United Healthcare Oxford

UnitedHealthcare Oxford
Medical Policy Update Bulletin: December 2025

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Take Note

Reminder: Oxford Health Plans to Use UnitedHealthcare Commercial Medical Policies

Effective **Jan. 1, 2026**, Oxford Health Plans will utilize the UnitedHealthcare Commercial Medical Policies and corresponding Medical Policy Update Bulletins at UHCprovider.com/policies > For Commercial Plans > Medical & Drug Policies; we will no longer maintain an Oxford-specific Clinical Policy library. Unless otherwise announced, there will be no change to policy guidelines as a result of this consolidation.

The Oxford Administrative Policies and corresponding update bulletins will continue to be available for your reference at UHCprovider.com/policies > For Commercial Plans > Oxford Administrative Policies.

Annual CPT/HCPCS Code Updates

Beginning **Jan. 1, 2026**, all applicable Medical and Administrative Policies will be updated to reflect the 2026 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

Complete details on impacted policies and corresponding code edits will be provided in the January 2026 edition of the Medical Policy Update Bulletin and Oxford Administrative Policy Update Bulletin.

Clinical Policy Updates

New

Policy Title	Effective Date	Coverage Rationale
Remote Physiologic Monitoring (RPM)	Jan. 1, 2026	**Remote Physiologic Monitoring (RPM) is proven and medically necessary when the individual has one or more of the following conditions:** • Heart failure (HF) • Hypertensive disorders of pregnancy (HDP) **Remote Physiologic Monitoring (RPM) is unproven and not medically necessary due to insufficient evidence of efficacy for all other indications not listed as proven, including but not limited to:** • Anxiety • Bipolar disorder • Chronic obstructive pulmonary disease (COPD) • Depression • Diabetes mellitus (DM) • Gestational diabetes • Hypertension (HTN) other than hypertensive disorders of pregnancy (HDP) • Obstructive sleep apnea (OSA) • Schizoaffective disorder **Notes**: • For information on cardiac remote devices used for diagnostic and/or screening purposes, refer to the Medical Policy titled Implantable Loop Recorders and Wearable Heart Rhythm Monitors. • For information on continuous glucose monitoring devices, refer to the Medical Policy titled Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes.

Updated

Policy Title	Effective Date	Summary of Changes
Apheresis	Dec. 1, 2025	**Coverage Rationale** • Replaced language indicating “therapeutic apheresis including plasma exchange (plasmapheresis) or photopheresis is unproven and not medically necessary for treating or managing *the [listed]* conditions/diagnoses” with “therapeutic apheresis including plasma exchange (plasmapheresis) or photopheresis is unproven and not medically necessary for treating or managing *any other* conditions/diagnoses *[not listed in the policy as proven and medically necessary]*” **Supporting Information** • Updated *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information
Catheter Ablation for Atrial Fibrillation	Jan. 1, 2026	**Template Update** • Created shared policy version to support application to Oxford plan membership

Clinical Policy Updates

Updated		
Policy Title	**Effective Date**	**Summary of Changes**
Catheter Ablation for Atrial Fibrillation (continued)	Jan. 1, 2026	**Related Policies** • Added reference link to the Medicare Advantage Medical Policy titled *Cardiovascular Diagnostic and Therapeutic Procedures* **Coverage Rationale** • Replaced reference to "InterQual® CP: Procedures, Electrophysiology (EP) Testing +/- *Radiofrequency Ablation (RFA) or Cryothermal* Ablation, Cardiac" with "InterQual® CP: Procedures, Electrophysiology (EP) Testing +/- *Catheter* Ablation, Cardiac" **Medical Records Documentation Used for Reviews** • Updated list of Medical Records Documentation Used for Reviews; replaced: ○ "Diagnosis" with "diagnosis *as documented by electrocardiogram (ECG), Holter, or rhythm strip*" ○ "Recent physical exam" with "recent physical exam *within the last 3 months*" ○ "Signs and symptoms including date of onset, duration, and frequency" with "signs and symptoms including date of onset, duration, frequency, and *whether the arrhythmia is symptomatic, paroxysmal, and/or persistent*" ○ "Reports of all recent imaging studies and applicable diagnostics" with "reports of all recent imaging studies and applicable diagnostics, *including electrolytes within the last 6 months; thyroid stimulating hormone (TSH) within the last 12 months, assessment for myocardial ischemia, e.g., stress test, within the last 12 months, and/or left ventricular ejection fraction by echocardiography or multigated acquisition (MUGA)*" **Applicable Codes** • Revised description for CPT code 93656
Interspinous Fusion and Decompression Devices	Dec. 1, 2025	**Medical Records Documentation Used for Reviews** • Updated list of Medical Records Documentation Used for Reviews: ○ Added "physician treatment plan, including device type and level" ○ Removed "describe the surgical technique(s) planned, including name of interspinous bony fusion device requested and use of an interbody cage" **Definitions** • Updated definition of: ○ Arthrodesis ○ Interlaminar Lumbar Instrumented Fusion (ILIF) ○ Interlaminar Stabilization Device ○ Neurogenic Claudication **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information
Liposuction for Lipedema	Dec. 1, 2025	**Medical Records Documentation Used for Reviews** • Updated list of Medical Records Documentation Used for Reviews; replaced "upon request we may require high-quality color photographs" with "upon request we may require high-quality color photographs *that include the transition points*"

Clinical Policy Updates

Updated		
Policy Title	**Effective Date**	**Summary of Changes**
Liposuction for Lipedema (continued)	Dec. 1, 2025	**Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information
Neurophysiologic Testing and Monitoring	Jan. 1, 2026	**Template Update** • Created shared policy version to support application to Oxford plan membership **Applicable Codes** • Removed CPT/HCPCs codes 95999 and A9279 **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information
Pharmacogenetic Panel Testing	Dec. 1, 2025	**Definitions** • Updated definition of "Multi-Gene Panel" **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information

Surgery of the Hip	Jan. 1, 2026	**Template Update**
		• Created shared policy version to support application to Oxford plan membership
		Applicable Codes
		• Added notation to indicate:
		  ○ Iliopsoas tendon release surgery, capsular repair, and capsular release surgery are considered integral to the primary hip procedure and not separately reimbursable
		  ○ Debridement during hip arthroscopy is considered integral to the FAI surgery (CPT codes 29914, 29915, and 29916) and would therefore not be separately reimbursable
		Supporting Information
		• Updated *Clinical Evidence* and *References* sections to reflect the most current information

Vagus and External Trigeminal Nerve Stimulation	Dec. 1, 2025	**Medical Records Documentation Used for Reviews** • Updated list of Medical Records Documentation Used for Reviews; removed "quality of life assessment with quantifiable measures of date-to-life besides the occurrence of seizures" **Definitions** • Updated definition of "Shared Decision Making" **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**

Electrical and Ultrasonic Bone Growth Stimulators	Feb. 1, 2026	**Title Change**
		• Previously titled *Electrical and Ultrasound Bone Growth Stimulators*
		Related Policies
		• Removed reference link to the Medicare Advantage Medical Policy titled *Electrical Stimulators*
		Coverage Rationale
		Electrical Bone Growth Stimulators
		• Added language to clarify the use of an Invasive or Non-Invasive Electrical Bone Growth Stimulator is unproven and not medically necessary for the treatment of all other indications [not listed in the policy as proven and medically necessary] *(including stress fractures)*
		Ultrasonic Bone Growth Stimulators
		• Revised coverage criteria for Ultrasonic Bone Growth Stimulators; replaced criterion requiring "less than 6 months have passed since the date of most recent surgical *operation*" with "less than 6 months have passed since the date of most recent surgical *procedure*"
		• Added language to clarify the use of Ultrasonic Bone Growth Stimulators is unproven and not medically necessary for the treatment of all other indications
			Electrical Bone Growth Stimulators
			The use of an Invasive or Non-Invasive spinal Electrical Bone Growth Stimulator is proven and medically necessary as an adjunct to lumbar spinal fusion surgery when the following two criteria are met:
			• Radiographic evidence of skeletal maturity; and
			• Increased risk for fusion failure demonstrated by any of the following:
			  ○ Previously failed fusion at the same site, when minimum of six months has elapsed since the last surgical procedure
			  ○ Spinal fusion performed or to be performed at more than one level as part of a single surgery
			  ○ Comorbid conditions associated with compromised bone healing (e.g., diabetes, obesity, osteoporosis, current tobacco use)
			  ○ Spondylolisthesis grade II or greater
			The use of an Invasive or Non-Invasive Electrical Bone Growth Stimulator is unproven and not medically necessary for the treatment of all other indications (including stress fractures) due to insufficient evidence of efficacy and/or safety.
			Ultrasonic Bone Growth Stimulators
			The use of Ultrasonic Bone Growth Stimulators is proven and medically necessary for the treatment of Nonunion of long bone fractures when all of the following criteria are met:
			• Fracture gap is less than or equal to 1 cm
			• Radiographic evidence of a persistent fracture line without bridging callus is present for 3 months or more
			• Fracture reduced and immobilized
			• Less than 6 months have passed since the date of most recent surgical procedure
			• Fracture that is not pathological or associated with malignancy
			• Radiographic evidence of skeletal maturity
			The use of Ultrasonic Bone Growth Stimulators is unproven and not medically necessary for the treatment of all other indications (including stress fractures) due to insufficient evidence of efficacy and/or safety.

