UMR
Medical Policy Update Bulletin: February 2026

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Airway Clearance Devices	Mar. 1, 2026	**Coverage Rationale**
		• Updated language pertaining to medical necessity clinical coverage criteria for a **high-frequency chest wall oscillation (HFCWO) system**; replaced reference to the "InterQual® Client Defined, CP: Durable Medical Equipment, Secretion Clearance Devices (Custom) - UHG" with "InterQual® Client Defined, CP: Durable Medical Equipment, *Airway or* Secretion Clearance Devices (Custom) - UHG"
		Medical Records Documentation Used for Reviews
		• Updated list of Medical Records Documentation Used for Reviews:
		  ○ Added:
		  ▪ Specific device being requested and if request is for initial trial or on-going request
		  ▪ Results of all recent relevant imaging and diagnostic testing
		  ▪ Comorbidities
		  ▪ For continuation beyond the two-month trial, include proper use
		  ○ Removed:
		  ▪ Current prescription from physician
		  ▪ CT scan report confirming diagnosis of Bronchiectasis if applicable
		  ○ Replaced "failed standard treatments to adequately mobilize retained secretions" with "treatments *tried*, failed, or *contraindicated* to adequately mobilize retained secretions; *include the dates, duration, and reason for discontinuation*"
		Applicable Codes
		• Revised description for ICD-10 diagnosis code G35.C2
		Supporting Information
		• Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect the most current information
		• Removed *Benefit Considerations* section

Deep Brain and Cortical Stimulation	Feb. 1, 2026	**Coverage Rationale** • Added language to clarify deep brain stimulation and/***or*** cortical stimulation are unproven and not medically necessary for treating obsessive-compulsive disorder (OCD) and all other indications [not listed in the policy as proven and medically necessary] **Supporting Information** • Updated *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information
Hearing Aids and Devices Including Wearable, Bone-Anchored, and Semi-Implantable	Mar. 1, 2026	**Definitions** • Updated Definition of "Conductive Hearing Loss" **Applicable Codes** • Removed list of applicable CPT/HCPCS codes for **Fitting and Testing of Hearing Aids**: 92590, 92591, 92592, 92593, 92594, 92595, S0618, V5010, V5011, V5014, V5020, V5264, V5265, and V5275

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Policy Title	**Effective Date**	**Summary of Changes**
Hearing Aids and Devices Including Wearable, Bone-Anchored, and Semi-Implantable (continued)	Mar. 1, 2026	**Benefit Considerations** • Removed content/language pertaining to over-the-counter Hearing Aids **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information
Manipulation Under Anesthesia	Feb. 1, 2026	**Definitions** • Updated definition of "Arthrofibrosis" **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information

Minimally Invasive Spine Surgery Procedures	Feb. 1, 2026	**Definitions**
		• Added definition of "Transforaminal Lumbar Interbody Fusion"
		• Removed definition of:
		  ○ Interlaminar Lumbar Instrumented Fusion (ILIF)
		  ○ Nucleoplasty
		  ○ Percutaneous or Endoscopic Lumbar Fusion
		  ○ Transforaminal (TESSYS®) and Interlaminar Endoscopic Surgical Systems
		  ○ Tubular Retractor
		• Updated definition of:
		  ○ Automated Percutaneous Lumbar Discectomy (APLD)
		  ○ Axial Lumbar Interbody Fusion (AxiaLIF)
		  ○ Endoscope
		  ○ Endoscopic Discectomy
		  ○ Fluoroscopy
		  ○ Image-Guided Minimally Invasive Lumbar Decompression (MILD®)
		  ○ Interbody Fusion
		  ○ Laparoscopic Anterior Lumbar Interbody Fusion (LALIF)
		  ○ Open Spine Surgery
		  ○ Percutaneous Endoscopic Lumbar Discectomy (PELD)
		  ○ Percutaneous Image-Guided Lumbar Decompression (PILD)
		  ○ Posterior Lumbar Spine Surgery
		  ○ Sacroplasty
		Supporting Information
		• Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect the most current information

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Screening Colonoscopy Procedures – Site of Service	Mar. 1, 2026	**Applicable Codes** • Added ICD-10 diagnosis codes Z15.060 and Z15.068
Transcranial Magnetic Stimulation for Treating Physical Health Conditions	Feb. 1, 2026	**Title Change** • Previously titled *Transcranial Magnetic Stimulation* **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect the most current information

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation	Mar. 1, 2026	**Coverage Rationale** • Revised list of unproven and not medically necessary indications; replaced "pulsed electrical stimulation (PES)" with "*pulsed electromagnetic field stimulation (PEMF)* [*also known as* pulsed electrical stimulation (PES)] **Medical Records Documentation Used for Reviews** • Updated list of Medical Records Documentation Used for Reviews: ***Functional Neuromuscular Stimulation (FES)*** ○ Added "physician treatment plan" ○ Replaced: ▪ "*Date of spinal cord* injury *and/or restorative* surgery" with "*prior relevant* surgery(ies) *and history of condition*	**Transcutaneous electrical nerve stimulator (TENS) is proven and medically necessary in certain circumstances.** For medical necessity clinical coverage criteria, refer to the InterQual® CP: Durable Medical Equipment, Transcutaneous Electrical Nerve Stimulation (TENS). Click here to view the InterQual® criteria. **Functional electrical stimulation (FES) is proven and medically necessary as a component of a comprehensive ambulation rehabilitation program in individuals with lower limb paralysis due to spinal cord injury (SCI) when all the following criteria are met:** • Demonstration of intact lower motor units (L1 and below) (both muscle and peripheral nerves) • Muscle and joint stability for weight-bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright support posture independently • Demonstration of brisk muscle contraction • Demonstration of sensory perception sufficient for muscle contraction • Demonstration of a high level of motivation, commitment, and cognitive ability for device use • Ability to transfer independently • Demonstration of independent standing tolerance for at least 3 minutes • Demonstration of hand and finger function to manipulate controls • Post recovery from SCI and restorative surgery of at least 6 months

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Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation (continued)	Mar. 1, 2026	*requiring procedure, including* dates of injury/surgery”” ▪ “Transfer ability and independent standing tolerance” with “independent transfer ability and standing tolerance” ▪ “Absence of hip and knee degenerative disease” with “*presence or* absence of hip and knee degenerative disease” ▪ “Absence of history of long bone fracture secondary to osteoporosis” with “*presence or* absence of history of long bone fracture secondary to osteoporosis” ▪ “*High level of* motivation, commitment, and cognitive ability for device use” with “*member’s* motivation level, commitment, and cognitive ability for device use” ***Neuromuscular Electrical Stimulators (NMES)*** ○ Added: ▪ Specific device being requested and if request is for initial trial, on-going	• Absence of hip and knee degenerative disease • Absence of history of long bone fracture secondary to osteoporosis **FES is unproven and not medically necessary due to insufficient evidence of efficacy for treating any other indication not listed above.** **Neuromuscular electrical stimulation (NMES) is proven and medically necessary for treating any of the following indications:** • Disuse muscle atrophy if: ○ The nerve supply to the muscle is intact; and ○ The disuse muscle atrophy is not of neurological origin but results from other conditions, such as casting, splinting, or contractures or • When used as part of a comprehensive lower limb rehabilitation program following total knee arthroplasty; or • To improve upper extremity function in persons with partial paralysis following stroke when used as part of a comprehensive rehabilitation program **NMES is unproven and not medically necessary due to insufficient evidence of efficacy for treating any condition not meeting the criteria above.** **The following are unproven and not medically necessary due to insufficient evidence of efficacy:** • Interferential therapy (IFT) for treating musculoskeletal disorders/injuries or to facilitate healing of nonsurgical soft tissue injuries or bone fractures • Microcurrent electrical nerve stimulation (MENS) • Percutaneous electrical nerve stimulation (PENS) or percutaneous neuromodulation therapy (PNT) • Percutaneous electrical nerve field stimulation (PENFS) • Percutaneous peripheral nerve stimulation (PNS)* • Peripheral subcutaneous field stimulation (PSFS) or peripheral nerve field stimulation (PNFS) • Pulsed electromagnetic field stimulation (PEMF) [also known as pulsed electrical stimulation (PES)] • Restorative neurostimulation

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Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation (continued)	Mar. 1, 2026	application, or replacement ▪ Comorbidities ○ Removed "current prescription from physician" ○ Replaced: ▪ "Diagnoses *for the* condition(s) *needing* treatment" with "diagnosis *and history of* condition *requiring* treatment" ▪ "*Clinical notes including history,* physical exam, and *laboratory* testing" with "*relevant* physician exam *and results of all recent relevant imaging and diagnostic* testing" ***Transcutaneous Electrical Nerve Stimulation (TENS)*** ○ Added: ▪ Condition requiring treatment ▪ Specific device being requested and if request is for initial trial, on-going application, or replacement ▪ Physician treatment plan ▪ For replacement, also include current device used and reason for replacement **Applicable Codes** • Added CPT code 64567 • Removed CPT code 0720T	• Scrambler therapy • Translingual stimulation for gait rehabilitation *For information regarding percutaneous peripheral nerve stimulation for occipital neuralgia and headache, refer to the Medical Policy titled Occipital Nerve Injections and Ablation (Including Occipital Neuralgia and Headache). **Note**: For information regarding dorsal root ganglion (DRG) stimulation, refer to the Medical Policy titled Implanted Electrical Stimulator for the Spinal Cord.

