UnitedHealthcare Commercial
Medical Policy Update Bulletin *Quick View*: February 2026

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: February 2026.**

Medical Policy Updates

Policy Title	Status	Effective Date
Airway Clearance Devices	Updated	Mar. 1, 2026
Deep Brain and Cortical Stimulation	Updated	Feb. 1, 2026
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation	Revised	Mar. 1, 2026
Gender Dysphoria Treatment	Revised	Apr. 1, 2026
Genetic Testing for Hereditary Cancer	Revised	Apr. 1, 2026
Hearing Aids and Devices Including Wearable, Bone-Anchored, and Semi-Implantable	Updated	Mar. 1, 2026
Intensity-Modulated Radiation Therapy	Revised	Mar. 1, 2026
Manipulation Under Anesthesia	Updated	Feb. 1, 2026
Minimally Invasive Spine Surgery Procedures	Updated	Feb. 1, 2026
Obstructive and Central Sleep Apnea Treatment	Revised	Apr. 1, 2026
Outpatient Radiology Procedures for EviCore Arrangement (for Oxford only)	Revised	Apr. 1, 2026
Percutaneous Vertebroplasty and Kyphoplasty	Revised	Mar. 1, 2026
Proton Beam Radiation Therapy	Revised	Mar. 1, 2026
Radiation Therapy: Fractionation, Image-guidance, and Special Services	Revised	Mar. 1, 2026
Screening Colonoscopy Procedures – Site of Service	Updated	Mar. 1, 2026
Transcranial Magnetic Stimulation for Treating Physical Health Conditions	Updated	Feb. 1, 2026
Treatment of Temporomandibular Joint Disorders	Revised	Mar. 1, 2026
Upper Extremity Prosthetic Devices	Revised	Apr. 1, 2026

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Elevidys® (Delandistrogene Moxeparvovec-Rokl)	Revised	Mar. 1, 2026
Intravenous Iron Replacement Therapy (Feraheme®, Injectafer®, & Monoferric®)	Updated	Feb. 1, 2026
Papzimeos™ (Zopapogene Imadenovec-Drba)	New	Feb. 1, 2026
Simponi Aria® (Golimumab) Injection for Intravenous Infusion	Revised	Mar. 1, 2026
Tocilizumab (Actemra®, Tofidence®, & Tyenne®) Injection for Intravenous Infusion	Revised	Mar. 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 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 Medical Policies and Medical Benefit Drug Policies is available at **UHCprovider.com/policies** > For Commercial Plans > Medical & Drug Policies.