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Electrical and Ultrasonic Bone Growth Stimulators (continued)	Feb. 1, 2026	[not listed in the policy as proven and medically necessary] *(including stress fractures)* **Medical Records Documentation Used for Reviews** • Updated list of Medical Records Documentation Used for Reviews: ***Electrical Bone Growth Stimulators*** ○ Added: ▪ Condition requiring procedure ▪ Detailed relevant imaging report, including: – Evidence of skeletal maturity – Presence or absence of spondylolisthesis, if present include grade ▪ Physician's treatment plan ○ Removed: ▪ List of applicable procedure codes ▪ Current physician prescription or order ▪ Spondylolisthesis (including grade) ○ Replaced: ▪ "*Member with* comorbid conditions *such as diabetes, obesity, osteoporosis, or current tobacco use* that could compromise bone healing" with "comorbid	

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Electrical and Ultrasonic Bone Growth Stimulators (continued)	Feb. 1, 2026	conditions that could compromise bone healing" ▪ "*If the member has had or will be having a* spinal fusion, include t*he following*: date of surgery, *either past or future and number* of vertebral levels fused; *or documentation of failed spinal fusion and date of reoperation of same site*" with "*history of previous* spinal fusion surgery(ies); include date(s) of *previous* surgery and *site and* number of *previous* vertebral levels fused" ***Ultrasonic Bone Growth Stimulators*** ○ Added: ▪ Condition requiring treatment ▪ Relevant surgical history, including dates ▪ Physician's treatment plan ○ Removed: ▪ List of applicable procedure codes ▪ Current physician prescription or order ○ Replaced: ▪ "Diagnostic imaging reports" with "*relevant* diagnostic imaging	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Electrical and Ultrasonic Bone Growth Stimulators (continued)	Feb. 1, 2026	reports, *including size of fracture gap, if applicable, and evidence of skeletal maturity*" ▪ "Treatment of the fracture, *including treatment already completed* [date *of surgery(ies) if applicable*] and treatment *planned*" with "*previous* treatments of the fracture *tried, failed, or contraindicated*; include the dates, *duration of* treatment, *and reason for discontinuation*" **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect the most current information	
Enteral Nutrition (Oral and Tube Feeding)	Jan. 1, 2026	**Template Update** • Created shared policy version to support application to Oxford plan membership **Coverage Rationale** ***Enteral Nutrition by Tube Feeding*** • Replaced language indicating "enteral nutrition administered by tube feeding (e.g., nasogastric, gastrostomy, or jejunostomy tube) is medically necessary in certain circumstances" with "enteral nutrition *(standard or Specialized*	**Enteral Nutrition by Tube Feeding** **Enteral nutrition (standard or Specialized Nutrient Formula) administered by tube feeding (e.g., nasogastric, gastrostomy, or jejunostomy tube) is medically necessary in certain circumstances.** For medical necessity clinical coverage criteria, refer to the InterQual® CP: Durable Medical Equipment, Enteral and Parenteral Nutrition Therapy. Click here to view the InterQual® criteria. **Note**: When used for tube feeding, standard formula may be considered medically necessary because standard foods cannot be administered through a tube.

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Enteral Nutrition (Oral and Tube Feeding) (continued)	Jan. 1, 2026	*Nutrient Formula)* administered by tube feeding (e.g., nasogastric, gastrostomy, or jejunostomy tube) is medically necessary in certain circumstances" • Added notation to indicate standard formula may be considered medically necessary when used for tube feeding because standard foods cannot be administered through a tube	**Oral Nutrition** **Specialized Nutrient Formula administered orally, as a primary or supplementary source of nutrition, is considered medically necessary when all of the following criteria are met:** • A physician, advanced practitioner (NP, CNS, or PA), or registered dietician prescribes the therapy; and • The condition is chronic and is expected to last for an undetermined or prolonged period of time; and • Adequate nutrition is not possible by dietary adjustment; and • The formula used is a Medical Food that is specially formulated for a specific condition; and • The individual has one of the following conditions: ○ Inborn Errors of Metabolism such as phenylketonuria (PKU), maple syrup urine disease, homocystinuria, methylmalonic acidemia, propionic acidemia, isovaleric acidemia, and other disorders of leucine metabolism; glutaric aciduria type I and tyrosinemia types I and II; or urea cycle disorders; or ○ Chronic kidney disease (CKD) stages 2 to 5 (or on dialysis) for individuals ages less than 24 months; or ○ Crohn's disease; or ○ Severe malabsorption syndrome (such as cystic fibrosis, short bowel syndrome, or intestinal failure); or ○ Malnutrition or individual will become malnourished or suffer from severe disorders such as physical disability, Intellectual Disability, or death if the nutritional therapy is not instituted; or ○ Severe food allergies, including eosinophilic esophagitis, other forms of eosinophilic gastrointestinal diseases, food protein-induced allergic proctocolitis (FPIAP) and food protein-induced enterocolitis syndrome (FPIES) which, if left untreated, will cause life-threatening allergic reactions, malnourishment, or death (mild and moderate food allergies or food intolerance can usually be treated with formula that is readily available in food stores and pharmacies, or by careful food selection; formulas for the treatment of such conditions are not considered medically necessary); or ○ Gastroesophageal reflux with failure to thrive (in children) **Note**: Refer to the *Benefit Considerations* section of this policy for additional information on coverage limitations and exclusions.

Clinical Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
FDA Cleared or Approved Companion Diagnostic Testing	Jan. 1, 2026	**Template Update** • Created shared policy version to support application to Oxford plan membership **Related Policies** • Added reference link to the Medical Policy titled *Oncology Medication Clinical Coverage* **Coverage Rationale** • Revised language to indicate: ○ This policy applies to tests that have been granted approval as FDA cleared or approved Companion Diagnostic (CDx) tests ○ FoundationOne® CDx is proven and medically necessary when used to inform management of any of the following indication/drug pairings: ▪ Breast cancer – Herceptin® (trastuzumab) – Kadcyla® (ado-trastuzumab emtansine) – Perjeta® (pertuzumab) – Piqray® (alpelisib) – Truqap® (capivasertib) in combination with Faslodex® (fulvestrant) ▪ Cholangiocarcinoma – Pemazyre® (pemigatinib)	This policy applies to tests that have been granted approval as FDA cleared or approved Companion Diagnostic (CDx) tests. **FoundationOne®CDx is proven and medically necessary when used to inform management of any of the following indication/drug pairings:** • Breast cancer ○ Herceptin® (trastuzumab) ○ Kadcyla® (ado-trastuzumab emtansine) ○ Perjeta® (pertuzumab) ○ Piqray® (alpelisib) ○ Truqap® (capivasertib) in combination with Faslodex® (fulvestrant) • Cholangiocarcinoma ○ Pemazyre® (pemigatinib) • Colorectal cancer ○ Erbitux® (cetuximab) ○ Vectibix® (panitumumab) • Glioma (low-grade) ○ Ojmeda® (tovorafenib) • Melanoma ○ Mekinist® (trametinib) ○ Tafinlar® (dabrafenib) ○ Tecentriq® (atezolizumab) in combination with Cotellic® (cobimetinib) and Zelboraf® (vemurafenib) ○ Zelboraf® (vemurafenib) • Non-small cell lung cancer (NSCLC) ○ Alecensa® (alectinib) ○ Braftovi® (encorafenib) in combination with Mektovi® (binimetinib) ○ Gilotrif® (afatinib) ○ Iressa® (gefitinib) ○ Lazcluze® (lazertinib) in combination with Rybrevant® (amivantamab) ○ Tabrecta® (capmatinib) ○ Tafinlar® (dabrafenib) in combination with Mekinist® (trametinib) ○ Tagrisso® (osimertinib) ○ Tarceva® (erlotinib) ○ Vizimpro® (dacomitinib) ○ Xalkori® (crizotinib) ○ Zykadia® (ceritinib)

Clinical Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
FDA Cleared or Approved Companion Diagnostic Testing (continued)	Jan. 1, 2026	▪ Colorectal cancer – Erbitux® (cetuximab) – Vectibix® (panitumumab) ▪ Glioma (low-grade) – Ojmeda® (tovorafenib) ▪ Melanoma – Mekinist® (trametinib) – Tafinlar® (dabrafenib) – Tecentriq® (atezolizumab) in combination with Cotellic® (cobimetinib) and Zelboraf® (vemurafenib) – Zelboraf® (vemurafenib) ▪ Non-small cell lung cancer (NSCLC) – Alecensa® (alectinib) – Braftovi® (encorafenib) in combination with Mektovi® (binimetinib) – Gilotrif® (afatinib) – Iressa® (gefitinib) – Lazcluze® (lazertinib) in combination with Rybrevant® (amivantamab) – Tabrecta® (capmatinib) – Tafinlar® (dabrafenib) in combination with Mekinist® (trametinib)	• Ovarian cancer ○ Lynparza® (olaparib) • Prostate cancer (metastatic castration-resistant) ○ Akeega® (niraparib and abiraterone acetate) ○ Lynparza® (olaparib) • Solid tumors ○ Keytruda® (pembrolizumab) ○ Retevmo® (selpercatinib) ○ Rozlytrek® (entrectinib) ○ Vitrakvi® (larotrectinib) **FoundationOne® Liquid CDx is proven and medically necessary when used to inform management of any of the following indication/drug pairings:** • Breast cancer ○ Itovebi® in combination with Ibrance® (palbociclib) and Faslodex® (fulvestrant) ○ Piqray® (alpelisib) • Colorectal cancer (metastatic) ○ Braftovi® (encorafenib) in combination with Erbitux® (cetuximab) • Non-small cell lung cancer (NSCLC) ○ Alecensa® (alectinib) ○ Braftovi® (encorafenib) in combination with Mektovi® (binimetinib) ○ Iressa® (gefitinib) ○ Lazcluze® (lazertinib) in combination with Rybrevant® (amivantamab) ○ Tabrecta® (capmatinib) ○ Tagrisso® (osimertinib) ○ Tarceva® (erlotinib) ○ Tepmetko® (tepotinib) • Prostate cancer (metastatic castration-resistant) ○ Akeega® (niraparib and abiraterone acetate) ○ Lynparza® (olaparib) ○ Rubraca® (rucaparib) • Solid tumors ○ Rozlytrek® (entrectinib)

