United Healthcare Community Plan

UnitedHealthcare Community Plan of Ohio
Medical Policy Update Bulletin *Quick View*: December 2025

A list of recently approved, revised, and/or retired Medical Policies and/or Medical Benefit Drug Policies is provided below for your reference. **For a comprehensive summary of the latest updates, refer to the Medical Policy Update Bulletin: December 2025.**

Medical Policy Updates

Policy Title	Status	Effective Date
Apheresis (for Ohio Only)	Updated	Jan. 1, 2026
Breast Reconstruction (for Ohio Only)	Updated	Jan. 1, 2026
Breast Reduction Surgery (for Ohio Only)	Updated	Jan. 1, 2026
Chromosome Microarray Testing (Non-Oncology Conditions) (for Ohio Only)	Updated	Jan. 1, 2026
Computer-Assisted Surgical Navigation for Musculoskeletal Procedures (for Ohio Only)	Revised	Feb. 1, 2026
Cosmetic and Reconstructive Procedures (for Ohio Only)	Revised	Jan. 1, 2026
Electrical and Ultrasonic Bone Growth Stimulators (for Ohio Only)	Updated	Feb. 1, 2026
Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions and Soft Tissue Indications (for Ohio Only)	Revised	Jan. 1, 2026
Implanted Electrical Stimulator for the Spinal Cord (for Ohio Only)	Revised	Feb. 1, 2026
Light and Laser Therapy (for Ohio Only)	Revised	Feb. 1, 2026
Lower Extremity Endovascular Procedures (for Ohio Only)	Updated	Feb. 1, 2026
Lower Extremity Prosthetics (for Ohio Only)	Updated	Jan. 1, 2026
Mechanical Stretching Devices (for Ohio Only)	Updated	Jan. 1, 2026
Molecular Oncology Testing for Hematologic Cancer Diagnosis, Prognosis, and Treatment Decisions (for Ohio Only)	Revised	Feb. 1, 2026
Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions (for Ohio Only)	Updated	Jan. 1, 2026
Nerve Graft to Restore Erectile Function During Radical Prostatectomy (for Ohio Only)	Updated	Jan. 1, 2026
Panniculectomy Surgery (for Ohio Only)	Revised	Jan. 1, 2026
Pneumatic Compression Devices (for Ohio Only)	Updated	Jan. 1, 2026
Sacral Nerve Stimulation for Urinary and Fecal Indications (for Ohio Only)	Updated	Jan. 1, 2026
Sleep Studies (for Ohio Only)	Updated	Feb. 1, 2026
Spinal Fusion and Bone Healing Enhancement Products (for Ohio Only)	Updated	Jan. 1, 2026
Stereotactic Body Radiation Therapy and Stereotactic Radiosurgery (for Ohio Only)	Revised	Feb. 1, 2026
Surgery for the Prevention and Treatment of Lymphedema (for Ohio Only)	Updated	Jan. 1, 2026
Surgery of the Knee (for Ohio Only)	Revised	Jan. 1, 2026
Transcranial Magnetic Stimulation (for Ohio Only)	Revised	Jan. 1, 2026
Vagus and External Trigeminal Nerve Stimulation (for Ohio Only)	Updated	Jan. 1, 2026

Policy Title	Status	Effective Date
Video Electroencephalographic (vEEG) Monitoring and Recording (for Ohio Only)	Updated	Jan. 1, 2026

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Brineura® (Cerliponase Alfa) (for Ohio Only)	Updated	Jan. 1, 2026
Briumvi® (Ublituximab-Xiiy) (for Ohio Only)	Updated	Jan. 1, 2026
Encelto™ (Revakinagene Taroretcel-Lwey) (for Ohio Only)	New	Jan. 1, 2026
Evkeeza® (Evinacumab-Dgnb) (for Ohio Only)	Revised	Jan. 1, 2026
FcRn Blockers (Rystiggo®, Vyvgart®, & Vyvgart Hytrulo®) (for Ohio Only)	Revised	Jan. 1, 2026
Hereditary Angioedema (HAE), Treatment and Prophylaxis (for Ohio Only)	Revised	Jan. 1, 2026
Ilaris® (Canakinumab) (for Ohio Only)	Updated	Jan. 1, 2026
Immunomodulatory Agents for Systemic Inflammatory Diseases (for Ohio Only)	Revised	Jan. 1, 2026
Krystexxa® (Pegloticase) (for Ohio Only)	Updated	Jan. 1, 2026
Leqvio® (Inclisiran) (for Ohio Only)	Updated	Jan. 1, 2026
Medical Therapies for Enzyme Deficiencies (for Ohio Only)	Updated	Jan. 1, 2026
Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease (for Ohio Only)	Revised	Jan. 1, 2026
Oxlumo® (Lumasiran) and Rivfloza™ (Nedosiran) (for Ohio Only)	Updated	Jan. 1, 2026
Self-Administered Medications (for Ohio Only)	Updated	Jan. 1, 2026
Synagis® (Palivizumab) (for Ohio Only)	Updated	Jan. 1, 2026
Tezspire® (Tezepelumab-Ekko) (for Ohio Only)	Updated	Jan. 1, 2026

General Information

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

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

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

Policy Update Classifications

New

New clinical coverage criteria have been adopted for a health service (e.g., test, drug, device, or procedure)

Updated

An existing policy has been reviewed and changes have not been made to the clinical coverage criteria; however, items such as the clinical evidence, FDA information, and/or list(s) of applicable codes may have been updated

Revised

An existing policy has been reviewed and revisions have been made to the clinical coverage criteria

Replaced

An existing policy has been replaced with a new or different policy

Retired

The health service(s) addressed in the policy are no longer being managed or are considered to be proven/medically necessary and are therefore not excluded as unproven/not medically necessary services, unless coverage guidelines or criteria are otherwise documented in another policy

The complete library of UnitedHealthcare Community Plan of Ohio Medical Policies and Medical Benefit Drug Policies is available at **UHCprovider.com/OH** > Community Plan (Medicaid) > Current Policies and Clinical Guidelines > Medical & Drug Policies.