  ▪ History of illness
		  ▪ Recent CT scan images are the optimal images to show the abnormality of the affected area including, when applicable the use of a scale such as the Modified Lund-Mackay Scoring System to define the severity
		  ○ Replaced:
		  ▪ “Treatments tried, failed, or contraindicated; include the dates and reason for discontinuation” with “treatments tried, failed, or contraindicated; include the dates, duration, and reason for discontinuation”
		  ▪ “Recent CT scan report documents which sinus has the disease, including side” with “recent CT scan report documents which sinus(es) are affected, including laterality”
		  ▪ “Recent CT scan images labeled with the date taken and applicable case number obtained at time of notification or member's name and ID number” with “when requested, diagnostic image(s) must be labeled with the date taken and applicable case number obtained at time of notification or member's name and ID number”
		Definitions
		• Added definition of “Acute Bacterial Rhinosinusitis”
		• Removed definition of:
		  ○ Draf Classification System for Endoscopic Frontal Sinus Drainage
		  ○ Rhinitis Medicamentosa (RM)
		• Updated definition of:
		  ○ Acute Rhinosinusitis
		  ○ Chronic Rhinosinusitis
		  ○ Functional Endoscopic Sinus Surgery
		  ○ Modified Lund-Mackay Scoring System

Updated

Policy Title	Effective Date	Summary of Changes
Sinus Surgeries and Interventions (continued)	Jul. 1, 2026	○ Recurrent Acute Rhinosinusitis **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect the most current information

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Brow Ptosis and Eyelid Repair	Aug. 1, 2026	**Coverage Rationale** • Replaced language indicating "lid retraction surgery (CPT code 67911) is considered reconstructive and medically necessary when all of the [listed] criteria are present" with "lid retraction surgery (CPT code 67911) is considered reconstructive and medically necessary *for conditions other than thyroid eye disease* when all the [listed] criteria are present" ***Thyroid Eye Disease*** • Revised coverage guidelines to indicate lid retraction surgery (CPT code 67911) for thyroid eye disease is considered reconstructive and medically necessary when either of the following criteria are met: ○ Moderate to severe disease where all the following apply: ▪ The disease is stable or inactive, and euthyroidism has been achieved and maintained ▪ Other causes of lid retraction have been eliminated (e.g., use of	**Note**: The InterQual® criteria below only apply to persons 18 years of age or older. **Brow ptosis repair and repair of the eyelid are considered reconstructive and medically necessary in certain circumstances.** For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures: • Blepharoplasty • Ectropion Repair • Entropion Repair • Eyelid Lesion Excision, +/- Reconstruction • Eyelid Reconstruction • Ptosis Repair Click here to view the InterQual® criteria. **Note**: If multiple procedures are requested, criteria for each individual procedure must be met. **Internal Browpexy for any condition is considered cosmetic and not medically necessary.** **Eyelid surgery for correction of Lagophthalmos is considered reconstructive and medically necessary when the upper eyelid is not providing complete closure to the eye, resulting in dryness and other complications.** **Lid retraction surgery (CPT code 67911) is considered reconstructive and medically necessary for conditions other than thyroid eye disease when all the following criteria are present:**

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Brow Ptosis and Eyelid Repair (continued)	Aug. 1, 2026	dilating eye drops or glaucoma medications) ▪ There is a functional impairment (e.g., dry eyes, pain/discomfort, tearing, blurred vision) ○ Severe, sight-threatening thyroid eye disease to address subluxation **Definitions** • Removed definition of "Marginal Reflex Distance -1 (MRD-1)" **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information	• Other causes have been eliminated as the reason for the lid retraction such as use of dilating eye drops or glaucoma medications; and • There is a functional impairment (e.g., dry eyes, pain/discomfort, tearing, blurred vision); and • Tried and failed conservative treatments **For thyroid eye disease, lid retraction surgery (CPT code 67911) is considered reconstructive and medically necessary, when either of the following criteria are met:** • Moderate to severe disease where all the following apply: ○ The disease is stable or inactive, and euthyroidism has been achieved and maintained; and ○ Other causes of lid retraction have been eliminated (e.g., use of dilating eye drops or glaucoma medications); and ○ There is a functional impairment (e.g., dry eyes, pain/discomfort, tearing, blurred vision) or • Severe, sight-threatening thyroid eye disease to address subluxation **Canthoplasty/Canthopexy (CPT codes 21280, 21282, and 67950) are considered reconstructive and medically necessary when all the following criteria are present:** • There is a functional impairment; and • Repair of ectropion or entropion will not correct condition; and • At least one of the following is present: ○ Epiphora (excess tearing) not resolved by conservative measures; or ○ Corneal dryness unresponsive to lubricants; or ○ Corneal ulcer **Repair of Floppy Eyelid Syndrome (CPT codes 67961 and 67966) is considered reconstructive and medically necessary when all the following are present and have been documented and confirmed by history and examination:** • Subjective symptoms must include eyelids spontaneously "flipping over" when the member sleeps due to rubbing on the pillow and one of the following: ○ Eye pain or discomfort; or