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
FDA Cleared or Approved Companion Diagnostic Testing (continued)	Jan. 1, 2026	– Tagrisso® (osimertinib) – Tarceva® (erlotinib) – Vizimpro® (dacomitinib) – Xalkori® (crizotinib) – Zykadia® (ceritinib) ▪ Ovarian cancer – Lynparza® (olaparib) ▪ Prostate cancer (metastatic castration-resistant) – Akeega® (niraparib and abiraterone acetate) – Lynparza® (olaparib) ▪ Solid tumors – Keytruda® (pembrolizumab) – Retevmo® (selpercatinib) – Rozlytrek® (entrectinib) – Vitrakvi® (larotrectinib) ○ FoundationOne® Liquid CDx is proven and medically necessary when used to inform management of any of the following indication/drug pairings: ▪ Breast cancer – Itovebi® in combination with Ibrance® (palbociclib) and Faslodex® (fulvestrant) – Piqray® (alpelisib)	**Guardant360® CDx is proven and medically necessary when used to inform management of any of the following indication/drug pairings:** • Breast cancer ○ Orserdu® (elacestrant) • Non-small cell lung cancer (NSCLC) ○ Enhertu® (fam-trastuzumab deruxtecan-nxki) ○ Lumakras® (sotorasib) ○ Rybrevant® (amivantamb) ○ Tagrisso® (osimertinib) **MI Cancer Seek™ is proven and medically necessary when used to inform management of any of the following indication/drug pairings:** • Breast cancer ○ Piqray® (alpelisib) • Colorectal cancer ○ Braftovi® (encorafenib) in combination with Erbitux® (cetuximab) ○ Vectibix® (panitumumab) • Melanoma ○ Braftovi® (encorafenib) in combination with Mektovi® (binimetinib) ○ Cotellic® (cobimetinib) in combination with Zelboraf® (vemurafenib) ○ Mekinist® (trametinib) ○ Tafinlar® (dabrafenib) ○ Zelboraf® (vemurafenib) • Non-small cell lung cancer (NSCLC) ○ Gilotrif® (afatinib) ○ Iressa® (gefitinib) ○ Lazcluze® (lazertinib) in combination with Rybrevant® (amivantamab) ○ Tagrisso® (osimertinib) ○ Tarceva® (erlotinib) ○ Vizimpro® (dacomitinib) • Solid tumors ○ Jemperli® (dostarlimab-gxly) ○ Keytruda® (pembrolizumab) **Oncomine™ Dx Express Test is proven and medically necessary when used to inform management of NSCLC with Zegfrovy® (sunvozertinib).**

Clinical Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
FDA Cleared or Approved Companion Diagnostic Testing (continued)	Jan. 1, 2026	▪ Colorectal cancer (metastatic) – Braftovi® (encorafenib) in combination with Erbitux® (cetuximab) ▪ Non-small cell lung cancer (NSCLC) – Alecensa® (alectinib) – Braftovi® (encorafenib) in combination with Mektovi® (binimetinib) – Iressa® (gefitinib) – Lazcluze® (lazertinib) in combination with Rybrevant® (amivantamab) – Tabrecta® (capmatinib) – Tagrisso® (osimertinib) – Tarceva® (erlotinib) – Tepmetko® (tepotinib) ▪ Prostate cancer (metastatic castration-resistant) – Akeega® (niraparib and abiraterone acetate) – Lynparza® (olaparib) – Rubraca® (rucaparib) ▪ Solid tumors – Rozlytrek® (entrectinib) ○ Guardant360® CDx is proven and medically necessary	**Oncomine™ Dx Target Test is proven and medically necessary when used to inform management of any of the following indication/drug pairings:** • Astrocytoma ○ Voranigo® (vorasidenib) • Cholangiocarcinoma ○ Tibsovo® (ivosidenib) • Non-small cell lung cancer (NSCLC) ○ Enhertu® (fam-trastuzumab deruxtecan-nxki) ○ Gavreto® (pralsetinib) ○ Hernexeos® (zongertinib) ○ Iressa® (gefitinib) ○ Retevmo® (selpercatinib) ○ Rybrevant® (amivantamb) ○ Tafinlar® (dabrafenib) ○ Xalkori® (crizotinib) • Oligodendroglioma ○ Voranigo® (vorasidenib) • Thyroid cancer, anaplastic ○ Tafinlar® (dabrafenib) in combination with Mekinist® (trametinib) • Thyroid cancer, medullary ○ Retevmo® (selpercatinib) **oncoReveal™ CDx is proven and medically necessary when used to inform management of any of the following indication/drug pairings:** • Colorectal cancer ○ Erbitux® (cetuximab) ○ Vectibix® (panitumumab) • Non-small cell lung cancer (NSCLC) ○ Gilotrif® (afatinib) ○ Iressa® (gefitinib) ○ Lazcluze® (lazertinib) in combination with Rybrevant® (amivantamab) ○ Tagrisso® (osimertinib) ○ Tarceva® (erlotinib) ○ Vizimpro® (dacomitinib)

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
FDA Cleared or Approved Companion Diagnostic Testing (continued)	Jan. 1, 2026	when used to inform management of any of the following indication/drug pairings: ▪ Breast cancer – Orserdu® (elacestrant) ▪ Non-small cell lung cancer (NSCLC) – Enhertu® (fam-trastuzumab deruxtecan-nxki) – Lumakras® (sotorasib) – Rybrevant® (amivantamb) – Tagrisso® (osimertinib) ○ MI Cancer Seek™ is proven and medically necessary when used to inform management of any of the following indication/drug pairings: ▪ Breast cancer – Piqray® (alpelisib) ▪ Colorectal cancer – Braftovi® (encorafenib) in combination with Erbitux® (cetuximab) – Vectibix® (panitumumab) ▪ Melanoma – Braftovi® (encorafenib) in combination with Mektovi® (binimetinib) – Cotellic® (cobimetinib) in combination with	**TruSight™ Oncology Comprehensive is proven and medically necessary when used to inform management of any of the following indication/drug pairings:** • Non-small cell lung cancer (NSCLC) ○ Retevmo® (selpercatinib) • Solid tumors ○ Vitrakvi® (larotrectinib) **xT CDx is proven and medically necessary when used to inform management of any of the following indication/drug pairings:** • Colorectal cancer ○ Erbitux® (cetuximab) ○ Vectibix® (panitumumab) **FDA cleared or approved CDx tests not listed above or used for indication/drug pairings not listed above are proven and medically necessary when both of the following criteria are met:** • The test results will be used to inform the use of a targeted oncology therapeutic product or group of products in an individual with the corresponding clinical indication; and • One of the following: ○ The test appears in the U.S. Food and Drug Administration (FDA)'s Cleared or Approved Companion Diagnostic Devices Table for use with the intended targeted therapeutic product and clinical indication; or ○ The test has an approval order designating it as an FDA cleared or approved CDx test for use with the intended targeted therapeutic product and clinical indication in the FDA Premarket Approval Database, but the approval does not yet appear in the U.S. Food and Drug Administration (FDA)'s Cleared or Approved Companion Diagnostic Devices Table **Subsequent use of an FDA cleared or approved CDx test on a new specimen for the purpose of assisting with therapy selection is considered proven and medically necessary when both of the following criteria are met:** • The criteria above for the CDx test are met; and

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
FDA Cleared or Approved Companion Diagnostic Testing (continued)	Jan. 1, 2026	Zelboraf® (vemurafenib) – Mekinist® (trametinib) – Tafinlar® (dabrafenib) – Zelboraf® (vemurafenib) ▪ Non-small cell lung cancer (NSCLC) – Gilotrif® (afatinib) – Iressa® (gefitinib) – Lazcluze® (lazertinib) in combination with Rybrevant® (amivantamab) – Tagrisso® (osimertinib) – Tarceva® (erlotinib) – Vizimpro® (dacomitinib) ▪ Solid tumors – Jemperli® (dostarlimab-gxly) – Keytruda® (pembrolizumab) ○ Oncomine™ Dx Express Test is proven and medically necessary when used to inform management of NSCLC with Zegfrovy® (sunvozertinib) ○ Oncomine™ Dx Target Test is proven and medically necessary when used to inform management of any of the following indication/drug pairings: ▪ Astrocytoma	• One of the following: ○ The individual is experiencing disease recurrence; or ○ The individual's cancer has progressed or did not respond to the most recent systemic therapy **Concurrent Testing using an FDA Cleared or Approved tissue-based CDx test and a Liquid Biopsy-based CDx test is considered proven and medically necessary for the following cancer types when the criteria above for the CDx test are met:** • Advanced or metastatic (stage IV) breast cancer • Advanced or metastatic (stage IV) NSCLC **Due to insufficient evidence of efficacy, all other uses of the above FDA cleared or approved CDx tests are unproven and not medically necessary.** **Note**: For molecular oncology tests that have not been cleared or approved by the FDA as CDx tests, refer to the Medical Policy titled Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions or Molecular Oncology Testing for Hematologic Cancer Diagnosis, Prognosis, and Treatment Decisions.