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Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation (continued)	Mar. 1, 2026	**Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	
Gender Dysphoria Treatment	Apr. 1, 2026	**Application** • Added language to indicate this Medical Policy does not apply to the states of **Florida** and **New Mexico**; refer to the member specific benefit plan document **Coverage Rationale** • Replaced language indicating: ○ "Surgical treatment for Gender Dysphoria may be indicated for individuals who provide the [listed] documentation" with "surgical treatment for Gender Dysphoria may be indicated for individuals who provide documentation *that the individual meets all of the* [listed] *criteria*" ○ "The [listed] surgical procedures and/or therapies to treat Gender Dysphoria are medically necessary and covered as a *proven* benefit when the criteria in the policy are met" with "the [listed] surgical procedures and/or therapies to treat Gender Dysphoria are medically necessary and covered as a benefit when the criteria in the policy are met"	**Note**: This Medical Policy does not apply to individuals with ambiguous genitalia or disorders of sexual development. **Surgical treatment for Gender Dysphoria may be indicated for individuals who provide documentation that the individual meets all of the following criteria:** • Persistent, well-documented Gender Dysphoria; and • Capacity to make a fully informed decision and to consent for treatment; and • Must be at least 18 years of age; and • Favorable psychosocial-behavioral evaluation including screening and identification of risk factors or potential postoperative challenges **For breast surgery** (mastectomy, breast reduction, or breast augmentation), in addition to the above criteria, a written clinical assessment from at least one Qualified Healthcare Professional experienced in treating Gender Dysphoria is required; the assessment must document that an individual meets the following criteria: • For breast augmentation, continued Gender Dysphoria following the completion of 12 months of continuous hormone therapy prior to the breast procedure is required **For thyroid cartilage reduction and/or voice modification surgery** (e.g., laryngoplasty, glottoplasty, or shortening of the vocal cords), in addition to the above criteria, a written clinical assessment from at least one Qualified Healthcare Professional experienced in treating Gender Dysphoria is required; the assessment must document that an individual meets **all** of the following criteria: • Completion of 6 months of continuous hormone therapy prior to surgery is required for voice masculinization • For voice modification surgery, documentation of presurgical voice lessons and/or therapy

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Gender Dysphoria Treatment (continued)	Apr. 1, 2026	• Revised coverage criteria for breast surgery (mastectomy, breast reduction, or breast augmentation); replaced criterion requiring "*for mastectomy or breast reduction,* individuals must be at least 18 years of age*, however, individuals within one calendar year of turning 18 can be considered on a case-by-case basis*" with "individuals must be at least 18 years of age" • Revised list of examples of ancillary procedures that are considered cosmetic and not medically necessary when performed as part of surgical treatment for Gender Dysphoria: ○ Added: ▪ Clavicular shortening ▪ Rib reconstruction ○ Replaced: ▪ "Facial bone remodeling *for facial feminization*" with "facial bone remodeling" ▪ "Pectoral implants *for chest masculinization*" with "pectoral implants" **Medical Records Documentation Used for Reviews** • Updated list of Medical Records Documentation Used for Reviews; replaced "results of psychosocial-behavioral evaluation including management	**For genital surgery**, in addition to the above criteria, a written clinical assessment from at least two Qualified Healthcare Professional experienced in treating Gender Dysphoria, who have independently assessed the individual, is required; the assessment must document that an individual meets **all** of the following criteria: • Complete at least 12 months of successful continuous full-time real-life involvement in the identified gender • Complete 12 months of continuous hormone therapy appropriate for the experienced gender (unless medically contraindicated or not indicated for gender) • Treatment plan that includes ongoing follow-up and care by a Qualified Healthcare Professional experienced in treating Gender Dysphoria **When the above criteria are met, the following surgical procedures and/or therapies to treat Gender Dysphoria are medically necessary and covered as a benefit:** • Bilateral mastectomy or breast reduction • Breast augmentation with breast implants or fat transfer • Clitoroplasty (creation of clitoris) • Hysterectomy (removal of uterus) • Labiaplasty (creation of labia) • Laser or electrolysis hair removal in advance of genital reconstruction prescribed by a physician for the treatment of Gender Dysphoria • Metoidioplasty (creation of penis, using clitoris) • Orchiectomy (removal of testicles) • Penectomy (removal of penis) • Penile prosthesis • Phalloplasty (creation of penis) • Salpingo-oophorectomy (removal of fallopian tubes and ovaries) • Scrotoplasty (creation of scrotum) • Testicular prostheses • Thyroid cartilage reduction/reduction thyroid chondroplasty/tracheal shave (removal or reduction of the Adam's apple) • Urethroplasty (reconstruction of female urethra) • Urethroplasty (reconstruction of male urethra) • Vaginectomy (removal of vagina)

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Gender Dysphoria Treatment (continued)	Apr. 1, 2026	of coexisting mental health condition" with "*date and* results of psychosocial-behavioral evaluation including management of coexisting mental health condition" **Benefit Considerations** • Updated list of examples of non-covered treatments/services; removed "reproduction services including but not limited to sperm preservation in advance of hormone treatment or Gender Dysphoria surgery, cryopreservation of fertilized embryos, oocyte preservation, surrogate parenting, donor eggs, donor sperm, and host uterus" • Added language for *Fully-Insured Group Policies in New York Only* to indicate: ○ In accordance with the requirements of New York Insurance Law, Section 4902 and the New York State Office of Mental Health (OMH) Memorandum: *Clinical Review Criteria for the Treatment of Gender Dysphoria: New Standards of Care for Transgender Health*, dated May 14, 2024: ▪ Health maintenance organizations and health insurers must apply utilization review criteria consistent with version 8	• Vaginoplasty (creation of vagina) • Voice lessons and/or voice therapy (with or without surgery) • Voice modification surgery (e.g., laryngoplasty, glottoplasty, or shortening of the vocal cords) • Vulvectomy (removal of vulva) **Gender affirming surgery is considered an irreversible intervention. Although infrequent, reversal of prior gender affirming surgery may be covered when the medical necessity criteria for the requested treatment above are met.** **Certain ancillary procedures, including but not limited to the following, are considered cosmetic and not medically necessary when performed as part of surgical treatment for Gender Dysphoria:** Refer to the *Benefit Considerations* section of the policy as member specific benefit plan language may vary. **Note**: For fully insured group policies in New York, refer to the *Benefit Considerations* section of the policy for more information. • Abdominoplasty (also refer to the Medical Policy titled Panniculectomy Surgery) • Blepharoplasty (also refer to the Medical Policy titled Brow Ptosis and Eyelid Repair) • Body contouring (e.g., fat transfer, lipoplasty, panniculectomy) (also refer to the Medical Policy titled Panniculectomy Surgery) • Brow lift • Calf implants • Cheek, chin, and nose implants • Clavicular shortening • Injection of fillers or neurotoxins (also refer to the Medical Benefit Drug Policy titled Botulinum Toxins A and B) • Face/forehead lift and/or neck tightening • Facial bone remodeling • Laser or electrolysis hair removal not related to genital reconstruction • Hair transplantation • Lip augmentation • Lip reduction

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Gender Dysphoria Treatment (continued)	Apr. 1, 2026	of the World Professional Association for Transgender Health (WPATH) Standards of Care when conducting utilization review of treatment for Gender Dysphoria ▪ Accordingly, for fully-insured plans in New York, coverage for medically necessary treatment of gender dysphoria is based on version 8 of the WPATH Standards of Care for the Health of Transgender and Gender Diverse People ○ The criteria in the *Coverage Rationale* section of this policy is applicable only to the degree that it does not conflict with version 8 of the WPATH Standards of Care **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information	• Liposuction (suction-assisted lipectomy) (also refer to the Medical Policy titled Panniculectomy Surgery) • Mastopexy • Pectoral implants • Rhinoplasty (also refer to the Medical Policy titled Rhinoplasty and Other Nasal Procedures) • Rib reconstruction • Skin resurfacing (e.g., dermabrasion, chemical peels, laser)
Genetic Testing for Hereditary Cancer	Apr. 1, 2026	**Coverage Rationale** ***Individuals With a Personal History of a Primary Solid Tumor*** • Revised coverage criteria for genetic testing with a Multigene hereditary cancer Panel for individuals with a personal history	Pretest genetic counseling is strongly recommended to inform persons being tested about the advantages and limitations of the test, as applied to a unique person. **Single-gene testing and known mutation testing for familial cancer are proven and medically necessary.**

