

**UMR**

# Medical Policy Update Bulletin: February 2024

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

## Medical Policy Updates

Policy Title	Status	Effective Date
Bariatric Surgery	Revised	Mar. 1, 2024
Electromagnetic Therapy for Wounds	Updated	Feb. 1, 2024
Embolization of the Ovarian and Iliac Veins for Pelvic Congestion Syndrome	Updated	Feb. 1, 2024
Gastrointestinal Pathogen Nucleic Acid Detection Panel Testing for Infectious Diarrhea	Revised	Mar. 1, 2024
Gender Dysphoria Treatment (for Commercial Only)	Revised	Mar. 1, 2024
Lower Extremity Prosthetics	Revised	Apr. 1, 2024
Spinal Fusion and Decompression	Revised	Mar. 1, 2024
Thermography	Retired	Feb. 1, 2024
Transcatheter Heart Valve Procedures	Revised	Apr. 1, 2024
Upper Extremity Prosthetic Devices	Revised	Apr. 1, 2024
Whole Exome and Whole Genome Sequencing (Non-Oncology Conditions)	Revised	Apr. 1, 2024

## Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Botulinum Toxins A and B	Updated	Mar. 1, 2024
Complement Inhibitors (Soliris® & Ultomiris®)	Revised	Mar. 1, 2024
Infliximab (Avsola®, Inflectra®, Remicade®, & Renflexis®)	Revised	Mar. 1, 2024
Intravenous Iron Replacement Therapy (Feraheme®, Injectafer®, & Monoferric®)	Revised	Mar. 1, 2024
Neonatal Fc Receptor Blockers (Vyvgart®, Vyvgart® Hytrulo, & Rystiggo®)	Revised	Mar. 1, 2024
Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors	Revised	Mar. 1, 2024
Simponi Aria® (Golimumab) Injection for Intravenous Infusion	Revised	Mar. 1, 2024
Stelara® (Ustekinumab)	Revised	Mar. 1, 2024

## General Information

The inclusion of a health service (e.g., test, drug, device, or procedure) in this bulletin indicates only that UnitedHealthcare is adopting a new policy and/or updated, revised, replaced, or retired an existing policy; it does not imply that UnitedHealthcare provides coverage for the health service. Note that most benefit plan documents exclude from benefit coverage health services identified as investigational or unproven/not medically necessary. Physicians and other health care professionals may not seek or collect payment from a member for services not covered by the applicable benefit plan unless first obtaining the member's written consent, acknowledging that the service is not covered by the benefit plan and that they will be billed directly for the service.

**Note:** The absence of a policy does not automatically indicate or imply coverage. As always, coverage for a health service must be determined in accordance with the member's benefit plan and any applicable federal or state regulatory requirements. Additionally, UnitedHealthcare reserves the right to review the clinical evidence supporting the safety and effectiveness of a medical technology prior to rendering a coverage determination.

UnitedHealthcare respects the expertise of the physicians, health care professionals, and their staff who participate in our network. Our goal is to support you and your patients in making the most informed decisions regarding the choice of quality and cost-effective care, and to support practice staff with a simple and predictable administrative experience. The Medical Policy Update Bulletin was developed to share important information regarding UnitedHealthcare Medical Policy and Medical Benefit Drug Policy updates. When information in this bulletin conflicts with applicable state and/or federal law, UnitedHealthcare follows such applicable federal and/or state law.

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## 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 UMR Medical Policies and Medical Benefit Drug Policies is available at [UHCprovider.com](https://www.uhcprovider.com) > Policies and Protocols for Healthcare Providers > For Commercial Plans > UnitedHealthcare | UMR Medical & Drug Policies.