UnitedHealthcare Community Plan of Kentucky
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
Discogenic Pain Treatment (for Kentucky Only)	Updated	Feb. 1, 2026
Elective Inpatient Services (for Kentucky Only)	Updated	Feb. 1, 2026
Electrical and Ultrasonic Bone Growth Stimulators (for Kentucky Only)	Updated	Feb. 1, 2026
FDA Cleared or Approved Companion Diagnostic Testing (for Kentucky Only)	Revised	Mar. 1, 2026
Gastrointestinal Pathogen Nucleic Acid Detection Panel Testing for Infectious Diarrhea (for Kentucky Only)	Updated	Feb. 1, 2026
Implanted Electrical Stimulator for the Spinal Cord (for Kentucky Only)	Revised	Mar. 1, 2026
Interspinous Fusion and Decompression Devices (for Kentucky Only)	Updated	Feb. 1, 2026
Lower Extremity Endovascular Procedures (for Kentucky Only)	Updated	Feb. 1, 2026
Molecular Oncology Testing for Hematologic Cancer Diagnosis, Prognosis, and Treatment Decisions (for Kentucky Only)	Revised	Mar. 1, 2026
Omnibus Codes (for Kentucky Only)	Revised	Mar. 1, 2026
Plagiocephaly and Craniosynostosis Treatment (for Kentucky Only)	Updated	Feb. 1, 2026
Sacroiliac Joint Interventions (for Kentucky Only)	Revised	Mar. 1, 2026
Skin and Soft Tissue Substitutes (for Kentucky Only)	Revised	Apr. 1, 2026
Sleep Studies (for Kentucky Only)	Updated	Feb. 1, 2026
Spinal Fusion and Bone Healing Enhancement Products (for Kentucky Only)	Updated	Feb. 1, 2026
Stereotactic Body Radiation Therapy and Stereotactic Radiosurgery (for Kentucky Only)	Revised	Mar. 1, 2026
Surgery of the Ankle (for Kentucky Only)	Revised	Mar. 1, 2026
Surgery of the Elbow (for Kentucky Only)	Updated	Feb. 1, 2026
Surgery of the Hip (for Kentucky Only)	Updated	Mar. 1, 2026
Transcatheter Procedures for Heart Valve Conditions (for Kentucky Only)	Revised	Mar. 1, 2026
Vagus and External Trigeminal Nerve Stimulation (for Kentucky Only)	Revised	Mar. 1, 2026
Video Electroencephalographic (vEEG) Monitoring and Recording (for Kentucky Only)	Updated	Feb. 1, 2026
Whole Exome and Whole Genome Sequencing (Non-Oncology Conditions) (for Kentucky Only)	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	Mar. 1, 2026
Simponi Aria® (Golimumab) Injection for Intravenous Infusion	Revised	Mar. 1, 2026
Tocilizumab	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 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.