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Genetic Testing for Hereditary Cancer (continued)	Apr. 1, 2026	of a Primary Solid Tumor (excluding basal or squamous cell skin cancer): ○ Added criterion requiring the: ▪ Individual has serous tubal intraepithelial carcinoma ▪ Individual has renal cell carcinoma and any of the following: – Diagnosed at 46 years of age or younger – Diagnosed at any age with bilateral or multifocal tumors – Has one or more first- or second-degree relatives with renal cell carcinoma – Has a personal or family history of mesothelioma or uveal melanoma ▪ Individual has renal cell carcinoma and tumors have the following histological characteristics: – Multifocal papillary histology – Hereditary leiomyomatosis and renal cell cancer-associated renal cell carcinoma, renal cell carcinoma with	**Individuals With a Personal History of a Primary Solid Tumor** ***BRCA1/2* gene testing is proven and medically necessary for individuals with a personal history of Breast Cancer diagnosed at age 65 years or younger.** **Genetic testing with a Multigene hereditary cancer Panel for individuals with a personal history of a Primary Solid Tumor (excluding basal or squamous cell skin cancer) is proven and medically necessary when at least one of the following criteria is met:** • Individual has a personal history of at least one of the following: ○ Breast Cancer diagnosed at age 50 years or younger ○ Metastatic Breast Cancer ○ Multiple primary Breast Cancers (as a prior diagnosis or as a bilateral primary cancer) ○ Triple-Negative Breast Cancer ○ Lobular Breast Cancer and a personal or family history of diffuse gastric cancer ○ Breast Cancer and Ashkenazi Jewish ancestry ○ Breast Cancer and individual was assigned male at birth ○ Breast Cancer and unknown or Limited Family History ○ Breast Cancer or prostate cancer and at least one first- or second-degree relative with a BRCA-Related Cancer ○ Ovarian Cancer (including fallopian tube cancer, primary peritoneal cancer, sex-cord tumors with annular tubules, and/or hypercalcemic-type small cell carcinoma of the ovary) ○ Serous tubal intraepithelial carcinoma ○ Pancreatic cancer ○ Metastatic prostate cancer ○ Lynch Syndrome-Associated Cancer ○ Neuroendocrine tumor (e.g., adrenocortical carcinoma, paraganglioma, pheochromocytoma) ○ Malignant phyllodes tumors ○ Renal cell carcinoma and any of the following: ▪ Diagnosed at 46 years of age or younger ▪ Diagnosed at any age with bilateral or multifocal tumors

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Genetic Testing for Hereditary Cancer (continued)	Apr. 1, 2026	fumarate hydratase deficiency or other histological features associated with hereditary leiomyomatosis and renal cell cancer – Birt-Hogg-Dubé syndrome-related histology – Angiomyolipomas of the kidney and one additional tuberous sclerosis complex criterion in the same individual – Succinate dehydrogenase-deficient renal cell carcinoma histology ○ Replaced criterion requiring the "individual has a Tyrer-Cuzick, BRCAPro, or *PENN11* score of 2.5% or greater for a BRCA1/2 pathogenic variant" with "individual has a Tyrer-Cuzick, BRCAPRO, or *CanRisk* score of 2.5% or greater for a BRCA1/2 pathogenic variant" ○ Revised list of examples of Ovarian Cancer; added "sex cord tumors with annular tubules and/or hypercalcemic-type small cell carcinoma of the ovary"	▪ Has one or more first- or second-degree relatives with renal cell carcinoma ▪ Has a personal or family history of mesothelioma or uveal melanoma ○ At least two different Primary Solid Tumors (excluding basal or squamous cell skin cancer) or • Individual has a personal history of a Primary Solid Tumor (excluding basal or squamous cell skin cancer) and a family history of cancer, which includes at least one of the following: ○ At least one Close Blood Relative with a history of a Lynch Syndrome-Associated Cancer ○ At least one Close Blood Relative diagnosed with a Primary Solid Tumor (excluding basal or squamous cell skin cancer) at age 40 years or younger ○ At least two Close Blood Relatives (in addition to affected individual) on the same side of the family diagnosed with any Primary Solid Tumor (excluding basal or squamous cell skin cancer) or • Individual has a personal history of a Primary Solid Tumor (excluding basal or squamous cell skin cancer) and at least one of the following: ○ A pathogenic variant was detected in tumor tissue that has clinical implications if detected in the germline (e.g., *BRCA1, BRCA2, BRIP1, MLH1, MSH2, MSH6, MUTYH, PALB2, PMS2, RAD51C, RAD51D, RET, SDHAF2, SDHB, SDHC, SDHD, TMEM127, TSC2, VHL APC, PTEN, RB1, TP53*) ○ Tumor tissue testing demonstrated that the cancer was microsatellite instability high or had immunohistochemical staining showing the absence of one or more mismatch repair proteins (*MLH1, MSH2, MSH6,* or *PMS2*) ○ Individual has renal cell carcinoma and tumors have the following histological characteristics: ▪ Multifocal papillary histology ▪ Hereditary leiomyomatosis and renal cell cancer-associated renal cell carcinoma, renal cell carcinoma with fumarate hydratase deficiency or other histological features associated with hereditary leiomyomatosis and renal cell cancer

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Genetic Testing for Hereditary Cancer (continued)	Apr. 1, 2026	***Individuals With No Personal History of a Primary Solid Tumor*** • Added language to indicate whole-exome and whole-genome sequencing for the purpose of identifying hereditary cancer syndromes or hereditary cancer syndrome risk is unproven and not medically necessary • Revised coverage criteria for genetic testing with a Multigene hereditary cancer Panel or testing of *BRCA1/2* for individuals with no personal history of a Primary Solid Tumor (excluding basal or squamous cell skin cancer): ○ Added criterion requiring the individual's family history includes: ▪ Two or more first- or second-degree relatives on the same side of the family with renal cell carcinoma ▪ A first-degree relative meeting criteria for genetic evaluation for renal cell carcinoma but is unwilling/unable to have genetic testing ○ Replaced criterion requiring the "individual has a Tyrer-Cuzick, BRCAPro, or *PENN11* score of 5% or greater for a BRCA1/2 pathogenic variant" with	▪ Birt-Hogg-Dubé syndrome–related histology ▪ Angiomyolipomas of the kidney and one additional tuberous sclerosis complex criterion in the same individual ▪ Succinate dehydrogenase–deficient renal cell carcinoma histology ○ Individual has a Tyrer-Cuzick, BRCAPRO, or CanRisk score of 2.5% or greater for a *BRCA1/2* pathogenic variant ○ Individual has a PREMM$_5$, MMRpro, or MMRpredict score of 2.5% or greater for having a Lynch syndrome gene mutation **Individuals With No Personal History of a Primary Solid Tumor** **Genetic testing with a Multigene hereditary cancer Panel or testing of *BRCA1/2* for individuals with no personal history of a Primary Solid Tumor (excluding basal or squamous cell skin cancer) is proven and medically necessary if at least one of the following criteria is met:** • At least one first-degree relative with a history of at least one of the following: ○ Two or more different Primary Solid Tumors (excluding basal or squamous cell skin cancer) ○ Lynch Syndrome-Associated Cancer ○ Neuroendocrine tumor (e.g., adrenocortical carcinoma, paraganglioma, pheochromocytoma) or • At least one first- or second-degree relative with a history of at least one of the following: ○ Breast Cancer diagnosed at age 50 years or younger ○ Triple-Negative Breast Cancer ○ Breast Cancer and relative was assigned male at birth ○ Metastatic prostate cancer ○ Ovarian Cancer (including fallopian tube cancer and/or primary peritoneal cancer) ○ Pancreatic cancer or • At least one second-degree relative with a history of at least one of the following: ○ Two or more Lynch Syndrome-Associated Cancers

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Genetic Testing for Hereditary Cancer (continued)	Apr. 1, 2026	"individual has a Tyrer-Cuzick, BRCAPRO, or *CanRisk* score of 5% or greater for a BRCA1/2 pathogenic variant" **Definitions** • Removed definition of: ○ High Penetrance Breast Cancer Susceptibility Genes ○ Penetrance • Updated definition of: ○ BRCA-Related Cancers ○ Lynch Syndrome-Associated Cancer ○ Ovarian Cancer ○ PREMM$_5$ **Applicable Codes** ***Whole Exome and Whole Genome Sequencing*** • Added CPT codes 0212U, 0213U, 0214U, 0215U, 0265U, 0266U, 81415, 81416, 81417, 81425, 81426, and 81427 **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect the most current information	○ Lynch Syndrome-Associated Cancer diagnosed at age 50 years or younger or • Family history includes at least one of the following: ○ Two or more second-degree relatives on the same side of the family with a Lynch Syndrome-Associated Cancer ○ Two or more first- or second-degree relatives on the same side of the family with renal cell carcinoma ○ At least three Close Blood Relatives on the same side of the family diagnosed with any Primary Solid Tumor (excluding basal or squamous cell skin cancer) ○ Ashkenazi Jewish ancestry and at least one Close Blood Relative with a BRCA-Related Cancer ○ Family member who meets diagnostic criteria (personal history of at least 10 cumulative adenomas) for a polyposis syndrome and affected family member(s) is unwilling/unable to have genetic testing ○ First-degree relative meeting criteria for genetic evaluation for renal cell carcinoma but is unwilling/unable to have genetic testing or • A personal history of colorectal polyposis with at least 10 adenomas; or • Any of the following: ○ Individual has a Tyrer-Cuzick, BRCAPRO, or CanRisk score of 5% or greater for a *BRCA1/2* pathogenic variant; or ○ Individual has a PREMM$_5$, MMRpro, or MMRpredict score of 5% or greater for having a Lynch syndrome gene mutation **Genetic testing with a Multigene hereditary cancer Panel for individuals diagnosed with cancer at age 18 years or younger is proven and medically necessary.** **Multigene hereditary cancer Panels are unproven and not medically necessary for all other indications.** **RNA panel testing for hereditary cancers is unproven and not medically necessary for all indications.** **Genetic testing for the purpose of polygenic risk scoring for hereditary**

