

UnitedHealthcare Community Plan of Nebraska Medical Policy Update Bulletin Quick View: April 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: April 2026](#).**

Take Note

Quarterly HCPCS Code Updates

Effective **Apr. 1, 2026**, all applicable Medical Benefit Drug Policies have been updated to reflect the quarterly Healthcare Common Procedure Coding System (HCPCS) code additions and revisions. Refer to the [Centers for Medicare & Medicaid Services: Healthcare Common Procedure Coding System \(HCPCS\) Quarterly Update](#) for information on the code updates.

Refer to the [Medical Policy Update Bulletin: April 2026](#) for a list of impacted policies and corresponding details.

Medical Policy Updates

Policy Title	Status	Effective Date
Chemotherapy Observation or Inpatient Hospitalization (for Nebraska Only)	Revised	Jun. 1, 2026
Deep Brain and Cortical Stimulation (for Nebraska Only)	Updated	Apr. 1, 2026
Hearing Aids and Devices Including Wearable, Bone-Anchored, and Semi-Implantable (for Nebraska Only)	Revised	Jun. 1, 2026
Lower Extremity Endovascular Procedures (for Nebraska Only)	Revised	Jun. 1, 2026
Treatment of Temporomandibular Joint Disorders (for Nebraska Only)	Revised	Jun. 1, 2026
Upper Extremity Prosthetic Devices (for Nebraska Only)	Revised	Jun. 1, 2026
Whole Exome and Whole Genome Sequencing (Non-Oncology Conditions) (for Nebraska Only)	Revised	Apr. 1, 2026

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Amondys 45® (Casimersen)	Revised	May 1, 2026
Enjaymo® (Sutimlimab-Jome)	Updated	Apr. 1, 2026
Exondys 51® (Eteplirsen)	Revised	May 1, 2026
Omvoh® (Mirikizumab-Mrkz)	Revised	May 1, 2026
Tremfya® (Guselkumab)	Revised	May 1, 2026
Viltepso® (Viltolarsen)	Revised	May 1, 2026
Vyondys 53® (Golodirsen)	Revised	May 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](#).