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Brow Ptosis and Eyelid Repair (continued)	Aug. 1, 2026		○ Excess tearing; or ○ Eye irritation, ocular redness, and discharge • Physical examination that documents all the following: ○ Both of the following: ▪ Eyelash ptosis; and ▪ Significant upper eyelid laxity and ○ One of the following: ▪ Presence of giant papillary conjunctivitis; or ▪ Corneal findings such as one of the following: – Superficial punctate erosions; or – Corneal abrasion (documentation of a history of corneal abrasion or recurrent erosion syndrome is considered sufficient); or – Microbial keratitis • Clear, high-quality, clinical photographs that clearly document Floppy Eyelid Syndrome and demonstrate both of the following: ○ Lids must be everted in the photographs; and ○ Conjunctival surface (underbelly) of the lids must be clearly visible • Documentation that conservative treatment has been tried and failed; examples may include: ○ Ocular lubricants both drops (daytime) and ointments (bedtime) ○ Short trial of antihistamines ○ Topical steroid drops ○ Eye shield and/or taping the lids at bedtime • Infections of the eye have been ruled out; examples may include: ○ Allergic conjunctivitis ○ Atopic keratoconjunctivitis ○ Blepharitis ○ Contact lens complication (e.g., giant papillary conjunctivitis) ○ Superior limbic keratoconjunctivitis
Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions	Aug. 1, 2026	**Coverage Rationale** • Added language to clarify this policy applies *only* to tests that have not been granted approval as a U.S. Food and Drug Administration–cleared or	This policy applies only to tests that have not been granted approval as a U.S. Food and Drug Administration–cleared or –approved companion diagnostic test. **Breast Cancer** **The use of one of the following Gene Expression Profiling (GEP) tests –**

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions (continued)	Aug. 1, 2026	–approved companion diagnostic *test* ***Breast Cancer*** • Revised listed of Gene Expression Profiling (GEP) tests; replaced: ○ "Oncotype Dx® Breast" with "Oncotype DX Breast *Recurrence Score®*" ○ "Prosigna® Breast Cancer *Prognostic Gene Signature* Assay *(formerly PAM 50)*" with "Prosigna® Breast Cancer Assay" ***Colorectal Cancer*** • Added language to indicate blood-based colorectal cancer (CRC) screening using Shield™ is proven and medically necessary when all the following criteria are met: ○ The individual agrees to undergo a follow-up colonoscopy if Shield results are abnormal ○ The individual has no lower gastrointestinal pain, blood in stool, or other signs or symptoms suggestive of colorectal disease ○ The individual is of average risk for developing CRC, defined as both of the following: ▪ No personal history of adenomatous polyps, CRC, or inflammatory	**MammaPrint®, Oncotype DX Breast Recurrence Score®, Prosigna® Breast Cancer Assay, Breast Cancer Index™, and EndoPredict® – is proven and medically necessary when used to inform treatment decisions in individuals with invasive breast cancer in the following situations:** • Newly diagnosed (within the last 6 months) when all the following criteria are met: ○ Lymph node negative (including lymph nodes with micrometastases no greater than 2 mm) or one to three positive ipsilateral axillary lymph nodes; and ○ No distant metastases; and ○ Hormone receptor positive (estrogen receptor positive, progesterone receptor positive, or both); and ○ HER2 receptor negative; and ○ Adjuvant chemotherapy is not precluded due to any other factor (e.g., advanced age and/or significant comorbidities) or • Currently receiving adjuvant hormonal therapy (e.g., tamoxifen or an aromatase inhibitor) for breast cancer when all the following criteria are met: ○ Hormone receptor positive (estrogen receptor positive, progesterone receptor positive, or both); and ○ HER2 receptor negative; and ○ Individual and treating physician have had a discussion prior to testing regarding the potential results of the test and determined to use the results to guide a decision regarding extended adjuvant hormonal therapy **The use of more than one predictive GEP for the same tumor in an individual with breast cancer is unproven and not medically necessary due to insufficient evidence of efficacy.** **Note**: This limitation does not apply to Breast Cancer Index testing, which can be used once in the evaluation of the role of extended endocrine therapy in a breast cancer that may have already had GEP to determine the role of adjuvant chemotherapy.

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Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions (continued)	Aug. 1, 2026	bowel disease (e.g., Crohn disease, ulcerative colitis) ▪ No first-degree relative(s) with CRC, adenomatous polyps, familial adenomatous polyposis, or Lynch syndrome (hereditary nonpolyposis CRC) ○ One of the following: ▪ The individual is aged 45 to 75 years and has not been screened with Shield or a U.S. Preventive Services Task Force–recommended CRC screening during the recommended screening interval, including but not limited to: – Shield in the past 3 years – Guaiac-based fecal occult blood test in the past year – Fecal immunochemical test in the past year – Multitargeted stool DNA test in the past 3 years – Colonoscopy in the past 10 years – Computed tomography	**Colorectal Cancer** **Blood-based colorectal cancer (CRC) screening using Shield™ is proven and medically necessary when all the following criteria are met:** • The individual agrees to undergo a follow-up colonoscopy if Shield results are abnormal; and • The individual has no lower gastrointestinal pain, blood in stool, or other signs or symptoms suggestive of colorectal disease; and • The individual is of average risk for developing CRC, defined as both of the following: ○ No personal history of adenomatous polyps, CRC, or inflammatory bowel disease (e.g., Crohn disease, ulcerative colitis); and ○ No first-degree relative(s) with CRC, adenomatous polyps, familial adenomatous polyposis, or Lynch syndrome (hereditary nonpolyposis CRC); and • One of the following: ○ The individual is aged 45 to 75 years and has not been screened with Shield or a U.S. Preventive Services Task Force–recommended CRC screening during the recommended screening interval, including but not limited to: ▪ Shield in the past 3 years ▪ Guaiac-based fecal occult blood test in the past year ▪ Fecal immunochemical test in the past year ▪ Multitargeted stool DNA test in the past 3 years ▪ Colonoscopy in the past 10 years ▪ Computed tomography colonography in the past 5 years ▪ Flexible sigmoidoscopy in the past 5 years or ○ The individual is aged 76 to 85 years and all of the following: ▪ Has never been screened for CRC by any method; and ▪ Is healthy enough to undergo treatment if CRC is detected; and ▪ Does not have comorbid conditions that would significantly limit life expectancy **Lung Cancer** **Multigene molecular profiling panels that include no more than 50 genes are medically necessary for non-small cell lung cancer.**