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Genetic Testing for Hereditary Cancer (continued)	Apr. 1, 2026		**cancers is unproven and not medically necessary for all indications.** **Whole-exome and whole-genome sequencing for the purpose of identifying hereditary cancer syndromes or hereditary cancer syndrome risk is unproven and not medically necessary.**
Intensity-Modulated Radiation Therapy	Mar. 1, 2026	**Coverage Rationale** • Revised list of conditions for which **Intensity-Modulated Radiation Therapy (IMRT) for Definitive Therapy** for the primary site is proven and medically necessary: ○ Replaced "breast cancer *in* the [listed] *circumstances*" with "breast cancer *when any of* the [listed] *criteria are met*" ○ Added: ▪ Hepatocellular carcinoma, unresectable ▪ Hodgkin lymphoma ▪ Intrahepatic cholangiocarcinoma, unresectable ▪ Rectal cancer when treatment involves inguinal lymph nodes ▪ Small cell lung cancer, limited stage ▪ Soft tissue sarcoma, retroperitoneal/intra-abdominal location ▪ Stage I to II non-small cell lung cancer undergoing hypofractionated radiation therapy up to 10 fractions	**Note**: This policy applies to individuals 19 years of age or older. Intensity-modulated radiation therapy (IMRT) is covered without further review for individuals younger than 19 years of age. **The following are proven and medically necessary:** • IMRT for Definitive Therapy for the primary site of the following conditions: ○ Anus/anal canal cancer ○ Breast cancer when any of the following criteria are met: ▪ When the left-sided internal mammary nodes are being treated; or ▪ Accelerated partial-breast irradiation of up to five fractions ○ Central nervous system tumors (primary or benign), including the brain, brainstem, and spinal cord ○ Cervical cancer ○ Endometrial cancer ○ Esophageal cancer ○ Head and neck cancers, including lymphoma and solitary plasmacytomas, when treatment includes the following areas: pharynx (nasopharynx, oropharynx, and hypopharynx), larynx, salivary glands, oral cavity (includes the tongue), nasal cavity, and paranasal sinuses ○ Hepatocellular carcinoma, unresectable ○ Intrahepatic cholangiocarcinoma, unresectable ○ Hodgkin lymphoma ○ Mediastinal tumors (e.g., lymphomas, thyroid, thymomas, tracheal cancer) ○ Non-small cell lung cancer when any of the following criteria are met: ▪ Stage I to II undergoing hypofractionated radiation therapy up to 10 fractions; or ▪ Stage III, undergoing chemoradiation therapy ○ Pancreatic cancer

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Intensity-Modulated Radiation Therapy (continued)	Mar. 1, 2026	○ Revised list of treatment areas for head and neck cancers; replaced "larynx *(stage III or IV cancer)*" with "larynx" ○ Revised list of examples of mediastinal tumors; added "thyroid" • Removed language indicating compensator based beam modulation treatment is proven and medically necessary when done in combination with an IMRT indication listed [in the policy] as proven • Replaced language indicating: ○ "Hippocampal-avoidance whole brain radiation therapy of up to 10 fraction is proven and medically necessary [when] all the [listed criteria are met]" with "hippocampal-avoidance whole brain radiation therapy of up to 10 fractions is *considered* proven and medically necessary when all the [listed] criteria are met" ○ "IMRT may be *covered* for a condition that is not *listed* [in the policy] *as proven*, including recurrences or metastases in selected cases" with "IMRT may be *considered medically necessary* for a condition that is not *defined* [as proven and	○ Prostate cancer ○ Rectal cancer when treatment involves inguinal lymph nodes ○ Small cell lung cancer, limited stage ○ Soft tissue sarcoma, retroperitoneal/intra-abdominal location ○ Vulvar cancer • Hippocampal-avoidance whole-brain radiation therapy of up to 10 fractions is considered proven and medically necessary when all the following criteria are met: ○ Brain metastasis; and ○ Eastern Cooperative Oncology Group performance status of ≤ 2 or Karnofsky performance status of ≥ 70; and ○ Prognosis of 4 months or greater; and ○ Absence of leptomeningeal disease • IMRT may be considered medically necessary for a condition that is not defined above, including recurrences or metastases in selected cases. Requests for an exception will be evaluated on a case-by-case basis when at least one of the following conditions is present: ○ Use of clinically appropriate radiation dose and a non-IMRT technique would increase the probability of clinically meaningful normal tissue toxicity (i.e., as specified by the Radiation Therapy Oncology Group or QUANTEC guidelines) and is demonstrated on a comparison of treatment plans for the IMRT and non-IMRT technique (e.g., 3D conformal treatment plan) ○ The same or an immediately adjacent area has been previously irradiated, and the dose distribution in the individual must be sculpted to avoid exceeding the cumulative tolerance dose of nearby normal tissue **The following is unproven and not medically necessary due to insufficient evidence of efficacy:** • IMRT used in conjunction with proton beam radiation therapy

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Intensity-Modulated Radiation Therapy (continued)	Mar. 1, 2026	medically necessary in the policy], including recurrences or metastases in selected cases" **Definitions** • Updated definition of "Definitive Therapy" **Applicable Codes** • Added notation to indicate: ○ Standard single-isocenter IMRT or VMAT should be billed under CPT code 77407 (radiation treatment delivery, intermediate) ○ CPT code 77412 (radiation treatment delivery, complex) should be used for treatments that require multiple isocenters or single-isocenter delivery with active motion-management techniques; when CPT code 77412 is reported, documentation must clearly describe the circumstances that justify level 3 rather than level 2 treatment delivery **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information	
Obstructive and Central Sleep Apnea Treatment	Apr. 1, 2026	**Coverage Rationale** ***Obstructive Sleep Apnea*** Diagnosis of Obstructive Sleep Apnea for Nonsurgical or Surgical Treatment	**Obstructive Sleep Apnea** ***Diagnosis of Obstructive Sleep Apnea for Non-Surgical or Surgical Treatment*** • An individual presenting with symptoms of Obstructive Sleep Apnea (OSA) has been seen for an evaluation (in person or via telemedicine)

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Obstructive and Central Sleep Apnea Treatment (continued)	Apr. 1, 2026	• Added language to indicate the diagnosis of Obstructive Sleep Apnea (OSA) for nonsurgical and surgical treatment requires: ○ An individual presenting with symptoms of OSA has been seen for an evaluation (in person or via telemedicine) with a qualified physician or with an Advanced Practice Provider working under the direct supervision of a physician prior to beginning treatment ○ A qualified physician or an Advanced Practice Provider working under the direct supervision of a physician will diagnose OSA and recommend the course of treatment Nonsurgical Treatment • Replaced language indicating: ○ "Removable Oral Appliances are proven and medically necessary for treating OSA as documented by a steep study *(e.g., Polysomnography* or Home Sleep Apnea Testing)" with "Removable Oral Appliances are proven and medically necessary for treating OSA *meeting the diagnosis requirements [listed in the policy] and which has been* documented by a sleep study [e.g., *Polysomnography*	with a qualified physician or with an Advanced Practice Provider working under the direct supervision of a physician prior to beginning treatment • A qualified physician or an Advanced Practice Provider working under the direct supervision of a physician will diagnose OSA and recommend the course of treatment ***Nonsurgical Treatment*** **Removable Oral Appliances are proven and medically necessary for treating OSA meeting the diagnosis requirements above and which has been documented by a sleep study (e.g., Polysomnography (Attended), Home Sleep Apnea Testing).** Refer to the Medical Policy titled Sleep Studies for further information. Oral Appliance therapy may be an effective alternative to failed Positive Airway Pressure (PAP) therapy. Documentation from the individual's treating physician or Advanced Practice Provider that PAP therapy resulted in no therapeutic efficacy, or an individual is intolerant or has refused is required. For medical necessity clinical coverage criteria for removable Oral Appliances, refer to the InterQual® CP: Durable Medical Equipment, Noninvasive Airway Assistive Devices. Click here to view the InterQual® criteria. ***Other Nonsurgical Procedures*** **The following are unproven and not medically necessary due to insufficient evidence of efficacy:** • Devices for treating Positional OSA • Nasal dilator devices for treating OSA • Intranasal expiratory resistance valve (e.g., Bongo Rx) • Prefabricated Oral Appliance/device • Nonsurgical electrical muscular training • Mandibular vertical repositioning devices (e.g., Slow Wave) • Morning repositioning devices • Epigenetic appliances [e.g., Homeoblock™, DNA® (Daytime/Nighttime appliance)]

