UnitedHealthcare Community Plan of Tennessee
Medical Policy Update Bulletin *Quick View*: May 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: May 2026.**

Take Note

Quarterly CPT/HCPCS Code Updates

Effective **May 1, 2026**, all applicable Medical Policies have been updated to reflect the quarterly Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) code additions. 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

Refer to the Medical Policy Update Bulletin: May 2026 for a list of impacted policies and corresponding details.

Medical Policy Updates

Policy Title	Status	Effective Date
Bariatric Surgery (for Tennessee Only)	Revised	Jul. 1, 2026
Catheter Ablation for Atrial Fibrillation (for Tennessee Only)	Revised	Jul. 1, 2026
Chemotherapy Observation or Inpatient Hospitalization (for Tennessee Only)	Revised	Jun. 1, 2026
Implantable Loop Recorders and Wearable Heart Rhythm Monitors (for Tennessee Only)	Revised	Jul. 1, 2026
Nerve Graft to Restore Erectile Function During Radical Prostatectomy (for Tennessee Only)	Replaced	Jul. 1, 2026
Obstructive and Central Sleep Apnea Treatment (for Tennessee Only)	Revised	Jul. 1, 2026
Omnibus Codes (for Tennessee Only)	Revised	Jul. 1, 2026
Prostate Surgeries and Interventions (for Tennessee Only)	Revised	Jul. 1, 2026
Rhinoplasty and Other Nasal Procedures (for Tennessee Only)	Updated	May 1, 2026

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Cosentyx® (Secukinumab)	Revised	Jun. 1, 2026
Hemgenix® (Etranacogene Dezaparvovec-Drlb)	Revised	Jun. 1, 2026
Ilumya® (Tildrakizumab-Asmn)	Revised	Jun. 1, 2026
Intravenous Enzyme Replacement Therapy (ERT) for Gaucher Disease	Revised	Jun. 1, 2026
Itvisma® (Onasemnogene Abeparvovec-Brve)	New	Jun. 1, 2026
Leqvio® (Inclisiran)	Revised	Jun. 1, 2026
Maximum Dosage and Frequency	Updated	May 1, 2026

Policy Title	Status	Effective Date
Orencia® (Abatacept) Injection for Intravenous Infusion	Revised	Jun. 1, 2026
Veopoz® (Pozelimab-Bbfg)	Updated	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 Tennessee 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 Tennessee Medical Policies and Medical Benefit Drug Policies is available at **UHCprovider.com/TN** > Community Plan (Medicaid) > Current Policies and Clinical Guidelines > Medical & Drug Policies.