UnitedHealthcare Community Plan of Nebraska
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.**

Take Note

Implementation Delay: Respiratory Pathogen Nucleic Acid Detection Testing (for Nebraska Only)

The new Medical Policy titled Respiratory Pathogen Nucleic Acid Detection Testing (for Nebraska Only) will not be effective on Jan. 1, 2026, as previously announced; implementation has been postponed until **Feb. 1, 2026**.

Annual CPT/HCPCS Code Updates

Beginning **Jan. 1, 2026**, all applicable Medical Policies and Medical Benefit Drug 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

Medical Policy Updates

Policy Title	Status	Effective Date
Abnormal Uterine Bleeding and Uterine Fibroids (for Nebraska Only)	Updated	Dec. 1, 2025
Airway Clearance Devices (for Nebraska Only)	Updated	Dec. 1, 2025
Apheresis (for Nebraska Only)	Updated	Dec. 1, 2025
Breast Imaging for Screening and Diagnosing Cancer (for Nebraska Only)	Revised	Feb. 1, 2026
Brow Ptosis and Eyelid Repair (for Nebraska Only)	Updated	Dec. 1, 2025
Chromosome Microarray Testing (Non-Oncology Conditions) (for Nebraska Only)	Updated	Dec. 1, 2025
Cochlear Implants (for Nebraska Only)	Updated	Dec. 1, 2025
Computer-Assisted Surgical Navigation for Musculoskeletal Procedures (for Nebraska Only)	Revised	Feb. 1, 2026
Electric Tumor Treatment Field Therapy (for Nebraska Only)	Revised	Feb. 1, 2026
Electrical and Ultrasonic Bone Growth Stimulators (for Nebraska Only)	Updated	Feb. 1, 2026
Facet Joint and Medial Branch Block Injections for Spinal Pain (for Nebraska Only)	Updated	Dec. 1, 2025
Genetic Testing for Cardiac Disease (for Nebraska Only)	Revised	Feb. 1, 2026
Implantable Loop Recorders and Wearable Heart Rhythm Monitors (for Nebraska Only)	Updated	Dec. 1, 2025

Policy Title	Status	Effective Date
Implanted Electrical Stimulator for the Spinal Cord (for Nebraska Only)	Revised	Feb. 1, 2026
Light and Laser Therapy (for Nebraska Only)	Revised	Feb. 1, 2026
Lower Extremity Endovascular Procedures (for Nebraska Only)	Revised	Feb. 1, 2026
Lower Extremity Prosthetics (for Nebraska Only)	Updated	Dec. 1, 2025
Mechanical Stretching Devices (for Nebraska Only)	Updated	Dec. 1, 2025
Molecular Oncology Testing for Hematologic Cancer Diagnosis, Prognosis, and Treatment Decisions (for Nebraska Only)	Revised	Feb. 1, 2026
Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions (for Nebraska Only)	Updated	Dec. 1, 2025
Negative Pressure Wound Therapy (for Nebraska Only)	Updated	Dec. 1, 2025
Omnibus Codes (for Nebraska Only)	Revised	Feb. 1, 2026
Plagiocephaly and Craniosynostosis Treatment (for Nebraska Only)	Updated	Dec. 1, 2025
Pneumatic Compression Devices (for Nebraska Only)	Updated	Dec. 1, 2025
Prostate Surgeries and Interventions (for Nebraska Only)	Updated	Dec. 1, 2025
Sacral Nerve Stimulation for Urinary and Fecal Indications (for Nebraska Only)	Updated	Dec. 1, 2025
Sinus Surgeries and Interventions (for Nebraska Only)	Updated	Dec. 1, 2025
Sleep Studies (for Nebraska Only)	Revised	Feb. 1, 2026
Spinal Fusion and Bone Healing Enhancement Products (for Nebraska Only)	Updated	Dec. 1, 2025
Surgery of the Elbow (for Nebraska Only)	Updated	Dec. 1, 2025
Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins (for Nebraska Only)	Updated	Dec. 1, 2025
Transarterial Radioembolization (TARE)/Selective Internal Radiation Therapy (SIRT) for the Treatment of Malignant Cancers of the Liver (for Nebraska Only)	Revised	Feb. 1, 2026
Upper Extremity Prosthetic Devices (for Nebraska Only)	Updated	Dec. 1, 2025
Vagus and External Trigeminal Nerve Stimulation (for Nebraska Only)	Updated	Dec. 1, 2025
Video Electroencephalographic (vEEG) Monitoring and Recording (for Nebraska Only)	Updated	Dec. 1, 2025

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Botulinum Toxins A and B	Revised	Jan. 1, 2026
Denosumab	Revised	Jan. 1, 2026
Elevidys® (Delandistrogene Moxparvovec-Rokl)	Revised	Jan. 1, 2026
Gamifant® (Emapalumab-Lzsg)	Revised	Jan. 1, 2026
Gene Therapies for Hemophilia B	Revised	Jan. 1, 2026
Immune Globulin (IVIG and SCIG)	Revised	Jan. 1, 2026
Luxturna® (Voretigene Neparvovec-Rzyl)	Revised	Jan. 1, 2026
Maximum Dosage and Frequency	Revised	Jan. 1, 2026
Natalizumab (Tyruko® & Tysabri®)	Revised	Jan. 1, 2026
Oncology Medication Clinical Coverage	Revised	Jan. 1, 2026
Provider Administered Drugs – Site of Care	Revised	Jan. 1, 2026
Rebyota® (Fecal Microbiota, Live-Jslm)	Updated	Dec. 1, 2025
Roctavian® (Valoctocogene Roxaparvovec-Rvox)	Revised	Jan. 1, 2026
Sodium Hyaluronate	Updated	Jan. 1, 2026
Spinraza® (Nusinersen)	Revised	Jan. 1, 2026
Tocilizumab	Revised	Jan. 1, 2026

Policy Title	Status	Effective Date
Vyjuvek® (Beramagene Geperpavec-Svdt)	Revised	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 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.