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Obstructive and Central Sleep Apnea Treatment (continued)	Apr. 1, 2026	*(Attended)* or Home Sleep Apnea Testing]" ○ "Oral Appliance therapy (OAT) may be an effective alternative to failed Positive Airway Pressure (PAP) therapy *for many individuals*" with "Oral Appliance Therapy (OAT) may be an effective alternative to failed Positive Airway Pressure (PAP) therapy" • Revised language pertaining to documentation requirements to indicate documentation that PAP therapy resulted in no therapeutic efficacy or an individual is intolerant or has refused is required • Removed reference link to the Medical Policy titled *Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/Replacements* for information on snoring and Oral Appliances Surgical Treatment • Revised coverage criteria for: *Uvulopalatopharyngoplasty (UPPP), Mandibular Osteotomy (MO), and Maxillomandibular Osteotomy and Advancement (MMA) in an Adult Individual* ○ Replaced criterion requiring "individual has moderate to	• Advanced Lightwire Functional appliances ***Surgical Treatment*** **Uvulopalatopharyngoplasty, mandibular osteotomy, and maxillomandibular osteotomy and advancement (MMA) are proven and medically necessary in an adult individual when all the following criteria are met:** • Moderate to severe OSA meeting the diagnosis requirements above [Apnea-Hypopnea Index (AHI) ≥ 15 or Respiratory Disturbance Index ≥ 15], as determined by Polysomnography (Attended)* • Excessive daytime sleepiness documented with an Epworth Sleepiness Scale of > 10 or with another validated tool • PAP therapy resulted in no therapeutic efficacy or individual's refusal or intolerance In addition, the following criteria need to be met: • For MMA, craniofacial disproportion or deformities with evidence of maxillomandibular deficiency • For mandibular osteotomy, retrolingual or lower pharyngeal function obstruction **Implantable hypoglossal nerve stimulation with a US Food and Drug Administration (FDA)-approved device is proven and medically necessary in an adult individual with moderate to severe OSA meeting the diagnosis requirements above when all the following criteria are met:** • Body Mass Index of ≤ 40 kg/m^2; and • AHI of ≥ 15 and ≤ 100, as determined by Polysomnography (Attended)*; and • Total AHI of < 25% for central and mixed Apneas, as evaluated by attended polysomnography; and • Absence of a complete blockage or complete concentric collapse of the soft palate, confirmed by drug-induced sleep endoscopy; and • PAP therapy resulted in no therapeutic efficacy or individual's refusal or intolerance; and • Used in accordance with FDA guidelines

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Obstructive and Central Sleep Apnea Treatment (continued)	Apr. 1, 2026	severe OSA Apnea Hypopnea Index (AHI) ≥ 15 or Respiratory Disturbance Index (RDI) ≥ 15 as determined by Polysomnography (Attended)" with "individual has moderate to severe OSA *meeting the diagnosis requirements [listed in the policy]* [Apnea Hypopnea Index (AHI) ≥ 15 or Respiratory Disturbance Index ≥ 15] as determined by Polysomnography (Attended)" *Implantable Hypoglossal Nerve Stimulation With an FDA-Approved Device in Adolescents Aged 10 to 18 Years With Down Syndrome* ○ Replaced criterion requiring: ▪ "Diagnosis of severe OSA [as determined by *Polysomnography* (Attended) and an AHI ≥ 10 and Respiratory Disturbance Index ≤ 50 events per hour]" with "diagnosis of severe OSA *meeting the diagnosis requirements [listed in the policy]* [as determined by *Polysomnogram* (Attended) and an AHI ≥ 10 and Respiratory Disturbance Index ≤ 50 events per hour]"	**Implantable hypoglossal nerve stimulation with an FDA-approved device is proven and medically necessary in adolescents aged 10 to 18 years with Down syndrome when all the following criteria are met:** • Diagnosis of severe OSA meeting the diagnosis requirements above and [as determined by a Polysomnogram (Attended)* and an AHI ≥ 10 and Respiratory Disturbance Index ≤ 50 events per hour]; and • Body Mass Index of < 95th percentile for age; and • Total AHI of < 25% for central and mixed Apneas; and • Contraindication for or not effectively treated with a prior adenotonsillectomy; and • Confirmed failure or intolerance of PAP therapy, despite attempts to improve adherence; and • Absence of tracheostomy use during sleep; and • Absence of a complete blockage or concentric collapse of the soft palate level, confirmed by drug-induced sleep endoscopy; and • Individual and caregiver refusal of an MMA procedure for nonconcentric palatal collapse; and • Used in accordance with FDA guidelines *Polysomnography should be repeated if there has been clinically significant weight loss or gain, changes in cardiovascular disease, or persistent or recurrent symptoms since the last study (Caples et al., 2021). ***Other Surgical Procedures*** **The following surgical procedures are unproven and not medically necessary for treating OSA due to insufficient evidence of efficacy (not an all-inclusive list):** • Lingual suspension – also referred to as tongue stabilization, tongue stitch, and tongue fixation • Isolated hyoid myotomy • Stand-alone uvulectomy • Transoral robotic surgery • Distraction osteogenesis for maxillary expansion **Central Sleep Apnea** **Implantable phrenic nerve stimulation devices (e.g., the remedē®**

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Obstructive and Central Sleep Apnea Treatment (continued)	Apr. 1, 2026	▪ "Confirmed failure or intolerance of PAP therapy, despite attempts to improve *compliance*" with "confirmed failure or intolerance of PAP therapy, despite attempts to improve *adherence*" • Replaced language indicating "implantable hypoglossal nerve stimulation with a U.S. Food and Drug Administration (FDA) approved device is proven and medically necessary in an adult *patient* with moderate to severe OSA when all the [listed] criteria are met" with "implantable hypoglossal nerve stimulation with a U.S. Food and Drug Administration (FDA) approved device is proven and medically necessary in an adult *individual* with moderate to severe OSA *meeting the diagnosis requirements [listed in the policy]* when all the [listed] criteria are met" Other Surgical Procedures • Revised list of unproven and not medically necessary procedures; removed: ○ Laser-assisted uvulopalatoplasty (LAUP) ○ Palatal implants ○ Radiofrequency ablation of the soft palate and/or tongue base	**System) for the treatment of Central Sleep Apnea are unproven and not medically necessary due to insufficient evidence of safety and/or efficacy.** **Removable Oral Appliances for treating Central Sleep Apnea are unproven and not medically necessary due to insufficient evidence of efficacy.**

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Obstructive and Central Sleep Apnea Treatment (continued)	Apr. 1, 2026	***Central Sleep Apnea*** • Replaced language indicating "implantable *neurostimulation* devices for the treatment of Central Sleep Apnea (CSA) are unproven and not medically necessary due to insufficient evidence of safety and/or efficacy" with "implantable *phrenic nerve* stimulation devices *(e.g., the remedē® System)* for the treatment of Central Sleep Apnea are unproven and not medically necessary due to insufficient evidence of safety and/or efficacy" **Medical Records Documentation Used for Reviews** • Updated list of Medical Records Documentation Used for Reviews: ***Oral Appliances*** ○ Added: ▪ Signs and symptoms ▪ Comorbidities ▪ Physician treatment plan ○ Removed "if the oral appliance is being prescribed for reasons other than OSA, an explanation of why appliance is needed" ○ Replaced "*documentation of most recent face-to-face* evaluation with *prescribing qualified* physician *(MD or*	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Obstructive and Central Sleep Apnea Treatment (continued)	Apr. 1, 2026	*DO) trained in sleep medicine* or an advanced practice provider (APP) under the direct supervision of a *sleep medicine* physician" with "*current* evaluation with a physician or an advanced practice provider (APP) *working* under the direct supervision of a physician" ***Surgical*** ○ Added "current evaluation with a physician or an advanced practice provider (APP) working under the direct supervision of a physician" ○ Replaced: ▪ "Reports of recent *applicable* imaging studies and diagnostic tests (e.g., Epworth Sleepiness Scale)" with "reports of recent *relevant* imaging studies and diagnostic tests (e.g., Epworth Sleepiness Scale)" ▪ "Treatments tried, failed, or contraindicated; include the dates, duration of treatment, and reason for discontinuation; also include if positive airway pressure (PAP) resulted in no therapeutic efficacy	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Obstructive and Central Sleep Apnea Treatment (continued)	Apr. 1, 2026	or patient refusal or intolerance" with "treatments tried, failed, or contraindicated; include the dates, duration of treatment, and reason for discontinuation; also include *documentation* if positive airway pressure (PAP) resulted in no therapeutic efficacy or patient refusal or intolerance, *when applicable*" ▪ "Presence or absence of complete concentric collapse at the soft palate level" with "presence or absence of *complete blockage or* concentric collapse at the soft palate level" **Definitions** • Added definition of "Positive Airway Pressure" • Removed definition of "Sleep Medicine Training" • Updated definition of: ○ Central Sleep Apnea ○ Oral Appliance **Applicable Codes** • Added CPT codes 64568 and 64569 • Removed CPT code 42299 **Supporting Information** • Updated *Description of Services*,	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Obstructive and Central Sleep Apnea Treatment (continued)	Apr. 1, 2026	*Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	