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
FDA Cleared or Approved Companion Diagnostic Testing (continued)	Jan. 1, 2026	– Voranigo® (vorasidenib) ▪ Cholangiocarcinoma – Tibsovo® (ivosidenib) ▪ Non-small cell lung cancer (NSCLC) – Enhertu® (fam-trastuzumab deruxtecan-nxki) – Gavreto® (pralsetinib) – Hernexeos® (zongertinib) – Iressa® (gefitinib) – Retevmo® (selpercatinib) – Rybrevant® (amivantamb) – Tafinlar® (dabrafenib) – Xalkori® (crizotinib) ▪ Oligodendroglioma – Voranigo® (vorasidenib) ▪ Thyroid cancer, anaplastic – Tafinlar® (dabrafenib) in combination with Mekinist® (trametinib) ▪ Thyroid cancer, medullary – Retevmo® (selpercatinib) ○ oncoReveal™ CDx is proven and medically necessary when used to inform management of any of the following indication/drug pairings: ▪ Colorectal cancer – Erbitux® (cetuximab)	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
FDA Cleared or Approved Companion Diagnostic Testing (continued)	Jan. 1, 2026	– Vectibix® (panitumumab) ▪ Non-small cell lung cancer (NSCLC) – Gilotrif® (afatinib) – Iressa® (gefitinib) – Lazcluze® (lazertinib) in combination with Rybrevant® (amivantamab) – Tagrisso® (osimertinib) – Tarceva® (erlotinib) – Vizimpro® (dacomitinib) ○ TruSight™ Oncology Comprehensive is proven and medically necessary when used to inform management of any of the following indication/drug pairings: ▪ Non-small cell lung cancer (NSCLC) – Retevmo® (selpercatinib) ▪ Solid tumors – Vitrakvi® (larotrectinib) ○ xT CDx is proven and medically necessary when used to inform management of any of the following indication/drug pairings: ▪ Colorectal cancer – Erbitux® (cetuximab) – Vectibix® (panitumumab) ○ FDA cleared or approved	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
FDA Cleared or Approved Companion Diagnostic Testing (continued)	Jan. 1, 2026	CDx tests not listed above or used for indication/drug pairings not listed above are proven and medically necessary when both of the following criteria are met: ▪ The test results will be used to inform the use of a targeted oncology therapeutic product or group of products in an individual with the corresponding clinical indication ▪ One of the following: – The test appears in the *U.S. Food and Drug Administration (FDA)'s Cleared or Approved Companion Diagnostic Devices Table* for use with the intended targeted therapeutic product and clinical indication – The test has an approval order designating it as an FDA cleared or approved CDx test for use with the intended targeted therapeutic product and clinical indication in the FDA Premarket Approval Database, but the approval does not yet	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
FDA Cleared or Approved Companion Diagnostic Testing (continued)	Jan. 1, 2026	appear in the *U.S. Food and Drug Administration (FDA)'s Cleared or Approved Companion Diagnostic Devices Table* ○ Subsequent use of an FDA cleared or approved CDx test on a new specimen for the purpose of assisting with therapy selection is considered proven and medically necessary when both of the following criteria are met: ▪ The criteria above for the CDx test are met ▪ One of the following: – The individual is experiencing disease recurrence; or – The individual's cancer has progressed or did not respond to the most recent systemic therapy ○ Concurrent Testing using an FDA Cleared or Approved tissue-based CDx test and a Liquid Biopsy-based CDx test is considered proven and medically necessary for the following cancer types when the criteria above for the CDx test are met:	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
FDA Cleared or Approved Companion Diagnostic Testing (continued)	Jan. 1, 2026	▪ Advanced or metastatic (stage IV) breast cancer ▪ Advanced or metastatic (stage IV) NSCLC ○ Due to insufficient evidence of efficacy, all other uses of the above FDA cleared or approved CDx tests are unproven and not medically necessary ○ For molecular oncology tests that have not been cleared or approved by the FDA as CDx tests, refer to the Medical Policy titled *Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions* or *Molecular Oncology Testing for Hematologic Cancer Diagnosis, Prognosis, and Treatment Decisions* **Medical Records Documentation Used for Reviews** • Updated list of Medical Records Documentation Used for Reviews: ○ Added “disease response to most recent systemic therapy and/or disease recurrence or progression, if applicable” ○ Removed “line of therapy being considered” ○ Replaced “results of prior companion diagnostic testing comprehensive genomic profiling, if applicable” with	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
FDA Cleared or Approved Companion Diagnostic Testing (continued)	Jan. 1, 2026	"results *and dates* of prior companion diagnostic testing *and/or* comprehensive genomic profiling, if applicable" **Definitions** • Added definition of "Concurrent Testing" • Removed definition of: ○ Comprehensive Genomic Profiling (CGP) ○ Next Generation Sequencing (NGS) • Updated definition of: ○ Advanced Cancer ○ Companion Diagnostic ○ Liquid Biopsy **Applicable Codes** • Added CPT codes 0211U and 0523U • Removed CPT codes 0179U, 81445, 81449, 81450, 81451, 81455, 81456, and 81599 **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	
Gastrointestinal Disorders Diagnostic Procedures	Feb. 1, 2026	**Title Change** • Previously titled *Gastrointestinal Motility Disorders, Diagnosis and Treatment* **Coverage Rationale** • Removed and relocated language pertaining to gastric electrical stimulation (GES) therapy; refer	**The following procedures are unproven and not medically necessary due to insufficient evidence of efficacy:** • Magnetic Resonance Imaging (MRI) Defecography for evaluating Constipation and Anorectal or pelvic floor disorders • Cutaneous, mucous, or serosal Electrogastrography, electroenterography, or body surface gastric mapping for diagnosing intestinal or gastric disorders including Gastroparesis • Esophageal Mucosal Integrity Testing by electrical impedance for the

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale

Gastrointestinal Disorders Diagnostic Procedures (continued)	Feb. 1, 2026	to the Medical Policy titled *Minimally Invasive Procedures for the Treatment of Upper Gastrointestinal Diseases*
		• Revised list of unproven and not medically necessary procedures:
		  ○ Added "functional lumen imaging probe (FLIP) technology for diagnosing Achalasia"
		  ○ Removed list of examples of:
		  ▪ Cutaneous, mucous, or serosal Electrogastrography, electroenterography, or body surface gastric mapping: Gastric Alimetry System, G-Tech Gut Tracker wireless patch system
		  ▪ Esophageal Mucosal Integrity Testing by electrical impedance: MiVu™ Mucosal Integrity Testing System
		Definitions
		• Added definition of:
		  ○ Achalasia
		  ○ Functional Lumen Imaging Probe (FLIP)
		Applicable Codes
		• Removed CPT codes 43647, 43648, 43881, 43882, 64590, and 64595
		Supporting Information
		• Updated *Description of Services*, *Clinical Evidence*, *FDA*, and
			diagnosis of gastroesophageal reflux disease (GERD), eosinophilic esophagitis (EoE), and nonacid reflux disease (non-GERD), or for the monitoring of treatment response in GERD and EoE
			• Functional Lumen Imaging Probe (FLIP) technology for diagnosing Achalasia

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Gastrointestinal Disorders Diagnostic Procedures (continued)	Feb. 1, 2026	*References* sections to reflect the most current information • Removed *Medical Records Documentation Used for Reviews* section	
Minimally Invasive Procedures for the Treatment of Upper Gastrointestinal Diseases	Feb. 1, 2026	**Title Change** • Previously titled *Minimally Invasive Procedures for Gastric and Esophageal Diseases* **Coverage Rationale** • Added language to indicate: ○ Gastric electrical stimulation (GES) therapy is proven and medically necessary for treating refractory Gastroparesis that has failed other therapies, or chronic intractable (drug-refractory) nausea and vomiting secondary to Gastroparesis of diabetic or idiopathic etiology; refer to the *U.S. Food and Drug Administration (FDA)* section for information regarding FDA labeling and Humanitarian Device Exemption (HDE) for GES (relocated from the Medical Policy titled *Gastrointestinal Disorders Diagnostic Procedures*) ○ Surgical pyloroplasty (open or laparoscopic) is proven and medically necessary for treating refractory Gastroparesis that has failed other therapies, or chronic-	**Gastric electrical stimulation (GES) therapy is proven and medically necessary for treating refractory Gastroparesis that has failed other therapies, or chronic intractable (drug-refractory) nausea and vomiting secondary to Gastroparesis of diabetic or idiopathic etiology.** Refer to the U.S. Food and Drug Administration (FDA) section of this policy for information regarding FDA labeling and Humanitarian Device Exemption (HDE) for GES. **Surgical pyloroplasty (open or laparoscopic) is proven and medically necessary for treating refractory Gastroparesis that has failed other therapies, or chronic-intractable (drug-refractory) nausea and vomiting secondary to Gastroparesis of diabetic or idiopathic etiology.** **The per oral endoscopic myotomy (POEM) procedure is proven and medically necessary for treating individuals with Achalasia or Diffuse Esophageal Spasm.** **Per oral endoscopic myotomy (POEM) is unproven and not medically necessary for all other indications (e.g., Zenker's diverticula) due to insufficient evidence of efficacy.** **Gastric per oral endoscopic myotomy (G-POEM) is unproven and not medically necessary for the treatment of Gastroparesis.** **The following are unproven and not medically necessary for treating Gastroesophageal Reflux Disease (GERD) due to insufficient evidence of efficacy:** • Endoscopic therapies • Injection or implantation techniques • LINX Reflux Management System

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Minimally Invasive Procedures for the Treatment of Upper Gastrointestinal Diseases (continued)	Feb. 1, 2026	intractable (drug-refractory) nausea and vomiting secondary to Gastroparesis of diabetic or idiopathic etiology • Removed language indicating functional lumen imaging probe technology is unproven and not medically necessary for diagnosing Achalasia **Medical Records Documentation Used for Reviews** • Added language to indicate: ○ Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service ○ Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested; refer to the guidelines titled Medical Records Documentation Used for Reviews **Definitions** • Updated definition of "Gastroparesis" **Applicable Codes** • Added CPT codes 43647, 43648, 43659, 43881, 43882, 64590, and	**Endoluminal therapy with GERDx™ is investigational, unproven, and not medically necessary for treating GERD as it has not received U.S. Food and Drug Administration (FDA) approval.** Refer to the Medical Policy titled Bariatric Surgery for information regarding endoscopic therapies for the treatment of obesity.

