

UnitedHealthcare Community Plan of Kentucky 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

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
Cardiovascular Disease Risk Tests (for Kentucky Only)	Revised	Jan. 1, 2026
Cochlear Implants (for Kentucky Only)	Revised	Jan. 1, 2026
Glaucoma Surgical Treatments (for Kentucky Only)	Revised	Jan. 1, 2026
Hearing Instruments and Devices Including Wearable, Bone-Anchored, and Semi-Implantable (for Kentucky Only)	Updated	Dec. 1, 2025
Injectable Dermal Fillers and Bulking Agents (for Kentucky Only)	Updated	Jan. 1, 2026
Manipulative Therapy (for Kentucky Only)	Revised	Jan. 1, 2026

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

Policy Title	Status	Effective Date
Rebyota® (Fecal Microbiota, Live-Jslm)	Updated	Dec. 1, 2025
Roctavian® (Valoctocogene Roxaparvovec-Rvox)	Revised	Jan. 1, 2026
Tocilizumab	Revised	Jan. 1, 2026
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 Kentucky 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 Kentucky Medical Policies and Medical Benefit Drug Policies is available at UHCprovider.com/KY > Community Plan (Medicaid) > Current Policies and Clinical Guidelines > [Medical & Drug Policies](#).