Percutaneous Vertebroplasty and Kyphoplasty	Mar. 1, 2026	**Coverage Rationale**
		• Revised list of examples of causes of spinal pain to be ruled out by computed tomography (CT) or magnetic resonance imaging (MRI); removed:
		  ○ Facet arthropathy
		  ○ Other spinal degenerative disease
		Medical Records Documentation Used for Reviews
		• Updated list of Medical Records Documentation Used for Reviews:
		  ○ Added "condition requiring procedure"
		  ○ Replaced:
		  ▪ "Onset of the condition, *length,* and duration" with "onset of the condition, *including dates* and duration"
		  ▪ "*Documentation of member's* symptoms, pain, location, and severity, including functional impairment that is interfering with activities of daily living *(meals, walking, getting dressed, driving)*" with "*signs and* symptoms,
			Percutaneous vertebroplasty and kyphoplasty are proven and medically necessary for treating pain causing Functional or Physical Impairment in cervical, thoracic, or lumbar vertebral bodies, within 4 months of pain onset, that has failed to respond to Optimal Medical Therapy for the following indications:
			• Osteoporotic vertebral compression fracture (VCF)
			• Steroid-induced vertebral fracture
			• Osteolytic metastatic disease involving a vertebral body
			• Multiple myeloma involving a vertebral body
			• Vertebral Hemangioma with aggressive features
			• Unstable fractures due to Osteonecrosis (e.g., Kummel disease)
			and
			Computed tomography (CT) or magnetic resonance imaging (MRI) has ruled out other causes of spinal pain, including but not limited to:
			• Foraminal stenosis
			• Herniated intervertebral disk
			• Other significant coexistent spinal or bony pain generators
			and
			The following are not present:
			• Clinical evidence of spinal cord compression, as confirmed by CT or MRI; or
			• Significant vertebral collapse or destruction (e.g., vertebra reduced to less than one-third of its original height), as confirmed by CT or MRI; or
			• Healed VCF, as confirmed by CT or MRI; or
			• Lesions of the sacrum or coccyx (refer to the Medical Policy titled Minimally Invasive Spine Surgery Procedures for additional information on percutaneous sacral augmentation); or
			• Asymptomatic VCFs; or
			• VCFs responding appropriately to conservative therapy
			
			Percutaneous vertebroplasty and kyphoplasty are unproven and not medically necessary for treating indications other than those listed

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Percutaneous Vertebroplasty and Kyphoplasty (continued)	Mar. 1, 2026	including pain, location, and severity, and functional impairment that interferes with activities of daily living" ▪ "*History and* comorbid medical condition(s)" with "comorbidities" ▪ "*No* evidence of spinal cord compression" with "*presence or absence of* evidence of spinal cord compression" ▪ "Treatments tried and failed" with "treatments tried, failed, *or contraindicated; include the dates, duration, and reason for discontinuation*" ▪ "*Complete report(s) of diagnostic* imaging *(MRI, CT Scan, X-rays, and/or* bone scan)" with "*results of all recent relevant* imaging, *including assessment of* bone density" **Definitions** • Updated definition of: ○ Functional or Physical Impairment ○ Optimal Medical Therapy **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information	**above due to insufficient evidence of efficacy.**

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Proton Beam Radiation Therapy	Mar. 1, 2026	**Related Policies** • Removed reference link to the Medical Policy titled *Intensity-Modulated Radiation Therapy* **Coverage Rationale** • Revised list of proven and medically necessary indications for proton beam radiation therapy (PBT) for Definitive Therapy: ○ Added: ▪ Primary Head and Neck Cancers [not listed in the policy] when all the following criteria are met: – The tumors are near critical anatomical structures, such as the orbit, skull base, or cavernous sinus or with intracranial extension or perineural invasion – When documentation is provided that sparing of the surrounding normal tissue cannot be achieved with standard photon radiation therapy techniques ▪ Primary Central Nervous System Tumors (e.g., brain or spinal cord) when all the following criteria are met: – The tumors are near	**Note**: This policy applies to individuals 19 years of age and older. Proton beam radiation therapy (PBRT, PBT) is covered without further review for individuals younger than 19 years of age. **Proton beam radiation therapy is proven and medically necessary for the following:** • Definitive Therapy for the following indications: ○ Base of Skull Tumors (e.g., chordomas, chondrosarcomas, paranasal sinus or nasopharyngeal tumors) ○ Primary Head and Neck Cancers (not included above) when all the following criteria are met: ▪ The tumors are near critical anatomical structures, such as the orbit, skull base, or cavernous sinus or with intracranial extension or perineural invasion; and ▪ When documentation is provided that sparing of the surrounding normal tissue cannot be achieved with standard photon radiation therapy techniques ○ Primary Central Nervous System Tumors (e.g., brain or spinal cord) when all the following criteria are met: ▪ The tumors are near critical anatomical structures such as the optic nerve, brainstem, or spinal cord; and ▪ When documentation is provided that sparing of the surrounding normal tissue cannot be achieved with standard photon radiation therapy techniques ○ Intracranial arteriovenous malformations ○ Ocular tumors, including intraocular/uveal melanoma (includes the iris, ciliary body, and choroid) ○ Primary liver malignancies, such as hepatocellular carcinoma and intrahepatic cancer (localized, unresectable) in the curative setting when documentation is provided that sparing of the surrounding normal tissue cannot be achieved with standard radiation therapy techniques, including intensity-modulated radiation therapy (IMRT), stereotactic body radiation therapy, and selective internal radiation spheres, and transarterial therapy (for example, chemoembolization) is contraindicated or not technically feasible ○ Primary mediastinal tumors (e.g., thymomas, mediastinal lymphomas, thoracic sarcomas)

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Proton Beam Radiation Therapy (continued)	Mar. 1, 2026	critical anatomical structures such as the optic nerve, brainstem, or spinal cord – When documentation is provided that sparing of the surrounding normal tissue cannot be achieved with standard photon radiation therapy techniques ▪ Primary mediastinal tumors (e.g., thymomas, mediastinal lymphomas, thoracic sarcomas) ▪ Reirradiation when all the following criteria are met: – Individuals have previously undergone radiation therapy to a specific anatomical site and now require an additional course of radiation to the same specific anatomical site – Documentation is provided that sparing of the surrounding normal tissue cannot be achieved with standard photon radiation therapy techniques	○ Reirradiation when all the following criteria are met: ▪ Individuals have previously undergone radiation therapy to a specific anatomical site and now require an additional course of radiation to the same specific anatomical site; and ▪ Documentation is provided that sparing of the surrounding normal tissue cannot be achieved with standard photon radiation therapy techniques **PBT and IMRT are proven and considered clinically equivalent for treating prostate cancer.** Medical necessity will be determined based on the terms of the member-specific benefit plan. **PBT is unproven and not medically necessary due to insufficient evidence of efficacy for treating all other indications; however, PBT may be covered for a diagnosis that is not listed above as proven, including recurrences or metastases in selected cases. Requests for exceptions will be evaluated on a case-by-case basis when both of the following criteria are met:** ● Documentation is provided that sparing of the surrounding normal tissue cannot be achieved with standard radiation therapy techniques; and ● Evaluation includes a comparison of treatment plans for PBT and photon-based radiation therapy (such as IMRT or stereotactic body radiation therapy) for the specific individual

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Proton Beam Radiation Therapy (continued)	Mar. 1, 2026	○ Replaced "hepatocellular carcinoma (HCC) (localized, unresectable) in the curative setting when documentation is provided that sparing of the surrounding normal tissue cannot be achieved with standard radiation therapy techniques, including intensity-modulated radiation therapy (IMRT), stereotactic body radiation therapy (SBRT), and selective internal radiation spheres, and transarterial therapy (for example, chemo-embolization) is contraindicated or not technically feasible" with "*primary liver malignancies, such as* hepatocellular carcinoma *and intrahepatic cancer* (localized, unresectable) in the curative setting when documentation is provided that sparing of the surrounding normal tissue cannot be achieved with standard radiation therapy techniques, including intensity-modulated radiation therapy (IMRT), stereotactic body radiation therapy, and selective internal radiation spheres, and transarterial therapy (for example, chemoembolization) is	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Proton Beam Radiation Therapy (continued)	Mar. 1, 2026	contraindicated or not technically feasible • Revised coverage criteria for evaluation of exception requests for a covered diagnosis of PBT that is not listed [in the policy] as proven; replaced criterion requiring the "evaluation includes a comparison of treatment plans for PBT, IMRT, and stereotactic body radiation therapy for the specific individual" with "evaluation includes a comparison of treatment plans for PBT *and photon-based radiation therapy (such as* PBT, IMRT, or stereotactic body radiation therapy) for a specific individual" **Medical Records Documentation Used for Reviews** • Updated list of Medical Records Documentation Used for Reviews; added "history of prior radiation therapy and need for the additional course of radiation therapy to the same anatomical site for re-irradiation" **Definitions** • Added definition of: ○ Base of Skull Tumors ○ Central Nervous System Tumors ○ Head and Neck Cancer • Updated definition of "Definitive Therapy"	

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Proton Beam Radiation Therapy (continued)	Mar. 1, 2026	**Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information	