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Minimally Invasive Procedures for the Treatment of Upper Gastrointestinal Diseases (continued)	Feb. 1, 2026	64595 **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	
Outpatient Cardiology Procedures for EviCore Arrangement (for Oxford Only)	Jan. 1, 2026	**Title Change** • Previously titled *Cardiology Procedures for eviCore healthcare Arrangement* **Coverage Rationale** • Replaced references to "eviCore healthcare" with "EviCore" • Removed EviCore fax number • Replaced language indicating "Oxford has engaged eviCore healthcare to perform initial reviews of requests for prior authorization that may include a site of service review" with "Oxford has engaged EviCore *by Evernorth (EviCore)* to perform initial reviews of requests for prior authorization that may include a site of service review" • Removed language indicating: ○ Oxford has engaged eviCore healthcare to manage the accreditation process for our provider network; accreditations should be submitted directly to the eviCore healthcare website ○ To ensure prompt handling of the accreditation, ensure that all applicable facility and	Oxford has engaged EviCore, by Evernorth, to perform initial reviews of requests for prior authorization that may include a site of service review (Oxford continues to be responsible for decisions to limit or deny coverage and for appeals). Refer to the Medical Policy titled Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Scan – Site of Service. All prior authorization requests are handled by EviCore. To obtain prior authorization for a cardiology procedure, contact EviCore via one of the three options below: • Providers can call 1-877-PRE-AUTH (1-877-773-2884); or • Providers can log onto the Prior Authorization and Notification App EviCore has established correct coding and evidence-based criteria to determine the medical necessity and appropriate billing of cardiology services. These criterions have been carefully researched and are continually updated in order to be consistent with the most current evidence-based criteria. The cardiology evidence-based criteria and management criteria are available on the EviCore website using the Prior Authorization and Notification App. Treating Cardiology providers may be asked to submit a clinical submission form. The following information/documentation may be required: • Copies of office notes and treatment planning documents • Results of key diagnostic studies and/or office notes In conjunction with board certified cardiologists and radiologists, EviCore staff will evaluate the submitted treatment and billing plans. Providers will be informed, in writing, as to which services have been approved for payment. Where provided by state regulations, a board-certified cardiologist will be available to discuss the payment decision with the treating provider.

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Outpatient Cardiology Procedures for EviCore Arrangement (for Oxford Only) (continued)	Jan. 1, 2026	physician information is included ○ This policy assumes board certification by an American Board of Medical Specialties (ABMS) recognized in the provider specialty listed [in the policy] ***Payment by Specialty and Accreditation Requirements*** • Added language to indicate: ○ Oxford has engaged EviCore to manage the accreditation process for our provider network; accreditations should be submitted directly to the EviCore website ○ To ensure prompt handling of the accreditation, ensure that all applicable facility and physician information is included ○ This policy assumes board certification by an American Board of Medical Specialties (ABMS) recognized in the provider specialty listed [in the policy] • Removed language indicating radiologists and cardiologists who are currently participating in the Oxford network or wish to participate in the Oxford network and perform coronary CT angiography (CCTA) are required to complete the physician application from eviCore	**Payment by Specialty and Accreditation Requirements** Participating providers will be reimbursed for radiology and cardiology services rendered in the office or in an outpatient setting. The following is a list of requirements by cardiac service that are payable to participating providers based on their specialty as well as their accreditation status. Prior authorization is required. Oxford has engaged EviCore to manage the accreditation process for our provider network. Accreditations should be submitted directly to the EviCore website. To ensure prompt handling of the accreditation, ensure that all applicable facility and physician information is included. This policy assumes board certification by an American Board of Medical Specialties (ABMS) recognized in the provider specialty listed below. **Note**: Hospitals are currently excluded from the privileging and accreditation requirements below. **Payment by Specialty requirements for participating providers to perform cardiac services:** **Modality** / **Specialty** Nuclear Medicine, Cardiac CT Scan, Cardiac PET, and Cardiac MRI: • Radiologist • Radiology center/facility • Certified cardiologist • Cardiovascular disease specialists Diagnostic Cardiac Heart Catheterizations: • Cardiovascular disease • Cardiology group • Pediatric cardiology • Cardiology • Clinical cardiac electro physician • Cardiac electrophysiology **Accreditation requirements for participating providers to perform cardiac services:**

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Outpatient Cardiology Procedures for EviCore Arrangement (for Oxford Only) (continued)	Jan. 1, 2026	healthcare; documents can be sent to a provider upon request or obtained on the eviCore healthcare website using the *Prior Authorization and Notification App* • Replaced language indicating "the [policy lists] *services* that are payable to participating *physicians* based on their specialty as well as accreditation/*certification requirements that are required*" with "the [policy lists] *requirements by cardiac service* that are payable to participating *providers* based on their specialty as well as *their* accreditation *status*" • Revised list of modalities with payment by specialty requirements; replaced: ○ "MRI" with "Cardiac MRI" ○ "PET" with "Cardiac PET" **Applicable Codes** • Revised list of CPT codes that require prior authorization through EviCore; removed 93306, 93307, and 93308 **Supporting Information** • Updated *Description of Services* section to reflect the most current information	**Modality** / **Certification Required** Cardiac CT Scan, Cardiac PET, Cardiac MRI, and Nuclear Medicine: ACR (American College of Radiology); IAC (Intersocietal Accreditation Commission); RadSite; or The Joint Commission (TJC) **Payment Guidelines** • The notification/authorization number is valid for 45 calendar days. It is specific to the advanced outpatient imaging procedure requested, to be performed one time, for one date of service within the 45-day period. • Current Procedural Terminology (CPT) codes that are not subject to TC/PC component may be reimbursed to both the physician and facility when billed for the same date of service (DOS). • ECG, diagnostic studies, and injection procedures must be billed in conjunction with an authorized cardiac catheterization code in order to be reimbursed on the same date of service. When billed in conjunction with an authorized cardiac catheterization, no separate authorization will be required in addition to the catheterization code for these services.
Outpatient Radiology Procedures for EviCore Arrangement (for Oxford Only)	Jan. 1, 2026	**Title Change** • Previously titled *Radiology Procedures for eviCore healthcare Arrangement*	Oxford has engaged EviCore, by Evernorth, to perform initial reviews of requests for prior authorization and medical necessity reviews that may include a site of service review. (Oxford continues to be responsible for decisions to limit or deny coverage and for appeals). Refer to the Medical

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Outpatient Radiology Procedures for EviCore Arrangement (for Oxford Only)	Jan. 1, 2026	**Coverage Rationale** • Replaced references to "eviCore healthcare" with "EviCore" • Replaced language indicating "Oxford has engaged eviCore healthcare to perform initial reviews of requests for prior authorization that may include a site of service review" with "Oxford has engaged EviCore *by Evernorth (Evicore)* to perform initial reviews of requests for prior authorization that may include a site of service review" **Applicable Codes** • Revised list of CPT/HCPCS codes that require prior authorization through EviCore; removed 0623T, 0624T, 0625T, 0626T, 0648T, 0649T, 74712, 74713, 76801, 76802, 76805, 76810, 76811, 76812, 76813, 76814, 76815, 76816, 76817, 76818, 76819, 76820, 76821, 76825, 76826, 76827, 76828, 77022, 78012, 78013, 78014, 78015, 78016, 78018, 78020, 78070, 78071, 78072, 78075, 78099, 78102, 78103, 78104, 78185, 78195, 78199, 78201, 78202, 78215, 78216, 78226, 78227, 78230, 78231, 78232, 78258, 78261, 78262, 78264, 78265, 78266, 78278, 78282, 78290, 78291, 78299, 78300, 78305, 78306, 78315, 78399, 78414, 78428, 78445, 78456,	Policy titled Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Scan – Site of Service. All prior authorization requests are handled by EviCore. To prior authorize a radiology procedure, contact EviCore via one of the two options listed below: • Providers can call EviCore at 1-877-PRE-AUTH (1-877-773-2884); or • Providers can log onto the Prior Authorization and Notification App **Note**: It is Oxford's policy not to accept prior authorization requests from persons or entities other than referring physicians. The notification/authorization number is valid for 45 calendar days. It is specific to the advanced outpatient imaging procedure requested, to be performed one time, for one date of service within the 45-day period. EviCore has established an infrastructure to support the review, development, and implementation of comprehensive outpatient imaging criteria. The radiology evidence-based guidelines and management criteria are available on the EviCore web site using the Prior Authorization and Notification App. **Accreditation Requirements for Participating Providers** **Note**: Hospitals are currently excluded from the accreditation requirements listed below. All MRI, PET, CT, nuclear medicine, and ultrasound studies must be performed on an American College of Radiology (ACR), American Institute of Ultrasound in Medicine (AIUM), Intersocietal Accreditation Commission (IAC), RadSite, or The Joint Commission (TJC) accredited unit or at accredited facilities. Refer to the Administrative Policy titled Accreditation Requirements for Radiology Services. Oxford has engaged EviCore to manage the accreditation process for our provider network. Accreditations should be submitted directly to the EviCore website. To ensure prompt handling of the accreditation, ensure that all applicable facility and physician information is included.