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions (continued)	Aug. 1, 2026	colonography in the past 5 years – Flexible sigmoidoscopy in the past 5 years ▪ The individual is aged 76 to 85 years, has never been screened for CRC by any method, is healthy enough to undergo treatment if CRC is detected, and does not have comorbid conditions that would significantly limit life expectancy ***Lung Cancer*** • Replaced language indicating "multigene molecular profiling (*including* no more than 50 genes, *or for more than 50 genes only when used in a manner consistent with the Medical Policy titled FDA Cleared or Approved Companion Diagnostic Testing) performed using tumor tissue or via Liquid Biopsy [cell-free DNA (cfDNA) or circulating tumor DNA (ctDNA)]* is proven and medically necessary for non-small cell lung cancer" with "multigene molecular profiling *panels that include* no more than 50 genes are medically necessary for non-small cell lung cancer" ***Prostate Cancer*** • Replaced reference to "Genomic Prostate Score® test *(previously*	**Prostate Cancer** **The use of the Genomic Prostate Score® test is proven and medically necessary for individuals with biopsy-proven, untreated, localized adenocarcinoma of the prostate (no clinical evidence of metastasis or lymph node involvement) when:** • Test is ordered by a physician specializing in the treatment of organ-confined prostate cancer, including surgical oncology/urology, radiation oncology, and medical oncology; and • Results will be used to assist with treatment decision-making when the individual has not yet received treatment for prostate cancer and is a candidate for either active surveillance or definitive therapy and all the following: ○ Life expectancy is greater than 10 years; and ○ Risk group is one of the following: ▪ Very Low-Risk Prostate Cancer; or ▪ Low-Risk Prostate Cancer; or ▪ Favorable Intermediate-Risk Prostate Cancer **The use of the Prolaris® Biopsy prostate cancer prognostic test or Decipher® Prostate Biopsy genomic classifier is proven and medically necessary for individuals with biopsy-proven, untreated, localized adenocarcinoma of the prostate (no clinical evidence of metastasis or lymph node involvement) when:** • Test is ordered by a physician specializing in the treatment of organ-confined prostate cancer, including surgical oncology/urology, radiation oncology, and medical oncology; and • Results will be used to assist with treatment decision-making when the individual has not yet received treatment for prostate cancer and is a candidate for either active surveillance or definitive therapy and all the following: ○ Life expectancy is greater than 10 years; and ○ Risk group is one of the following: ▪ Very Low-Risk Prostate Cancer; or ▪ Low-Risk Prostate Cancer; or ▪ Favorable Intermediate-Risk Prostate Cancer; or ▪ Unfavorable Intermediate-Risk Prostate Cancer; or ▪ High-Risk Prostate Cancer

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions (continued)	Aug. 1, 2026	*Oncotype DX® GPS)*" with "Genomic Prostate Score® test" ***Indeterminate Thyroid Nodules*** • Replaced language indicating: ○ "*The use of* molecular testing for thyroid nodules *with indeterminate cytology* is proven and medically necessary when the [listed] criteria are met" with "molecular testing of thyroid nodules is proven and medically necessary when the [listed] criteria are met" ○ "The use of more than one molecular *profile* test *in an individual with an indeterminate* thyroid nodule is unproven and not medically necessary" with "the use of more than one molecular test *on a single* thyroid nodule is unproven and not medically necessary" ***Unproven Molecular Tests*** • Revised language to indicate all other molecular oncology testing for solid tumor cancer [not listed in the policy as proven and medically necessary] is unproven and not medically necessary due to insufficient evidence of efficacy, including but not limited to: ○ Next-Generation Sequencing panels or Comprehensive Genomic Profiling unless	**The use of the Decipher Prostate RP genomic classifier is proven and medically necessary to inform adjuvant treatment after radical prostatectomy for either of the following:** • Adverse features are found (e.g., high-grade disease, Gleason score of 8 or higher, extracapsular extension, positive surgical margins, seminal vesicle invasion); or • Prostate-specific antigen is greater than 0 at any point following prostatectomy **Anaplastic Thyroid Cancer** **Comprehensive Genomic Profiling of confirmed anaplastic thyroid cancer is proven and medically necessary.** **Indeterminate Thyroid Nodules** **Molecular testing of thyroid nodules [e.g., Afirma® Genomic Sequencing Classifier (GSC), ThyroSeq® V3, ThyGeNEXT®/ThyraMIR®] is proven and medically necessary when all the following criteria are met:** • Follicular pathology on fine-needle aspiration is indeterminate (Bethesda III/IV); and • The results of the test will be used for making decisions about further surgery **The use of more than one molecular test on a single thyroid nodule is unproven and not medically necessary due to insufficient evidence of efficacy.** **Uveal Melanoma** **GEP (e.g., DecisionDx®-UM) is considered proven and medically necessary when used to assist with predicting disease severity and making treatment decisions when all the following criteria are met:** • Individual has primary, localized uveal melanoma; and • There is no evidence of metastatic disease; and • Individual has not previously had DecisionDx-UM testing for current diagnosis