Radiation Therapy: Fractionation, Image-guidance, and Special Services	Mar. 1, 2026	**Coverage Rationale**
		Radiation Therapy Fractionation
		Breast Adenocarcinoma
		• Revised coverage criteria:
		  ○ Added criterion requiring "delivery of up to 10 fractions for accelerated partial-breast irradiation with 3D technique"
		  ○ Replaced criterion requiring "delivery of up to 33 fractions (inclusive of a boost to the tumor bed) when the individual has a connective tissue disorder such as lupus or scleroderma" with "delivery of up to 33 fractions (inclusive of a boost to the tumor bed) when the individual has a connective tissue disorder such as *systemic* lupus *erythematosus* or scleroderma"
		Image-Guided Radiation Therapy
		• Added instruction to refer to the coding clarifications in the *Applicable Codes* section of the policy
		• Removed language indicating image-guided radiation therapy (IGRT) is not medically necessary for superficial treatment of skin
			Radiation Therapy Fractionation
			Bone Metastases
			When providing palliative external beam radiation therapy (EBRT) for the treatment of bone metastases, the following are medically necessary:
			• Delivery of up to 10 fractions of radiation therapy
			• Delivery of greater than 10 fractions for the treatment of a site that has previously received radiation therapy
			Breast Adenocarcinoma
			When providing EBRT for breast adenocarcinoma, the following are medically necessary:
			• Delivery of up to five fractions for accelerated partial-breast irradiation with intensity-modulated radiation therapy
			• Delivery of up to 10 fractions for accelerated partial-breast irradiation with 3D technique
			• Delivery of up to 21 fractions (inclusive of a boost to the tumor bed)
			• Delivery of up to 33 fractions (inclusive of a boost to the tumor bed) when any of the following criteria are met:
			  ○ Treatment of supraclavicular and/or internal mammary lymph nodes; or
			  ○ Postmastectomy radiation therapy; or
			  ○ Individual has received previous thoracic radiation therapy; or
			  ○ Individual has a connective tissue disorder such as systemic lupus erythematosus or scleroderma
			When providing EBRT for breast cancer, delivery of greater than 33 fractions (inclusive of a boost to the tumor bed) is not medically necessary.
			Locally Advanced Non-Small Cell Lung Cancer

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Radiation Therapy: Fractionation, Image-guidance, and Special Services (continued)	Mar. 1, 2026	cancer including superficial radiation therapy or electronic brachytherapy when the [listed] criteria are not met **Definitions** • Updated definition of "Definitive Treatment" ***Coding Clarifications*** CPT Codes 77402, 77407, and 77412 • Added notation to indicate: ○ Radiation treatment delivery should be reported using the appropriate level of complexity ▪ Conventional single electron field, multiple electron fields, or 2D photons should be reported under CPT code 77402 (Level 1) ▪ Standard single-isocenter 3D or intensity-modulated radiation therapy (IMRT)/volumetric modulated arc therapy (VMAT) treatments should be reported under CPT code 77407 (Level 2) ▪ CPT code 77412 should be used only when delivery requires multiple isocenters with photon therapy, single-isocenter treatment with active motion-management	**When providing EBRT, with or without chemotherapy, for locally advanced non-small cell lung cancer, the following is medically necessary:** • Delivery of up to 35 fractions **When providing EBRT, with or without chemotherapy, for locally advanced non-small cell lung cancer, delivery of greater than 35 fractions is not medically necessary.** ***Prostate Adenocarcinoma*** **When providing EBRT for prostate adenocarcinoma, the following are medically necessary:** • Delivery of up to 20 fractions for Definitive Treatment in an individual with Limited Metastatic Disease • Delivery of up to 28 fractions for localized prostate cancer • Delivery of up to 45 fractions for localized prostate cancer when any of the following criteria are met: ○ Individual with high-risk prostate cancer is undergoing radiation treatment to pelvic lymph nodes; or ○ Radiation therapy is delivered post prostatectomy; or ○ Individual has a history of inflammatory bowel disease such as ulcerative colitis or Crohn disease; or ○ Individual has received previous pelvic radiation therapy **When providing EBRT for localized prostate cancer, delivery of greater than 45 fractions is not medically necessary.** **Image-Guided Radiation Therapy** (Refer to the *Coding Clarifications* in the *Applicable Codes* section of the policy) **Image guidance for radiation therapy is medically necessary under any of the following circumstances:** • When used with intensity-modulated radiation therapy (IMRT; e.g., prostate cancer); or • When used with proton beam radiation therapy (PBRT); or • When the target has received prior radiation therapy or abuts a previously irradiated area; or

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Radiation Therapy: Fractionation, Image-guidance, and Special Services (continued)	Mar. 1, 2026	techniques, total-skin electrons, or mixed electron/photon fields (Level 3); when CPT code 77412 is reported, documentation must clearly describe the circumstances that justify Level 3 rather than Level 2 treatment delivery ○ When image-guided radiation therapy is used with 2D, 3D, IMRT techniques, the technical component is included under CPT codes 77402, 77407, and 77412 and should not be reported separately; the professional component of IGRT should be reported as 77387-26 CPT Codes 77436, 77437, 77438, and 77439 • Updated notation to indicate megavoltage planning, imaging, and treatment delivery codes should not be reported during superficial, surface, or orthovoltage radiation therapy regardless of the number of treatment sites; CPT codes 77436, 77437, 77438, and 77439 should be reported for superficial, surface, or orthovoltage radiation therapy CPT Code 77331 • Updated notation to indicate special dosimetry (CPT code	• When implanted fiducial markers are being used for target localization; or • During Definitive Treatment, using 3D conformal radiation therapy (3D-CRT) for the following: ○ Breast cancer and any of the following: ▪ Accelerated partial-breast irradiation ▪ Breast boost with the use of photons ▪ Hypofractionated radiation therapy delivered up to five fractions to the whole breast or chest wall ▪ Individual is being treated in the prone position ▪ Left breast cancer and deep inspiration breath-hold technique is being used ○ During boost treatment of rectal and bladder cancer ○ Esophageal cancer ○ Gastric cancer ○ Head and neck cancer ○ Hepatobiliary cancer ○ Lung cancer ○ Pancreatic cancer ○ Soft tissue sarcoma ○ Image-guided radiation therapy (IGRT) when used with 3D-CRT may be medically necessary for a condition that is not listed above when documentation is provided, showing one or more of the following: ▪ Clinically significant difference in normal tissue sparing between deep inspiration breath-hold and free breathing, as documented by comparison plans and dose-volume histogram (DVH; e.g., right-sided breast cancer) ▪ Member unable to tolerate immobilization during computed tomography (CT) simulation ▪ Significant target motion, as documented by imaging ▪ Smaller clinical target volume (CTV) margins are required than what is traditionally used for 3D-CRT **When the above criteria are not met, IGRT is not medically necessary, including but not limited to the following circumstance:** • To align bony landmarks without implanted fiducials (i.e., during palliative radiation therapy)

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Radiation Therapy: Fractionation, Image-guidance, and Special Services (continued)	Mar. 1, 2026	77331) should be used to document the measurement of radiation dose at a specific point within a treatment area using specialized devices such as thermoluminescent dosimeters, optically simulated dosimeters, diode probes, special dosimetry probes, film dosimetry, and implanted markers ○ CPT code 77331 is used when radiation dose measurements are needed in treatment areas that fall outside the standard parameters of the treatment planning system or equipment calibration ○ When special dosimetry is requested, the number of measurements typically ranges from one to six, depending on the clinical need; any requests beyond this standard range must be supported with documentation and will be considered on a case-by-case basis ○ IMRT planning (CPT code 77301) includes special dosimetry CPT Code 77301 • Removed notation indicating CPT code 77301 is considered for coverage only when the primary radiation procedure is proven and	**Note**: Refer to the *Coding Clarifications* section of the policy for special services and the use of IGRT with brachytherapy, stereotactic radiosurgery, and stereotactic body radiation therapy.

Medical Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Radiation Therapy: Fractionation, Image-guidance, and Special Services (continued)	Mar. 1, 2026	medically necessary **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect the most current information	
Treatment of Temporomandibular Joint Disorders	Mar. 1, 2026	**Coverage Rationale** • Revised list of unproven and not medically necessary services; removed: ○ Craniosacral manipulation/therapy ○ Jaw mobility mechanical stretching devices (e.g., Therabite Jaw Motion Rehabilitation System®, Jaw Dynasplint® System) ○ Multiple occlusal splints (i.e., daytime and nighttime splints, maxillary and mandibular splints) **Applicable Codes** • Removed CPT codes 21089 and 21499 **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect the most current information	**The following nonsurgical services are proven and medically necessary for treating disorders of the temporomandibular joint (TMJ):** • Arthrocentesis • Intra-articular injections of corticosteroids • Trigger point injections • Physical therapy • Occlusal splint (stabilization and repositioning splints) **The following TMJ surgical services are proven and medically necessary in certain circumstances.** For medical necessity clinical coverage criteria, refer to the: • InterQual® CP: Procedures: ○ Arthroscopy, Temporomandibular Joint (TMJ) ○ Discectomy, Temporomandibular Joint (TMJ) ○ Reconstruction, Temporomandibular Joint (TMJ) • InterQual® Client Defined, CP: Procedures, Arthroplasty, Temporomandibular Joint (TMJ) (Custom) – UHG Click here to view the InterQual® criteria. **The following services are unproven and not medically necessary for treating disorders of the TMJ due to insufficient evidence of efficacy (this list is not all inclusive):** • Biofeedback • Jaw mobility mechanical stretching devices (e.g., TheraBite Jaw Motion Rehabilitation System®, Jaw Dynasplint® System) • Multiple occlusal splints (e.g., daytime and nighttime splints, maxillary and mandibular splints) • Epigenetic appliances [e.g., Homeoblock™, DNA® (Daytime/Nighttime appliance), Advanced Lightwire Functional appliance]

