United Healthcare Community Plan

UnitedHealthcare Community Plan of Nebraska
Medical Policy Update Bulletin *Quick View*: March 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: March 2026.**

Policy Title	Status	Effective Date
Airway Clearance Devices (for Nebraska Only)	Updated	Mar. 1, 2026
Autologous Cellular Therapy (for Nebraska Only)	Updated	Mar. 1, 2026
Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/Replacements (for Nebraska Only)	Revised	May 1, 2026
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation (for Nebraska Only)	Revised	May 1, 2026
Embolization of the Ovarian and Iliac Veins for Pelvic Congestion Syndrome (for Nebraska Only)	Updated	Mar. 1, 2026
Genetic Testing for Hereditary Cancer (for Nebraska Only)	Revised	May 1, 2026
Glaucoma Surgical Treatments (for Nebraska Only)	Updated	Mar. 1, 2026
Hysterectomy (for Nebraska Only)	Updated	Mar. 1, 2026
Intensity-Modulated Radiation Therapy (for Nebraska Only)	Revised	May 1, 2026
Manipulation Under Anesthesia (for Nebraska Only)	Updated	Mar. 1, 2026
Minimally Invasive Spine Surgery Procedures (for Nebraska Only)	Updated	Mar. 1, 2026
Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions (for Nebraska Only)	Updated	Mar. 1, 2026
Noncontact Warming Therapy, Ultrasound Therapy, and Fluorescence Imaging for Wounds (for Nebraska Only)	Updated	Mar. 1, 2026
Orthognathic (Jaw) Surgery (for Nebraska Only)	Updated	Mar. 1, 2026
Percutaneous Vertebroplasty and Kyphoplasty (for Nebraska Only)	Revised	May 1, 2026
Proton Beam Radiation Therapy (for Nebraska Only)	Revised	May 1, 2026
Spinal Fusion and Decompression (for Nebraska Only)	Revised	May 1, 2026
Surgery for the Prevention and Treatment of Lymphedema (for Nebraska Only)	Updated	Mar. 1, 2026
Surgery of the Hip (for Nebraska Only)	Updated	May 1, 2026
Surgery of the Knee (for Nebraska Only)	Updated	Mar. 1, 2026
Transcranial Magnetic Stimulation for Treating Physical Health Conditions (for Nebraska Only)	Updated	Mar. 1, 2026
Vertebral Body Tethering for Scoliosis (for Nebraska Only)	Revised	May 1, 2026
Walkers (for Nebraska Only)	Replaced	May 1, 2026

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Complement Inhibitors	Revised	Apr. 1, 2026

Policy Title	Status	Effective Date
Evkeeza® (Evinacumab-Dgnb)	Updated	Apr. 1, 2026
FcRn Blockers	Revised	Apr. 1, 2026
Oncology Medication Clinical Coverage	Revised	Apr. 1, 2026
Ophthalmologic Vascular Endothelial Growth Factor (VEGF) Inhibitors	Revised	Apr. 1, 2026
Sodium Hyaluronate	Revised	Apr. 1, 2026
Somatostatin Analogs	Revised	Apr. 1, 2026
Uplizna® (Inebilizumab-Cdon)	Revised	Apr. 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.