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions (continued)	Aug. 1, 2026	otherwise specified, such as: ▪ OncoDEEP ○ Testing of breast cancers and ductal carcinoma in situ unless otherwise specified [in the policy], such as: ▪ BluePrint ▪ DCISionRT ▪ Oncotype DX Breast DCIS Score ○ Testing of thyroid cancer or thyroid nodules unless otherwise specified [in the policy], such as: ▪ Afirma Xpression Atlas ▪ NeoTYPE Thyroid Profile ○ Testing for the purpose of identifying tumor origin or primary site, such as: ▪ CancerTYPE ID ○ Blood-based CRC screening tests unless otherwise specified [in the policy], such as: ▪ ColoHealth ▪ ColonSentry ▪ FirstSight ▪ Signal-C ▪ Shield for individuals aged < 45 years and > 85 years ○ Testing of bladder cancer, including for early detection of bladder cancer, such as: ▪ Bladder EpiCheck ▪ Cxbladder Triage ▪ Cxbladder Monitor	**Unproven Molecular Tests** **All other molecular oncology testing for solid tumor cancer is unproven and not medically necessary due to insufficient evidence of efficacy, including but not limited to:** • Next-Generation Sequencing panels or Comprehensive Genomic Profiling unless otherwise specified, such as: ○ OncoDEEP • Testing of breast cancers and ductal carcinoma in situ unless otherwise specified above, such as: ○ BluePrint ○ DCISionRT ○ Oncotype DX Breast DCIS Score • Testing of thyroid cancer or thyroid nodules unless otherwise specified above, such as: ○ Afirma Xpression Atlas ○ NeoTYPE Thyroid Profile • Testing for the purpose of identifying tumor origin or primary site, such as: ○ CancerTYPE ID • Blood-based CRC screening tests unless otherwise specified above, such as: ○ ColoHealth ○ ColonSentry ○ FirstSight ○ Signal-C ○ Shield for individuals aged < 45 years and > 85 years • Testing of bladder cancer, including for early detection of bladder cancer, such as: ○ Bladder EpiCheck ○ Cxbladder Triage ○ Cxbladder Monitor ○ Decipher Bladder Genomic Classifier • Testing of cutaneous cancers and head and neck cancers, including circulating tumor tissue–modified human papillomavirus DNA analysis, such as: ○ DecisionDx-Melanoma ○ DiffDx-Melanoma

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions (continued)	Aug. 1, 2026	▪ Decipher Bladder Genomic Classifier ○ Testing of cutaneous cancers and head and neck cancers, including circulating tumor tissue–modified human papillomavirus DNA analysis, such as: ▪ DecisionDx-Melanoma ▪ DiffDx-Melanoma ▪ DecisionDx-SCC ▪ DermTech PLA ▪ Merlin ▪ MyPath Melanoma ▪ NavDx ○ Testing of prostate cancers, including for early detection of prostate cancer, unless otherwise specified [in the policy], such as: ▪ Confirm mdx ▪ ExoDx Prostate ▪ MyProstateScore 2.0 ▪ ProsTAV ▪ Select mdx ○ Measurable Residual Disease assays, whether tumor informed or tumor naive, such as: ▪ Geneseeq Shielding ULTRA ▪ Geneseeq Vanguard ▪ Guardant Reveal ▪ Haystack MRD ▪ Invitae Personalized Cancer Monitoring ▪ Oncodetect	○ DecisionDx-SCC ○ DermTech PLA ○ Merlin ○ MyPath Melanoma ○ NavDx • Testing of prostate cancers, including for early detection of prostate cancer, unless otherwise specified above, such as: ○ Confirm mdx ○ ExoDx Prostate ○ MyProstateScore 2.0 ○ ProsTAV ○ Select mdx • Measurable Residual Disease assays, whether tumor informed or tumor naive, such as: ○ Geneseeq Shielding ULTRA ○ Geneseeq Vanguard ○ Guardant Reveal ○ Haystack MRD ○ Invitae Personalized Cancer Monitoring ○ Oncodetect ○ Personalis NeXT Personal ○ Plasma Detect ○ RaDaR ○ Signatera • Multicancer detection/screening tests, such as: ○ Cancerguard ○ Galleri ○ Geneseeq Mercury • Testing of CRCs, such as: ○ Oncotype DX Colon Recurrence Score ○ GeneFx Colon (also known as ColDx) ○ OnkoSight Advanced Colorectal Cancer • Testing of lung cancers or lung nodules unless otherwise specified above, such as: ○ Percepta Genomic Sequencing Classifier • Solid tumor profiling that includes Whole-Exome Sequencing, Whole-Genome Sequencing, or whole-transcriptome sequencing, such as:

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Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions (continued)	Aug. 1, 2026	▪ Personalis NeXT Personal ▪ Plasma Detect ▪ RaDaR ▪ Signatera ○ Multicancer detection/screening tests, such as: ▪ Cancerguard ▪ Galleri ▪ Geneseeq Mercury ○ Testing of CRCs, such as: ▪ Oncotype DX Colon Recurrence Score ▪ GeneFx Colon (also known as ColDx) ▪ OnkoSight Advanced Colorectal Cancer ○ Testing of lung cancers or lung nodules unless otherwise specified [in the policy], such as: ▪ Percepta Genomic Sequencing Classifier ○ Solid tumor profiling that includes Whole-Exome Sequencing, Whole-Genome Sequencing, or whole-transcriptome sequencing, such as: ▪ CancerVision ▪ Caris Assure ▪ Tempus xE ▪ Tempus xR ▪ OncoExTra ○ Tempus Immune Profile Score	○ CancerVision ○ Caris Assure ○ Tempus xE ○ Tempus xR ○ OncoExTra • Tempus Immune Profile Score • Whole-genome methylation profiling • EpiSwitch Checkpoint inhibitor Response Test