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Outpatient Radiology Procedures for EviCore Arrangement (for Oxford Only) (continued)	Jan. 1, 2026	78457, 78458, 78580, 78582, 78597, 78598, 78599, 78600, 78601, 78605, 78606, 78610, 78630, 78635, 78645, 78650, 78660, 78699, 78700, 78701, 78707, 78708, 78709, 78725, 78730, 78740, 78761, 78799, 78800, 78801, 78802, 78803, 78804, 78831, 78832, 78999, C8900, C8901, C8902, C8903, C8905, C8906, C8908, C8909, C8910, C8911, C8912, C8913, C8914, C8918, C8919, C8920, C8931, C8932, C8933, C8934, C8935, C8936, S8042, and S8085 **Supporting Information** • Updated *Background* section to reflect the most current information	The Oxford Radiology Prior Notification/Authorization Crosswalk Table contains a list of CPT® codes that are interchangeable for prior authorization. If a provider obtains prior authorization for a procedure that corresponds with the Crosswalk Table, then the substitution is appropriate.
Preventive Care Services	Jan. 1, 2026	**Template Update** • Created shared policy version to support application to Oxford plan membership **Frequently Asked Questions (FAQ)** • Added Q&A #6 pertaining to listing required diagnosis codes on claims **Applicable Codes** ***Preventive Care Services*** Chlamydia Infection Screening ***and*** Gonorrhea Screening • Updated list of applicable CPT codes; added 87494 Syphilis Screening: Asymptomatic Pregnant Women • Revised service description: ○ Removed Sep. 2018 USPSTF "A" rating ○ Added May 2025 USPSTF "A" rating to indicate the USPSTF recommends early, universal screening for syphilis infection during pregnancy; if an individual is not screened early in pregnancy, the USPSTF recommends screening at the first available opportunity Wellness Examinations • Revised list of services with HRSA requirements for wellness examinations:	

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Policy Title	Effective Date	Summary of Changes / Coverage Rationale
Preventive Care Services (continued)	Jan. 1, 2026	○ Added "patient navigation services for breast and cervical cancer screening" ○ Replaced "screening and counseling for *interpersonal* domestic violence" with "screening and counseling for *intimate partner and* domestic violence" **Screening for Intimate Partner Violence** • Revised service description: ○ Removed Oct. 2018 USPSTF "B" rating ○ Added Jun. 2025 USPSTF "B" rating to indicate the USPSTF recommends that clinicians screen for intimate partner violence (IPV) in women of reproductive age, including those who are pregnant and postpartum ***Expanded Women's Preventive Health*** **Contraceptive Methods (Including Sterilizations): Code Group 6** • Updated list of applicable CPT codes; revised description for 58562 • Removed list of applicable ICD-10 diagnosis codes: Z30.432 and Z30.433 • Revised preventive benefit instructions to indicate the listed CPT code does not have diagnosis code requirements for preventive benefits to apply **Screening and Counseling for Intimate Partner and Domestic Violence** • Revised service description: ○ Removed Dec. 2016 HRSA requirement ○ Added Dec. 2024 HRSA requirement to indicate: ▪ The Women's Preventive Services Initiative recommends screening adolescent and adult women for intimate partner and domestic violence, at least annually, and, when needed, providing or referring to intervention services ▪ Intimate partner and domestic violence includes physical violence, sexual violence, stalking and psychological aggression (including coercion), reproductive coercion, neglect, and the threat of violence, abuse, or both ▪ Intervention services include, but are not limited to, counseling, education, harm reduction strategies, and appropriate supportive services **Breast Cancer Screening for Women at Average Risk** • Revised service description: ○ Removed Dec. 2016 HRSA requirement ○ Added Dec. 2024 HRSA requirement to indicate: ▪ The Women's Preventive Services Initiative recommends that women at average risk of breast cancer initiate mammography screening no earlier than age 40 years and no later than age 50 years; screening mammography should occur at least biennially and as frequently as annually ▪ Women may require additional imaging to complete the screening process or to address findings on the initial screening mammography; if additional imaging [e.g., magnetic resonance imaging (MRI),

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Preventive Care Services (continued)	Jan. 1, 2026	ultrasound, mammography] and pathology evaluation are indicated, these services also are recommended to complete the screening process for malignancies ▪ Screening should continue through at least age 74 years, and age alone should not be the basis for discontinuing screening ▪ Women at increased risk also should undergo periodic mammography screening; however, recommendations for additional services are beyond the scope of this recommendation • Removed instruction to refer to the *Screening Mammography* section of this policy for applicable codes and preventive benefit instructions • Added lists of applicable codes and preventive benefit instructions for: *Mammography Screening* ○ Added CPT codes 77063 and 77067 ○ Added revenue code 0403 ○ Added language to indicate: ▪ The listed CPT codes do not have diagnosis code requirements for the preventive benefit to apply ▪ There is no age limit for mammography screening *Mammography Diagnostic – To Complete the Screening Process* ○ Added CPT/HCPCS codes 77061, 77062, 77065, 77066, and G0279 ○ Added revenue code 0401 ○ Added language to indicate: ▪ The listed CPT/HCPCS codes require one of the listed *Average Risk Diagnosis Codes* ▪ There is no age limit for mammography diagnostics to complete the screening process *Breast Ultrasound – To Complete the Screening Process* ○ Added CPT codes 0857T, 76641, and 76642 ○ Added language to indicate: ▪ The listed CPT codes require one of the listed *Average Risk Diagnosis Codes* ▪ There is no age limit for breast ultrasound to complete the screening process *Breast MPI – To Complete the Screening Process* ○ Added CPT/HCPCS codes 77046, 77047, 77048, 77049, A9575, A9576, A9577, A9578, A9579, A9581, and A9585 ○ Added language to indicate: ▪ The listed CPT/HCPCS codes require one of the listed *Average Risk Diagnosis Codes* ▪ There is no age limit for breast MRI to complete the screening process *Pathology Evaluation – To Complete the Screening Process* ○ Added CPT/HCPCS codes 19081, 19082, 19083, 19084, 19085, 19086, 19100, 19101, 19281, 19282, 19283, 19284, 19285, 19286, 19287, 19288, 76942, 77002, 88172, 88173, 88177, 88305, 96374, 99152, 99153, 99156, 99157, and Q9967

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Preventive Care Services (continued)	Jan. 1, 2026	○ Added language to indicate: ▪ The listed CPT/HCPCS codes require one of the listed *Average Risk Diagnosis Codes* ▪ There is no age limit for breast pathology evaluation to complete the screening process *Average Risk Diagnosis Codes* ○ Added ICD-10 diagnosis codes for: ▪ **Cysts**: N60.01, N60.02, N60.09, N60.11, N60.12, N60.19, N60.41, N60.42, and N60.49 ▪ **Hypertrophy**: N62 ▪ **Mammographic calcification or inconclusive findings**: R92.0, R92.1, R92.2, R92.8 ▪ **Dense breast(s)**: R92.30, R92.311, R92.312, R92.313, R92.321, R92.322, R92.323, R92.331, R92.332, R92.333, R92.341, R92.342, and R92.343 ▪ **Screening**: Z12.31, Z12.39, Z13.71, and Z13.79 ▪ **Personal history, genetic susceptibility, or family history**: Z14.8, Z15.01, Z15.02, Z15.09, Z15.89, Z71.83, Z80.3, Z85.3, and Z86.000 ▪ **Prophylactic or acquired absence of breast/nipple**: Z40.01, Z90.10, Z90.11, Z90.12, and Z90.13 ○ Added language to indicate one of these average risk diagnosis codes are required for: ▪ Mammography diagnostic to complete the screening process ▪ Breast ultrasound to complete the screening process ▪ Breast MRI to complete the screening process ▪ Pathology evaluation to complete the screening process Patient Navigation Services for Breast and Cervical Cancer Screening • Added Dec. 2024 HRSA requirement to indicate: ○ The Women's Preventive Services Initiative recommends patient navigation services for breast and cervical cancer screening and follow-up, as relevant, to increase utilization of screening recommendations based on an assessment of the patient's needs for navigation services ○ Patient navigation services involve person-to-person (e.g., in-person, virtual, hybrid models) contact with the patient; components of patient navigation services should be individualized ○ Services include, but are not limited to, person-centered assessment and planning, health care access and health system navigation, referrals to appropriate support services (e.g., language translation, transportation, and social services), and patient education ○ Added instruction to refer to the *Wellness Examinations* section of the policy for applicable codes and preventive benefit instructions	
Sleep Studies	Jan. 1, 2026	**Template Update** • Created shared policy version to support application to Oxford plan membership **Coverage Rationale**	**Home Sleep Apnea Testing** **Home Sleep Apnea Testing (HSAT), using a portable monitor, is medically necessary for evaluating adults with suspected Obstructive Sleep Apnea (OSA).** Where HSAT is indicated, an autotitrating Positive Airway Pressure (APAP) device is an option to determine a fixed PAP pressure.

