

UMR 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 |
| 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®, & Monoferic®) | 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.

UMR is a wholly owned subsidiary of UnitedHealthcare, a part of UnitedHealth Group. UMR is a third-party administrator (TPA) for self-funded plans.

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 UMR Medical Policies and Medical Benefit Drug Policies is available at UHCprovider.com/policies > For Commercial Plans > [UnitedHealthcare | UMR Medical & Drug Policies](#).