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions (continued)	Aug. 1, 2026	○ Whole-genome methylation profiling ○ EpiSwitch Checkpoint inhibitor Response Test **Medical Records Documentation Used for Reviews** • Updated list of Medical Records Documentation Used for Reviews to reflect/include: ○ Name and specialty of the provider ordering the testing ○ Primary cancer diagnosis, pathology, tumor size, and nodal status ○ Results and dates of prior testing or screening, such as hormone receptor status, biopsy, fine needle aspiration, or genetic testing ○ How clinical management will be impacted based on the results of this [service] **Definitions** • Removed definition of: ○ Comparative Genome Hybridization (CGH) ○ Very High-Risk Prostate Cancer • Updated definition of: ○ Favorable Intermediate-Risk Prostate Cancer ○ High-Risk Prostate Cancer ○ Measurable Residual Disease ○ Unfavorable Intermediate-Risk Prostate Cancer ○ Whole-Exome Sequencing	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions (continued)	Aug. 1, 2026	**Applicable Codes** • Added CPT/HCPCS codes 0285U, 0405U, 0534U, 0560U, 0561U, and S3854 • Removed CPT codes 0022U, 0037U, 0211U, 0239U, 0242U, 0523U, and 0592U **Supporting Information** • Added *Benefit Considerations* section • Updated *Clinical Evidence* and *References* sections to reflect the most current information	
Skin and Soft Tissue Substitutes	Aug. 1, 2026	**Coverage Rationale** • Revised list of skin and soft tissue substitutes that are unproven and not medically necessary for any indication; added: ○ A/C Wrap ○ AmnioBind or DermaBind TL+ or TL X ○ BIOBRANE or BIOBRANE Glove ○ BioLab Membrane Wrap Flow, BioLab Membrane Wrap Flow Solo, BioLab Membrane Wrap-Lite Flow, or BioLab Tri-Membrane Wrap Flow ○ CuraMatrix ○ DermaBind CH N or CH X, DermaBind DL N, DL+, or DL X, or DermaBind SL N, SL+, or SL X ○ DermaBind TL+ or TL X ○ Foundation Dermal Regeneration Scaffold (DRS)	**EPIFIX® or GRAFIX® (GRAFIX PL, GRAFIX PRIME, and GRAFIX PL PRIME) (Noninjectable)** **EPIFIX or GRAFIX is proven and medically necessary for treating a diabetic foot ulcer when all the following criteria are met:** • Adequate circulation to the affected extremity, as indicated by one or more of the following: ○ Pedal pulses palpable or pulses confirmed with Doppler examination ○ Ankle-Brachial Index between 0.7 and 1.2 • Glycated hemoglobin test < 12% (within the last 90 days) • Ulcer has failed to demonstrate adequate healing, with at least 4 weeks of standard wound care, which includes **all** the following: ○ Application of dressings to maintain a moist wound environment ○ Debridement of necrotic tissue if present ○ Offloading • No known contraindications, which may include but are not limited to the following: ○ Active Charcot deformity or major structural abnormalities of the affected foot ○ Chronic infection to the ulcer site ○ Known or suspected malignancy of the current ulcer being treated ○ Ulcer being treated does not extend to tendon, muscle, capsule, or bone

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Skin and Soft Tissue Substitutes (continued)	Aug. 1, 2026	+ Duo or DRS + Solo ○ Instagraft ○ NOVASHIELD or NovaGen Wound Matrix ○ Omeza Complete Matrix ○ Pretect ○ Renati Membrane and Renati AC Membrane ○ Revival AC ○ Revive FT or Revive TL ○ Suprello **Applicable Codes** • Added HCPCS codes A2040, A2041, A2042, A2043, A2044, A2045, Q4418, Q4419, Q4421, Q4422, Q4423, Q4424, Q4425, Q4426, Q4427, Q4428, Q4429, Q4435, Q4436, Q4437, Q4438, Q4439, and Q4440 • Revised description for HCPCS codes A2014 and A2037 **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information	**Due to insufficient evidence of efficacy, EPIFIX and/or GRAFIX are unproven and not medically necessary for all other indications.** **TransCyte®** **TransCyte is proven and medically necessary for treating surgically excised Full-Thickness Thermal Burn wounds and deep Partial-Thickness Thermal Burn wounds before autograft placement.** **TransCyte is unproven and not medically necessary for all other indications due to insufficient evidence of efficacy.** **Other Skin and Soft Tissue Substitutes** Refer to the policy for a list of skin and soft tissue substitutes that are unproven and not medically necessary for any indication due to insufficient evidence of efficacy. Refer to the Medical Policy titled Breast Reconstruction for information about coverage for skin and soft tissue substitutes used during postmastectomy breast reconstruction procedures. **Note**: Refer to the *Clinical Evidence* section of the policy for specific product information.
Spinal Fusion and Decompression	Sep. 1, 2026	**Coverage Rationale** • Revised language pertaining to medical necessity clinical coverage criteria: ○ Added reference to the InterQual® Client Defined, CP: Procedures, Decompression +/- Fusion, Lumbar (Custom) - UHG ○ Removed reference to the InterQual® CP: Procedures,	**Spinal procedures for the treatment of spine pain are proven and medically necessary in certain circumstances.** For medical necessity clinical coverage criteria, refer to the: • InterQual® CP: Procedures: ○ Decompression +/- Fusion, Cervical ○ Decompression +/- Fusion, Thoracic ○ Fusion, Cervical Spine ○ Fusion, Lumbar Spine ○ Fusion, Thoracic Spine ○ Scoliosis or Kyphosis Surgery ○ Scoliosis or Kyphosis Surgery (Pediatric)

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**

Spinal Fusion and Decompression (continued)	Sep. 1, 2026	Decompression +/- Fusion, Lumbar
		Medical Records Documentation Used for Reviews
		• Updated list of Medical Records Documentation Used for Reviews:
		  ○ Added "diagnostic image(s) report(s) by a radiologist including presence or absence of signs of infection"
		  ○ Removed:
		  ▪ Failure of conservative therapy through lack of clinically significant improvement between at least two measurements on a validated pain or function scale or quantifiable symptoms despite concurrent conservative therapies
		  ▪ Progressive deficits with clinically significant worsening based on at least two measurements over time
		  ▪ Disabling symptoms
		  ▪ Diagnostic image(s) report(s) by a radiologist including presence or absence of disc herniation; quantification of subluxation, translation by flexion, angulation when appropriate;
			• InterQual® Client Defined, CP: Procedures, Decompression +/- Fusion, Lumbar (Custom) - UHG
			
			Click here to view the InterQual® criteria.
			