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Sleep Studies (continued)	Jan. 1, 2026	***Home Sleep Apnea Testing (HSAT)*** • Added notation to indicate performing a repeat HSAT is not recommended when an initial test is negative, inconclusive, or technically inadequate, due to the higher likelihood that a second test will also be negative, inconclusive, or technically inadequate; therefore, after a single negative, inconclusive, or technically inadequate HSAT result, performance of attended full-channel polysomnography is strongly recommended ***Attended Full-Channel Polysomnography, Performed in a Healthcare Facility or Laboratory Setting*** Suspected Obstructive Sleep Apnea (OSA) • Revised coverage criteria for attended full-channel Polysomnography for evaluating individuals with suspected OSA; replaced criterion requiring "results of previous HSAT are negative, indeterminate, or technically inadequate to make a diagnosis of OSA" with "results of previous *(within the past 12 months)* HSAT are negative, indeterminate, or technically inadequate to make a diagnosis of OSA"	**Note**: Performing a repeat HSAT is not recommended when an initial test is negative, inconclusive or technically inadequate, due to the higher likelihood that a second test will also be negative, inconclusive or technically inadequate. Therefore, after a single negative, inconclusive or technically inadequate HSAT result, performance of attended full-channel Polysomnography is strongly recommended (Kapur et al., 2017). **Attended Full-Channel Polysomnography, Performed in a Healthcare Facility or Laboratory Setting** ***Suspected Obstructive Sleep Apnea*** **Attended full-channel Polysomnography is medically necessary for evaluating individuals with suspected OSA when:** • Results of previous (within the past 12 months) HSAT are negative, indeterminate, or technically inadequate to make a diagnosis of OSA (Kapur et al., 2017; Centers for Medicare and Medicaid Services); or • Individual is a child or adolescent (i.e., less than 18 years of age); or • Individual is known to have one or more of the following comorbid medical conditions that prohibits the use of a HSAT: ○ Significant Chronic Pulmonary Disease as defined by a forced expiratory volume (FEV_1) % predicted of < 60 (Pellegrino et al., 2005) ○ Progressive neuromuscular disease/neurodegenerative disorder (examples include but are not limited to Parkinson's disease, myotonic dystrophy, amyotrophic lateral sclerosis, multiple sclerosis with associated pulmonary disease, and history of stroke with persistent neurological sequelae) ○ Moderate to severe heart failure [New York Heart Association class III or IV (NYHA, 1994) or left ventricular ejection fraction ≤ 40 (Yancy et al., 2013; Yancy et al., 2017)] ○ Body mass index (BMI) > 50 (DeMaria et al., 2007; Blackstone and Cortés, 2010) ○ Obesity Hypoventilation Syndrome ○ Documented ongoing epileptic seizures in the presence of symptoms of sleep disorder ○ Chronic opiate medication use (> 3 months) (Dowell et al., 2022)

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale

Sleep Studies (continued)	Jan. 1, 2026	***Daytime Sleep Studies***
		• Replaced language indicating "Multiple Sleep Latency Testing (MSLT) is medically necessary *when it is indicated by* suspected narcolepsy or idiopathic Hypersomnia and other cause of Excessive Sleepiness have been excluded by appropriate clinical assessment" with "Multiple Sleep Latency Testing (MSLT) is medically necessary *for evaluating* suspected Narcolepsy *when* other causes of Excessive Sleepiness have been excluded by appropriate clinical assessment"
		• Revised language pertaining to medical necessity clinical coverage criteria; removed reference to the InterQual® CP: Procedures, Sleep Studies for Maintenance of Wakefulness Testing (MWT)
		Attended Repeat Testing
		• Replaced language indicating "repeat attended full-channel polysomnography and repeat Positive Airway Pressure (PAP) titration are medically necessary for *certain* individuals who have persistent or new symptoms, despite documented appropriate current treatment or PAP therapy" with "repeat attended full-channel polysomnography and repeat Positive Airway Pressure (PAP)
			Also, refer to the Repeat Testing section below.
			Other Conditions
			Attended full-channel Polysomnography is medically necessary following an appropriate clinical assessment either because OSA has been excluded, OSA has been adequately treated, or documented symptoms suggest one of the following conditions:
			• Periodic Limb Movement Disorder (PLMD) (not leg movements associated with another disorder such as sleep disordered breathing)
			• Restless Legs Syndrome (RLS)/Willis-Ekbom Disease that has not responded to treatment
			• Parasomnia with documented disruptive, violent, or potentially injurious sleep behavior suspicious of Rapid Eye Movement Sleep Behavior Disorder (RBD)
			• Narcolepsy, once other causes of Excessive Sleepiness have been ruled out by appropriate clinical assessment (also refer to the Daytime Sleep Studies section below)
			• Central Sleep Apnea
			Implantable Hypoglossal Nerve Stimulator
			Attended full-channel Polysomnography is medically necessary to rule out Central Sleep Apnea prior to implantation and/or calibration of an implantable hypoglossal nerve stimulator when the device is indicated. Refer to the Medical Policy titled Obstructive and Central Sleep Apnea Treatment for implantable hypoglossal nerve stimulator indications.
			Other Studies
			The following studies are not medically necessary due to insufficient evidence of efficacy:
			• Attended full-channel Polysomnography for evaluating any of the following conditions:
			  ○ Circadian Rhythm Disorders
			  ○ Depression
			  ○ Insomnia
			• Actigraphy for any sleep disorders

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Sleep Studies (continued)	Jan. 1, 2026	titration are medically necessary for individuals who have persistent, *recurrent,* or new symptoms, despite documented appropriate current treatment or PAP therapy" • Added language to indicate repeat attended full-channel polysomnography and repeat PAP titration are medically necessary for individuals who have experienced a clinically significant weight loss or gain (≥10%) or changes in cardiovascular disease since the last study **Medical Records Documentation Used for Reviews** • Updated list of Medical Records Documentation Used for Reviews; added "for Attended Repeat Testing and/or appliance adjustment, in addition to the [listed documentation requirements], also include reason why repeat study should be performed" **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information	**Daytime Sleep Studies** **Note**: The following sleep studies may be performed during the night if necessary to match an individual's normal sleep pattern. **Multiple Sleep Latency Testing (MSLT) is medically necessary for evaluating suspected Narcolepsy or idiopathic Hypersomnia when other causes of Excessive Sleepiness have been excluded by appropriate clinical assessment.** For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures: • Sleep Studies • Sleep Studies (Pediatric) Click here to view the InterQual® criteria. **Maintenance of Wakefulness Testing (MWT) is medically necessary for evaluating the following:** • An adult who is unable to stay awake, resulting in a safety issue; or • Assessing response to treatment in adults with sleep disorders **MWT is unproven and not medically necessary in children and adolescents less than 18 years of age.** **Abbreviated daytime sleep studies (e.g., PAP-Nap) are not medically necessary due to insufficient evidence of efficacy.** **Attended PAP Titration** **When an individual meets the above criteria for an attended full-channel Polysomnography sleep study, the following are medically necessary:** • A split-night sleep study, performed in a healthcare facility or laboratory setting, for diagnosis and PAP titration; or

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Sleep Studies (continued)	Jan. 1, 2026		• A full night study for PAP titration, when a split-night sleep study is inadequate or not feasible and the individual has a confirmed diagnosis of OSA Also, refer to the Repeat Testing section below. **Attended Repeat Testing** **Repeat attended full-channel Polysomnography and repeat PAP titration are medically necessary in the following circumstances:** • Individuals who have persistent, recurrent or new symptoms, despite documented appropriate current treatment or PAP therapy (e.g., equipment failure, improper mask fit, pressure leaks, unsuccessful titration, inadequate pressure, and medical problems including nasal congestion have been addressed and appropriately managed); or • Individuals who have experienced a clinically significant weight loss or gain (≥ 10%) or changes in cardiovascular disease since the last study (Caples et al., 2021; Peppard et al., 2000). **Repeat Testing for Oral Appliance Adjustments** Repeat testing and repositioning/adjustments for oral sleep appliances can be done in the home unless the individual meets criteria for an attended sleep study.
Total Artificial Disc Replacement for the Spine	Feb. 1, 2026	**Coverage Rationale** • Revised language to indicate: ***Cervical*** ○ Cervical total artificial disc replacement (TADR) is proven and medically necessary when all of the following are present and InterQual® criteria are met: ▪ An FDA-approved prosthetic intervertebral disc is utilized ▪ Individual diagnosed with only one or two	**Cervical** **Cervical total artificial disc replacement (TADR) is proven and medically necessary when all of the following are present AND InterQual criteria are met:** • An FDA-approved prosthetic intervertebral disc is utilized • Individual diagnosed with only one or two Contiguous Levels of cervical degenerative disc disease (C3-C7) • Skeletally Mature individual with radiculopathy and/or myelopathy • The arthroplasty will be performed at all symptomatic Contiguous Levels (up to two levels between C3-C7) **Note**: For two-level contiguous cervical total artificial disc replacement, the device being utilized must be FDA-approved for two levels. When a cervical

