

UnitedHealthcare Oxford Policy Update Bulletin: February 2022

Access a policy listed below for complete details on the latest updates. A comprehensive summary of changes is provided at the bottom of every policy document for your reference. To view a detailed version of this bulletin, click [here](#).

Clinical Policy Updates

Policy Title	Status	Effective Date
Articular Cartilage Defect Repairs	Revised	Mar. 1, 2022
Catheter Ablation for Atrial Fibrillation	Updated	Feb. 1, 2022
Drug Coverage Criteria: New and Therapeutic Equivalent Medications	Revised	Mar. 1, 2022
Drug Coverage Guidelines <ul style="list-style-type: none"> • Actemra (Tocilizumab): Sq Injection • Adbry (Tralokinumab-Ldrm) • Aptiom (Eslicarbazepine Acetate) • Brexafemme (Ibrexafungerp) • Briviact (Brivaracetam) • Budesonide Tablet (Generic Uceris) • Cequa (Cyclosporine) • Cimzia (Certolizumab Pegol) • Cortrophin Gel (Adrenocorticotropic Hormone) • Cosentyx (Secukinumab) • Dartisla ODT (Glycopyrrolate) • Descovy (Emtricitabine/Tenofovir Alafenamide) • Dupixent (Dupilumab) • Enbrel (Etanercept) • Envarsus XR (Tacrolimus) • Epidiolex (Cannabidiol) • Eulexin (Flutamide) • Fintepla (Fenfluramine) • Fycompa (Perampanel) • Gvoke Kit (Glucagon Injection) • Hetlioz (Tasimelteon) • Hetlioz LQ (Tasimelteon) • Humira (Adalimumab) • Humira (Adlimumab): 10 mg/0.1 ml, 20 mg/0.2 ml, 40 mg/0.4 ml, 80 mg/0.8 ml Strengths Only • Hydroxychloroquine 100, 300, 400 mg (Generic Plaquenil) • Ilumya (Tildrakizumab-Asmn) • Kerendia (Finerenone) • Kevzara (Sarilumab) • Nurtec ODT (Rimegepant) • Olumiant (Baricitinib) • Orencia (Abatacept): Sq Injection • Qulipta (Atogepant) • Recorlev (Levoketoconazole) • Restasis (Cyclosporine Ophthalmic Emulsion) Single-Use Vials 	Revised	Mar. 1, 2022

Policy Title	Status	Effective Date
<ul style="list-style-type: none"> ● Restasis (Cyclosporine Ophthalmic Emulsion) (Multi-Use) ● Rinvoq (Upadacitinib) ● Scemblix (Asciminib) ● Siliq (Brodalumab) ● Simponi (Golimumab) ● Stelara (Ustekinumab): Subcutaneous Injection ● Stiolto Respimat (Olodaterol/Tiotropium) ● Taltz (Ixekizumab) ● Talzenna (Talazoparib) ● Tarpeyo (Budesonide) ● Tremfya (Guselkumab) ● Tyrvaya (Varenicline Solution) ● Ubrelvy (Ubrogepant) ● Vimpat (Lacosamide): Tablet ● Xcopri (Cenobamate) ● Xeljanz (Tofacitinib): Oral Solution ● Xeljanz (Tofacitinib): Tablet ● Xeljanz (Tofacitinib) XR ● Xiidra (Lifitegrast 5% Ophthalmic Solution) ● Zeposia (Ozanimod) ● Zolmitriptan (Generic Zomig) ● Zomig (Zolmitriptan) (Nasal Spray) (Brand Only) 		
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation	Revised	Mar. 1, 2022
Implanted Electrical Stimulator for Spinal Cord	Revised	Mar. 1, 2022
Infliximab (Avsola™, Inflectra®, Remicade®, & Renflexis®)	Revised	Mar. 1, 2022
Intravenous Iron Replacement Therapy (Feraheme®, Injectafer®, & Monoferric®)	Revised	Mar. 1, 2022
Pneumatic Compression Devices	Revised	Mar. 1, 2022
Surgery of the Ankle	Updated	Feb. 1, 2022
Surgery of the Hip	Revised	Mar. 1, 2022
Surgery of the Knee	Revised	Feb. 1, 2022
Surgery of the Shoulder	Updated	Feb. 1, 2022
Surgery of the Shoulder	Revised	Mar. 1, 2022
Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins	Updated	Feb. 1, 2022
Surgical Treatment for Spine Pain	Updated	Feb. 1, 2022
Total Artificial Disc Replacement for the Spine	Updated	Feb. 1, 2022
Vagus and External Trigeminal Nerve Stimulation	Revised	Mar. 1, 2022
Whole Exome and Whole Genome Sequencing	Revised	Mar. 1, 2022

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 UnitedHealthcare Oxford® Clinical, Administrative, and Reimbursement Policy updates. 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



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