			Dividing treatment of symptomatic, multisite spinal pathology via an anterior or posterior approach into serial or Staged Multiple Sessions when one session can address all sites is unproven and not medically necessary due to insufficient evidence of safety and efficacy.
			
			The following procedures for the treatment of spine pain are unproven and not medically necessary due to insufficient evidence of efficacy:
			• Dynamic Stabilization systems
			• Facet Joint Replacement
			• Isolated Facet Joint Fusion, with or without instrumentation
			• Vertebral joint implants that replace the disc and facet joints (e.g., MOTUS)

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Spinal Fusion and Decompression (continued)	Sep. 1, 2026	discitis; and epidural abscess ▪ Physical exam, including neurologic exam and quantification of relevant muscle strength ▪ For revision surgery include documentation of clinical complications, relevant laboratory findings, relevant imaging, and prior treatments for complications tried, failed, or contraindicated. Include the dates and reason for discontinuation ○ Replaced: ▪ "Surgical history, including dates and outcomes" with "*relevant* surgical history, including dates and outcomes" ▪ "Diagnostic image(s) report(s) by a radiologist including presence or absence of segment(s) instability and spinal cord compression" with "diagnostic image(s) report(s) by a radiologist including presence or absence of segment(s) instability *using a validated scale (e.g., Meyerding Classification) and Radiographic*	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Spinal Fusion and Decompression (continued)	Sep. 1, 2026	*Dynamic Instability* and spinal cord compression *including levels*" ▪ "*Complete* report(s) of diagnostic tests *including results of* biopsy(ies) *and results of bone aspirate*" with "reports of *all relevant recent* diagnostic tests (*e.g.,* biopsy, *culture*)" ▪ "Describe the surgical technique(s) planned" with "describe the surgical technique(s) planned *and in the case of revision, provide rationale*" **Definitions** • Added definition of: ○ Anticipated Instability Due to Procedure ○ Instability ○ Lumbar Spinal Decompression With Interbody Lumbar Spinal Fusion ○ Meyerding Classification System of Spondylolisthesis ○ Radiographic Dynamic Instability ○ Unstable Grade I Degenerative Spondylolisthesis **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Spinal Fusion and Decompression (continued)	Sep. 1, 2026	most current information	

Surgery of the Elbow	Aug. 1, 2026	**Coverage Rationale**
		• Revised language pertaining to medical necessity clinical coverage criteria; removed reference to the InterQual® CP: Procedures:
		  ○ Arthroscopy, Diagnostic, +/- Synovial Biopsy, Elbow
		  ○ Removal or Revision, Arthroplasty, Elbow
		Applicable Codes
		• Removed CPT codes 24370, 24371, and 29830
			Surgery of the elbow is proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures:
			• Arthroscopy, Surgical, Elbow
			• Joint Replacement, Elbow
			
			Click here to view the InterQual® criteria.

Surgery of the Wrist or Thumb	Aug. 1, 2026	**Title Change** • Previously titled *Surgery of the Hand or Wrist* **Related Policies** • Added reference link to the Medical Policy titled *Outpatient Surgical Procedures – Site of Service* **Coverage Rationale** • Replaced language indicating "surgery of the *hand or* wrist is proven and medically necessary in certain circumstances" with "surgery of the wrist *or thumb* is proven and medically necessary in certain circumstances" • Revised language pertaining to medical necessity clinical coverage criteria; removed	**Surgery of the wrist or thumb is proven and medically necessary in certain circumstances.** For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures: • Arthroplasty, Carpometacarpal (CMC) Joint, Thumb • Arthroscopy or Arthroscopically Assisted Surgery, Wrist • Joint Replacement, Wrist Click here to view the InterQual® criteria.

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Surgery of the Wrist or Thumb (continued)	Aug. 1, 2026	reference to the InterQual® CP: Procedures: ○ Arthroplasty, Metacarpophalangeal (MCP) Joint, Digits ○ Arthroplasty, Proximal Interphalangeal (PIP) Joint, Fingers ○ Arthroscopy, Diagnostic, +/- Synovial Biopsy, Wrist ○ Removal or Revision, Arthroplasty, Wrist **Medical Records Documentation Used for Reviews** • Updated list of Medical Records Documentation Used for Reviews; replaced "prior therapies/treatments tried, failed, or contraindicated; include the dates and reason for discontinuation" with "prior therapies/treatments tried, failed, or contraindicated; include the dates, *duration*, and reason for discontinuation" **Applicable Codes** • Removed CPT codes 25449, 26530, 26531, 26535, 26536, and 29840 **Supporting Information** • Updated *FDA* section to reflect the most current information	

Medical Benefit Drug Policy Updates

Updated		
Policy Title	**Effective Date**	**Summary of Changes**

Adzynma (ADAMTS13, Recombinant-Krhn)	Jul. 1, 2026	**Template Update**
		• Transferred content to shared policy template that applies to both UnitedHealthcare Commercial and Individual Exchange benefit plans
		• Added *Application* section to indicate this policy applies to:
		  ○ UnitedHealthcare Commercial benefit plans
		  ○ Individual Exchange benefit plans