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Total Artificial Disc Replacement for the Spine (continued)	Feb. 1, 2026	Contiguous Levels of cervical degenerative disc disease (C3-C7) ▪ Skeletally Mature individual with radiculopathy and/or myelopathy ▪ The arthroplasty will be performed at all symptomatic Contiguous Levels (up to two levels between C3-C7) ○ For two-level contiguous cervical total artificial disc replacement, the device being utilized must be FDA-approved for two levels; when a cervical total artificial disc replacement was previously performed, the second contiguous level artificial disc must be FDA approved for two levels ○ Cervical total artificial disc replacement in an individual with a history of prior cervical spinal fusion is proven and medically necessary when all of the following are present and InterQual® criteria are met: ▪ An FDA-approved prosthetic intervertebral disc is utilized ▪ Treating individuals with only one level or two Contiguous Levels of	total artificial disc replacement was previously performed, the second Contiguous Level artificial disc must be FDA approved for two levels. **Cervical total artificial disc replacement in an individual with a history of prior cervical spinal fusion is proven and medically necessary when all of the following are present and InterQual criteria are met:** • An FDA-approved prosthetic intervertebral disc is utilized • Treating individuals with only one level or two Contiguous Levels of cervical degenerative disc disease (C3-C7) • Skeletally Mature individual with radiculopathy and/or myelopathy • The arthroplasty will be performed at all symptomatic Contiguous Levels (up to two levels between C3-C7) • Radiographically Confirmed Complete Arthrodesis of a previous cervical spinal fusion at another level (adjacent or non-adjacent) For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Artificial Disc Replacement, Cervical. Click here to view the InterQual® criteria. **Cervical artificial disc removal or replacement with an FDA-approved (one or two-level) prosthetic intervertebral disc is proven and medically necessary in individuals with implant failure after prior disc replacement.** **Cervical total artificial disc replacement is unproven and not medically necessary when performed at one level combined with cervical spinal fusion surgery at another level (adjacent or non-adjacent), as part of the same surgical plan (Hybrid Cervical Surgery).** **Lumbar** **Lumbar total artificial disc replacement is proven and medically necessary when all of the following are present and InterQual criteria are met:** • An FDA-approved prosthetic intervertebral disc is utilized • Treating individuals with only single level of lumbar degenerative disc disease

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Total Artificial Disc Replacement for the Spine (continued)	Feb. 1, 2026	cervical degenerative disc disease (C3-C7) ▪ Skeletally Mature individual with radiculopathy and/or myelopathy ▪ The arthroplasty will be performed at all symptomatic Contiguous Levels (up to two levels between C3-C7) ▪ Radiographically Confirmed Complete Arthrodesis of a previous cervical spinal fusion at another level (adjacent or non-adjacent) ○ For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Artificial Disc Replacement, Cervical ○ Cervical artificial disc removal or replacement with an FDA-approved (one or two-level) prosthetic intervertebral disc is proven and medically necessary in individuals with implant failure after prior disc replacement ○ Cervical total artificial disc replacement is unproven and not medically necessary when performed at one level combined with cervical spinal fusion surgery at another level (adjacent or non-	• Skeletally Mature individual • Symptomatic intractable discogenic low back pain attributable to that level For medical necessity clinical coverage criteria, refer to the InterQual® Client Defined, CP: Procedures, Artificial Disc Replacement, Lumbar (Custom) - UHG. Click here to view the InterQual® criteria. **Lumbar total artificial disc replacement is unproven and not medically necessary due to insufficient evidence of efficacy when:** • Performed at one level combined with an existing lumbar spinal fusion surgery at another level (adjacent or non-adjacent); or • Performed with lumbar spinal fusion surgery as part of the same surgical plan (Hybrid Lumbar Surgery); or • Performed at more than one spinal level

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Total Artificial Disc Replacement for the Spine (continued)	Feb. 1, 2026	adjacent), as part of the same surgical plan (Hybrid Cervical Surgery) ***Lumbar*** ○ Lumbar total artificial disc replacement is proven and medically necessary when all of the following are present and InterQual® criteria are met: ▪ An FDA-approved prosthetic intervertebral disc is utilized ▪ Treating individuals with only single level of lumbar degenerative disc disease ▪ Skeletally Mature individual ▪ Symptomatic intractable discogenic low back pain attributable to that level ○ For medical necessity clinical coverage criteria, refer to the InterQual® Client Defined, CP: Procedures, Artificial Disc Replacement, Lumbar (Custom) - UHG ○ Lumbar total artificial disc replacement is unproven and not medically necessary due to insufficient evidence of efficacy when: ▪ Performed at one level combined with an existing lumbar spinal fusion surgery at another level	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Total Artificial Disc Replacement for the Spine (continued)	Feb. 1, 2026	(adjacent or non-adjacent) ▪ Performed with lumbar spinal fusion surgery as part of the same surgical plan (Hybrid Lumbar Surgery) ▪ Performed at more than one spinal level **Medical Records Documentation Used for Reviews** • Updated list of Medical Records Documentation Used for Reviews: o Added: ▪ Relevant imaging and diagnostic testing, including documentation of instability ▪ For total artificial disc removal or replacement, also include: – Details of complication – Surgical plan o Replaced: ▪ "Physical exam, including *spasticity, including investigation for other etiologies*" with "physical exam, including *detailed neurological findings*" ▪ "Treatments tried, failed, or contraindicated; include the dates and reason for discontinuation" with "treatments tried, failed,	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Total Artificial Disc Replacement for the Spine (continued)	Feb. 1, 2026	or contraindicated; include the dates, *duration*, and reason for discontinuation" ▪ "Physician treatment plan" with "physician treatment plan, *including surgical technique to be used and the number of levels involved and their location*" ▪ "For lumbar surgery, in addition to the [listed documentation requirements], *provide medical notes documenting the following, when applicable: provide* psychosocial-behavioral, *documentation of instability (listhesis-, spondylolisthesis and grade), and provide the surgical technique to be used and the number of levels involved and their location*" with "for lumbar surgery, in addition to the [listed documentation requirements], *also include* psychosocial-behavioral *evaluation*" **Definitions** • Added definition of: ○ Contiguous Levels ○ Hybrid Cervical Surgery	

Clinical Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Total Artificial Disc Replacement for the Spine (continued)	Feb. 1, 2026	○ Hybrid Lumbar Surgery ○ Radiographically Confirmed Complete Arthrodesis • Updated definition of "Skeletally Mature" **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information	

Administrative Policy Updates

Updated

Policy Title	Effective Date	Summary of Changes
Oxford's Outpatient Imaging Self-Referral Policy	Jan. 1, 2026	• Revised list of applicable CPT codes for: ***Pediatric Cardiologists*** ○ Removed instruction to refer to the Clinical Policy titled *Obstetrical Ultrasonography* for additional information for CPT codes 76820, 76821, 76825, 76826, 76827, and 76828 ***Nuclear Medicine*** ○ Removed instruction to refer to the Clinical Policy titled *Cardiology Procedures for eviCore healthcare Arrangement* ***Infertility Specialists Practicing within an Infertility Clinic, Maternal and Fetal Medicine, Neonatal/Perinatal Medicine, Nurse Practitioner (NP), Obstetricians/ Gynecologists (OBGYN), Physician Assistant (PA), and Reproductive Endocrinologists*** ○ Removed 76801, 76802, 76805, 76810, 76811, 76812, 76813, and 76814 ○ Removed instruction to refer to the Clinical Policy titled *Obstetrical Ultrasonography* for additional information for CPT codes 76801-76828

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Wigs	Jan. 1, 2026	**Applicable Codes** • Added ICD-10 diagnosis codes L66.0, L66.10, L66.11, L66.12, L66.19, L66.3, L66.4, L66.81, L66.89, T20.55XD, T20.55XS, T20.65XD, T20.65XS, T20.75XD, T20.75XS, T45.1X5D, and Z79.63	Coverage for wigs is based upon State Mandates. • **Connecticut (CT) Groups**: Wigs are included in coverage for Connecticut (CT) groups when: ⊖ A member suffers hair loss due to a result of chemotherapy or radiation therapy; and ○ The wig is prescribed by a licensed oncologist. • **New York (NY) Groups**: Wigs are included in coverage for New York (NY) groups when the member has severe hair loss due to injury, disease, or as a side effect of the treatment of a disease. Coverage is limited to one wig per member, per lifetime. • **New Jersey (NJ) Large Groups**: Wigs are included in coverage for New Jersey (NJ) Large groups when the member has severe hair loss due to injury, sickness, or as a side effect of the treatment of a disease. Coverage is limited to one wig per member, per lifetime. **Severe hair loss due to injury, disease, and/or sickness includes:** • Alopecia areata • Alopecia totalis • Burns to the scalp • Chemotherapy

Administrative Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Wigs (continued)	Jan. 1, 2026		• Congenital baldness • Lupus • Radiation therapy • Traumatic injury to the head/scalp • Any condition that results in severe hair loss not listed above **Exceptions** • NJ Small products do not provide coverage for wigs • Applicable state taxes • Coverage is not available for repair or replacement of the wig due to misuse, malicious damage, gross neglect, or to replace a lost or stolen wig • Hair implants or hair plugs • Human hair (unless an allergy exists to a synthetic wig) • Natural or premature aging (female pattern baldness, male pattern baldness, androgenetic alopecia) • Pregnancy or postpartum alopecia • Styling, coloring, or color correction

General Information

The inclusion of a health service (e.g., test, drug, device, or procedure) in this bulletin indicates only that UnitedHealthcare Oxford® is adopting a new policy and/or updated, revised, replaced, or retired an existing policy; it does not imply that UnitedHealthcare Oxford® 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 Oxford® reserves the right to review the clinical evidence supporting the safety and effectiveness of a medical technology prior to rendering a coverage determination.

UnitedHealthcare Oxford® 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 Policy Update Bulletin was developed to share important information regarding changes to our UnitedHealthcare Oxford® Clinical and Administrative Policies. When information in this bulletin conflicts with applicable state and/or federal law, UnitedHealthcare Oxford® 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 Oxford Clinical and Administrative Policies is available at **UHCprovider.com/policies** > For Commercial Plans > UnitedHealthcare Oxford Clinical and Administrative Policies.