UnitedHealthcare Community Plan of Nebraska
Medical Policy Update Bulletin *Quick View*: June 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: June 2025.**

Medical Policy Updates

Policy Title	Status	Effective Date
Bariatric Surgery (for Nebraska Only)	Revised	Aug. 1, 2025
Breast Reduction Surgery	Updated	Jun. 1, 2025
Cell-Free Fetal DNA Testing (for Nebraska Only)	Revised	Aug. 1, 2025
Chelation Therapy	Revised	Aug. 1, 2025
Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes (for Nebraska Only)	Updated	Jun. 1, 2025
Epidural Steroid Injections for Spinal Pain	Revised	Aug. 1, 2025
Gynecomastia Surgery	Revised	Aug. 1, 2025
Home Health, Skilled, and Custodial Care Services (for Nebraska Only)	Revised	Aug. 1, 2025
Lithotripsy for Salivary Stones	Retired	Jun. 1, 2025
Mechanical Stretching Devices	Updated	Jun. 1, 2025
Proton Beam Radiation Therapy	Revised	Aug. 1, 2025
Surgery of the Knee	Updated	Jun. 1, 2025
Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins	Revised	Aug. 1, 2025
Unicondylar Spacer Devices for Treatment of Pain or Disability	Retired	Jun. 1, 2025
Upper Extremity Prosthetic Devices	Revised	Jun. 1, 2025
Whole Exome and Whole Genome Sequencing (Non-Oncology Conditions) (for Nebraska Only)	Revised	Jun. 1, 2025

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Amondys 45® (Casimersen)	Revised	Jul. 1, 2025
Entyvio® (Vedolizumab)	Revised	Jul. 1, 2025
Exondys 51® (Eteplirsen)	Revised	Jul. 1, 2025
Immune Globulin (IVIG and SCIG)	Revised	Jul. 1, 2025
Intravenous Enzyme Replacement Therapy (ERT) for Gaucher Disease	Revised	Jul. 1, 2025
Maximum Dosage and Frequency	Revised	Jul. 1, 2025
Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease	Revised	Jul. 1, 2025
Oncology Medication Clinical Coverage	Revised	Jul. 1, 2025
Ophthalmologic Vascular Endothelial Growth Factor (VEGF) Inhibitors	Revised	Jul. 1, 2025

Policy Title	Status	Effective Date
Oxlumo® (Lumasiran) and Rivfloza® (Nedosiran)	Revised	Jul. 1, 2025
RNA-Targeted Therapies (Amvuttra® and Onpattro®)	Revised	Jul. 1, 2025
Spevigo® (Spesolimab-Sbzo)	Revised	Jul. 1, 2025
Testosterone Replacement or Supplementation Therapy	Revised	Jul. 1, 2025
Viltepso® (Viltolarsen)	Revised	Jul. 1, 2025
Vyondys 53® (Golodirsen)	Revised	Jul. 1, 2025
Zulresso® (Brexanolone)	Retired	Jun. 1, 2025

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 Nebraska 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 Nebraska Medical Policies and Medical Benefit Drug Policies is available at **UHCprovider.com/NE** > Community Plan (Medicaid) > Current Policies and Clinical Guidelines > Medical & Drug Policies.