Itvisma® (Onasemnogene Abeparvovec-Brve)	Jul. 1, 2026	**Coverage Rationale** • Removed reference link to the Medical Benefit Drug Policy titled *Review at Launch for New to Market Medications* **Applicable Codes** • Updated list of applicable HCPCS codes to reflect quarterly edits; replaced C9309 with J3405

Saphnelo® (Anifrolumab-Fnia)	Jul. 1, 2026	**Template Update**
		• Transferred content to shared policy template that applies to both UnitedHealthcare Commercial and Individual Exchange benefit plans
		• Added *Application* section to indicate this policy applies to:
		  ○ UnitedHealthcare Commercial benefit plans
		  ○ Individual Exchange benefit plans
		Coverage Rationale
		• Added language to indicate:
		  ○ This policy refers to Saphnelo (anifrolumab-fnia) injection for intravenous infusion
		  ○ Saphnelo Pen (anifrolumab-fnia) for self-administered subcutaneous injection is obtained under the pharmacy benefit, unless otherwise specified in the member's benefit plan documents; exception: for members enrolled in UnitedHealthcare of California plans with a delegated provider group conducting the prior authorization review, the self-administered Saphnelo Pen (anifrolumab-fnia) may be obtained under the medical benefit
		Supporting Information
		• Updated *CMS* and *References* sections to reflect the most current information

Scenesse® (Afamelanotide)	Jul. 1, 2026	**Template Update**
		• Transferred content to shared policy template that applies to both UnitedHealthcare Commercial and Individual Exchange benefit plans
		• Added *Application* section to indicate this policy applies to:
		  ○ UnitedHealthcare Commercial benefit plans
		  ○ Individual Exchange benefit plans

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale

Clotting Factors, Coagulant Blood Products, & Other Hemostatics	Sep. 1, 2026	**Coverage Rationale**
		• Revised list of applicable drug products for:
		  ○ **Factor VIII (recombinant)**; removed Kogenate® FS [antihemophilic factor (recombinant)]
		  ○ **Fibrinogen Concentrate (plasma-derived)**; added Fesilty™ (fibrinogen, human-chmt)
		Hemophilia A
		• Removed language indicating Kogenate FS is proven when [the listed] criteria are met
		• Revised medical necessity criteria for **Antihemophilic Factor (recombinant) (Xyntha)**; removed Kogenate® FS from the lists of recombinant factor products the patient must have a history of hypersensitivity or failure to meet clinical goals
		Fibrinogen Deficiency
		• Added language to indicate Fibrinogen Concentrate (plasma-derived) (Fesilty) is proven when both of the following criteria are met:
		  ○ Diagnosis of congenital fibrinogen deficiency, including afibrinogenemia and hypofibrinogenemia
		  ○ Treatment of bleeding episodes
			Refer to the policy for complete details.

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Clotting Factors, Coagulant Blood Products, & Other Hemostatics (continued)	Sep. 1, 2026	**Applicable Codes** • Added HCPCS code J7176 **Supporting Information** • Updated *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	

Intracanalicular and Intravitreal Corticosteroid Implants	Aug. 1, 2026	**Template Update**
		• Transferred content to shared policy template that applies to both UnitedHealthcare Commercial and Individual Exchange benefit plans
		• Added *Application* section to indicate this policy applies to:
		  ○ UnitedHealthcare Commercial benefit plans
		  ○ Individual Exchange benefit plans
		Coverage Rationale
		• Revised list of applicable intracanalicular and intravitreal corticosteroid implant products; removed Yutiq® (fluocinolone acetonide intravitreal implant)
		• Removed language indicating Yutiq is proven when all of the following criteria are met:
		  ○ Diagnosis of chronic non-infectious uveitis affecting the posterior segment of the eye
		  ○ Dose does not exceed one implant per eye
		  ○ Authorization is for no more than 60 days
			This policy provides information about the use of certain specialty pharmacy medications administered by the intracanalicular and intravitreal route for certain ophthalmologic conditions.
			
			This policy refers to the following intracanalicular and intravitreal corticosteroid implant products:
			• Dextenza® (dexamethasone ophthalmic insert)
			• Iluvien® (fluocinolone acetonide intravitreal implant)
			• Ozurdex® (dexamethasone intravitreal implant)
			• Retisert® (fluocinolone acetonide intravitreal implant)
			
			Dextenza is proven when all of the following criteria are met:
			• **One** of the following diagnoses:
			  ○ Ocular inflammation and pain following ophthalmic surgery; **or**
			  ○ Ocular itching associated with allergic conjunctivitis
			and
			• Prescribed by or in consultation with an ophthalmologist; **and**
			• Dose does not exceed one insert per eye; **and**
			• Authorization is for no more than 60 days
			
			Iluvien is proven when all of the following criteria are met:
			• **One** of the following:
			  ○ Chronic non-infectious uveitis affecting the posterior segment of the eye; **or**
			  ○ **Both** of the following:
			  ▪ Diagnosis of diabetic macular edema (DME); **and**
			  ▪ **Both** of the following:
			  – Member has been previously treated with a course of corticosteroids; **and**

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Intracanalicular and Intravitreal Corticosteroid Implants (continued)	Aug. 1, 2026	**Applicable Codes** • Removed HCPCS code J7314 **Supporting Information** • Updated *Background*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	– Member did not have a clinically significant rise in intraocular pressure **and** • Dose does not exceed one implant per eye; **and** • Authorization is for no more than 60 days **Ozurdex is proven when all of the following criteria are met:** • Diagnosis of **one** of the following: ○ Macular edema following branch retinal vein occlusion (BRVO); **or** ○ Macular edema following central retinal vein occlusion (CRVO); **or** ○ Non-infectious uveitis affecting the posterior segment of the eye; **or** ○ Diabetic macular edema (DME) **and** • Dose does not exceed one implant per eye; **and** • Authorization is for no more than 60 days **Retisert is proven when all of the following criteria are met:** • Diagnosis of chronic non-infectious uveitis affecting the posterior segment of the eye; **and** • Dose does not exceed one implant per eye; **and** • Authorization is for no more than 60 days **Intracanalicular and intravitreal corticosteroid implant products are unproven and not medically necessary for the treatment any other indication due to insufficient evidence of efficacy including, but not limited to the following:** • Cystoid macular edema after cataract surgery • Radiation retinopathy
Kebilidi® (Eladocagene Exuparvovec-Tneq)	Aug. 1, 2026	**Template Update** • Transferred content to shared policy template that applies to both UnitedHealthcare Commercial and Individual Exchange benefit plans • Added *Application* section to indicate this policy applies to: ○ UnitedHealthcare	**Kebilidi is proven and medically necessary for the treatment of aromatic L-amino acid decarboxylase (AADC) deficiency in patients who meet all of the following criteria:** • Submission of medical records documenting **all** of the following: ○ Genetically confirmed AADC deficiency due to biallelic mutations in the dopa decarboxylase (*DDC*) gene; **and** ○ Patient has one or more of the following typical clinical characteristics associated with AADC deficiency (e.g., hypotonia, oculogyric crises, dystonia, hypokinesia, autonomic dysfunction,

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Kebilidi® (Eladocagene Exuparvovec-Tneq) (continued)	Aug. 1, 2026	○ Commercial benefit plans ○ Individual Exchange benefit plans **Coverage Rationale** • Revised coverage criteria; replaced criterion requiring "the patient is unable to ambulate independently" with "the patient is unable to ambulate independently *with or without an assistive device such as cane or walker*"	developmental delay); **and** ○ Decreased AADC enzyme activity in plasma per current laboratory standards **and** • Patient has achieved skull maturity, as confirmed by neuroimaging, necessary for stereotactic neurosurgical administration of Kebilidi; **and** • Patient has persistent symptoms of AADC deficiency (e.g., hypotonia, oculogyric crises, dystonia, hypokinesia, autonomic dysfunction, developmental delay) despite use of standard medical therapy (e.g., dopamine agonists, monoamine oxidase inhibitors, pyridoxine, other forms of vitamin B6); **and** • Patient is unable to ambulate independently with or without an assistive device such as cane or walker; **and** • Patient does not have an anti-adeno-associated virus, serotype 2 (anti-AAV2) antibody titer higher than 1:1200 or > 1 optical density value by enzyme-linked immunosorbent assay (ELISA); **and** • Prescribed by a neurologist or neurosurgeon; **and** • Patient has not previously received treatment with Kebilidi or other gene therapy for the treatment of AADC deficiency in their lifetime; **and** • Dosing is in accordance with the United States Food and Drug Administration approved labeling; **and** • Authorization will be issued for no more than one treatment per lifetime and for no longer than 60 days from approval
Tzield® (Teplizumab-Mzwv)	Aug. 1, 2026	**Coverage Rationale** • Revised coverage criteria; replaced criterion requiring "the patient is ***8*** years of age or older" with "the patient is ***1*** year of age or older" **Supporting Information** • Updated *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	**Tzield, administered as a one-time 14-day course of therapy, is proven to delay the onset of stage 3 type 1 diabetes in pediatric and adult patients that meet the following criteria:** • Patient is 1 year of age or older; **and** • Diagnosis of stage 2 type 1 diabetes confirmed by **all** of following: ○ At least two positive pancreatic islet autoantibodies ○ Dysglycemia without overt hyperglycemia using an oral glucose tolerance test (OGTT) ○ Clinical history of patient does not suggest type 2 diabetes **and** • Dosing is in accordance with the United States Food and Drug Administration approved labeling; **and** • Patient has not been previously treated with Tzield; **and** • Authorization will be issued for no more than 14 doses

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Tzield® (Teplizumab-Mzwv) (continued)	Aug. 1, 2026		**Tzield is medically necessary when all of the following criteria are met:** • Patient is 1 year of age or older; **and** • Diagnosis of stage 2 type 1 diabetes confirmed by **all** of the following: ○ Presence of at least **two** of the following pancreatic islet autoantibodies: ▪ Glutamic acid decarboxylase 65 (GAD) autoantibodies ▪ Insulin autoantibody (IAA) ▪ Insulinoma-associated antigen 2 autoantibody (IA-2A) ▪ Zinc transporter 8 autoantibody (ZnT8A) ▪ Islet cell autoantibody (ICA) **and** ○ Presence of dysglycemia without overt hyperglycemia defined by **one** of the following: ▪ Fasting plasma glucose ≥ 100 mg/dL and < 126 mg/dL; **or** ▪ 2-hour post-prandial plasma glucose level ≥ 140 mg/dL and < 200 mg/dL; **or** ▪ A1C ≥ 5.7 and < 6.5% or ≥ 10% increase in A1C **and** ○ Patient does not have symptoms associated with stage 3 type 1 diabetes (e.g., increased urination, excessive thirst, weight loss); **and** ○ Diagnosis of type 2 diabetes has been ruled out **and** • Prescribed by or in consultation with an endocrinologist; **and** • Dosing is in accordance with the United States Food and Drug Administration approved labeling; **and** • Patient has not been previously treated with Tzield; **and** • Authorization will be issued for no more than one treatment course (i.e., 14 doses) per lifetime

Retired

Policy Title	Effective Date	Summary of Changes
Synagis® (Palivizumab)	Jul. 1, 2026	• Retired policy; product discontinued by manufacturer

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 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 Medical Policies and Medical Benefit Drug Policies is available at **UHCprovider.com/policies** > For Commercial Plans > Medical & Drug Policies.