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Treatment of Temporomandibular Joint Disorders (continued)	Mar. 1, 2026		For information regarding intra-articular injections of sodium hyaluronate for TMJ disorders, refer to the Medical Benefit Drug Policies titled Sodium Hyaluronate (for Commercial Only) and Sodium Hyaluronate (for Individual Exchange Only). For information regarding botulinum toxin injections for TMJ disorders, refer to the Medical Benefit Drug Policies titled Botulinum Toxins A and B (for Commercial Only) and Botulinum Toxins A and B (for Individual Exchange Only).
Upper Extremity Prosthetic Devices	Apr. 1, 2026	**Coverage Rationale** • Revised coverage criteria for **upper extremity prosthetic for amputations** and **upper extremity Myoelectric Prosthetic hand, partial hand, or artificial digit(s) for amputations below the wrist**; replaced criterion requiring "prosthetic needs evaluated for member by a healthcare professional with appropriate prosthetic qualifications and training under the supervision of the ordering physician" with "prosthetic needs *have been* evaluated for the member by *a physician*, health care professional, *or another licensed practitioner of the healing arts acting within the scope of practice authorized under State law*, with appropriate prosthetic qualifications and training under the supervision of the ordering physician *annually*" **Definitions** • Updated definition of:	**An upper extremity prosthetic for amputations is proven and medically necessary when all of the following criteria are met:** • Member has a traumatic or surgical amputation of the upper extremity or a congenital absence or defect; and • Prosthetic replaces all or part of a missing limb; and • Prosthetic will help the member regain or maintain function; and • Prosthetic device is ordered by or under the direction of a physician; and • Prosthetic needs have been evaluated for the member by a physician, health care professional, or an other licensed practitioner of the healing arts acting within the scope of practice authorized under State law, with appropriate prosthetic qualifications and training under the supervision of the ordering physician annually; and • Member is willing and able to participate in the training for the use of the prosthetic; and • Member with expected rehabilitation potential undergoes functional assessment [including Activities of Daily Living (ADLs) and Instrumental ADLs] evaluation **An upper extremity Myoelectric Prosthetic for amputations above the wrist is proven and medically necessary in certain circumstances.** For medical necessity clinical coverage criteria, refer to the InterQual® CP: Durable Medical Equipment, Prosthetics, Myoelectric, Upper Extremity, Above the Wrist (Custom) – UHG. Click here to view the InterQual® criteria. **An upper extremity Myoelectric Prosthetic hand, partial hand, or artificial digit(s) for amputations below the wrist is medically necessary**

Medical Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Upper Extremity Prosthetic Devices (continued)	Apr. 1, 2026	○ Activities of Daily Living ○ Instrumental Activities of Daily Living ○ Myoelectric Prosthetic **Supporting Information** • Updated *Description of Services*, *Benefit Considerations*, *Clinical Evidence*, and *References* sections to reflect the most current information	**when all of the following criteria are met:** • Member has a traumatic or surgical amputation below the wrist or a congenital missing or dysfunctional hand or finger; and • Prosthetic replaces all or part of a missing limb; and • Prosthetic will help the member regain or maintain function; and • Prosthetic needs have been evaluated for the member by a physician, health care professional, or an other licensed practitioner of the healing arts acting within the scope of practice authorized under State law, with appropriate prosthetic qualifications and training under the supervision of the ordering physician annually; and • Member is willing and able to participate in the training for the use of the prosthetic; and • Member is able to operate the simulator of the computerized prosthetic or microprocessor; and • Member with expected rehabilitation potential undergoes functional assessment (including ADLs and Instrumental ADLs) evaluation; and • Remaining musculature of the arm(s) contains the minimum microvolt threshold to allow operation of a Myoelectric Prosthetic device (usually three to five muscle groups must be activated to use a computerized hand), no external switch; and • Ordering physician authorizes the final prosthetic proposal **Myoelectric Prosthetic components for hand, partial hand, and artificial digits below the wrist are considered not medically necessary in members who do not meet the criteria above.** **A bone-anchored percutaneous limb Prosthesis [e.g., Osseoanchored Prostheses for the Rehabilitation of Amputees (OPRA) Implant System] is unproven and not medically necessary due to insufficient evidence of efficacy.**

Medical Benefit Drug Policy Updates

New

Policy Title	Effective Date	Coverage Rationale
Papzimeos™ (Zopapogene Imadenovec-Drba)	Feb. 1, 2026	**Papzimeos™ (zopapogene imadenovec-drba) has been added to the Review at Launch program. Some members may not be eligible for coverage of this medication at this time. Refer to the Medical Benefit Drug Policy titled Review at Launch for New to Market Medications for additional details.** **Papzimeos is proven and medically necessary for the treatment of recurrent respiratory papillomatosis in patients who meet all of the following criteria:** • Diagnosis of recurrent respiratory papillomatosis (RRP); **and** • Patient is 18 years of age or older; **and** • Patient has required surgery (i.e., surgical resection of papillomas, laser ablation of papillomas) to remove laryngotracheal papillomas prior to treatment with Papzimeos; **and** • Surgical debulking of present visible papilloma will be performed prior to the initial, third, and fourth dose of Papzimeos; **and** • Prescribed by or in consultation with a specialist knowledgeable in the treatment of recurrent respiratory papillomatosis (e.g., otolaryngologist, pulmonologist, oncologist); **and** • Patient has not received a previous complete treatment course (i.e., four doses over a 12-week interval) with Papzimeos; **and** • Dosing is in accordance with the United States Food and Drug Administration approved labeling; **and** Authorization will be issued for no more than one treatment course (i.e., four doses) per lifetime

Updated

Policy Title	Effective Date	Summary of Changes
Intravenous Iron Replacement Therapy (Feraheme®, Injectafer®, & Monoferric®)	Feb. 1, 2026	**Definitions** • Updated definition of "Iron Deficiency Anemia (IDA) With CKD, Without End Stage Renal Disease (ESRD), or Acute or Chronic Inflammatory Conditions" **Supporting Information** • Updated *Clinical Evidence*, *CMS*, and *References* sections to reflect the most current information

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Elevidys® (Delandistrogene Moxeparvovec-Rokl)	Mar. 1, 2026	**Coverage Rationale** • Revised coverage criteria; replaced criterion requiring: ○ "The patient does not have preexisting hepatic impairment, acute liver disease (e.g., acute hepatic viral infection), *chronic*	**Elevidys is proven and medically necessary for the treatment of Duchenne muscular dystrophy (DMD) in patients who meet all of the following criteria:** • Diagnosis of Duchenne muscular dystrophy by, or in consultation with, a pediatric neuromuscular specialist with expertise in the diagnosis of DMD; **and** • Submission of medical records (e.g., chart notes, laboratory values) confirming **both** of the following:

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Elevidys® (Delandistrogene Moxeparvovec-Rokl) (continued)	Mar. 1, 2026	*hepatic condition*, or *elevated* GGT" with "the patient does not have preexisting hepatic impairment *[defined as gamma-glutamyl transferase (*GGT*) > 2 times the upper limit of normal or total bilirubin > the upper limit of normal not due to Gilbert's syndrome]*, or acute liver disease (e.g., acute hepatic viral infection)" ○ "The prescriber attests that troponin-I will be monitored weekly for the first month following Elevidys administration and thereafter *per recommendations in the prescribing information*" with "the prescriber attests that troponin-I will be monitored weekly for the first month following Elevidys administration and thereafter *in accordance with the FDA approved labeling*" **Supporting Information** • Updated *FDA* section to reflect the most current information	○ A mutation in the DMD gene; **and** ○ The mutation is not a deletion in exon 8 or exon 9 **and** • Patient is aged 4 or 5 years of age; **and** • Submission of medical records (e.g., chart notes) confirming that the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.); **and** • **Both** of the following: ○ Patient does not have preexisting hepatic impairment [defined as gamma-glutamyl transferase (GGT) > 2 x upper limit of normal or total bilirubin > the upper limit of normal not due to Gilbert's syndrome] or acute liver disease (e.g., acute hepatic viral infection); **and** ○ Prescriber attests that liver function (clinical exam, GGT, and total bilirubin) will be monitored weekly for the first 3 months following Elevidys administration and thereafter in accordance with the Food and Drug Administration (FDA) approved labeling **and** • **Both** of the following: ○ Patient does not have a left ventricle ejection fraction (LVEF) < 40%; **and** ○ Prescriber attests that troponin-I will be monitored weekly for the first month following Elevidys administration and thereafter in accordance with the FDA approved labeling **and** • Patient does not have an elevated anti-AAVrh74 total binding antibody titer ≥ 1:400; **and** • Patient will receive a corticosteroid regimen prior to and following receipt of Elevidys in accordance with the FDA approved labeling; **and** • Elevidys is prescribed by, or in consultation with, a pediatric neuromuscular specialist with expertise in the treatment of DMD; **and** • Patient will not receive exon-skipping therapies for DMD [e.g., Amondys (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)] concomitantly or following Elevidys treatment; **and** • Patient has not previously received gene therapy for the treatment of DMD; **and** • Provider does not request a planned inpatient admission for the sole

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Elevidys® (Delandistrogene Moxeparvovec-Rokl) (continued)	Mar. 1, 2026		purpose of administering Elevidys; **and** • Elevidys dosing is in accordance with FDA approved labeling; **and** • Authorization will be issued for no more than one treatment per lifetime and for no longer than 45 days from approval or until 6 years of age, whichever is first **Elevidys is unproven and not medically necessary for the treatment of:** • Becker muscular dystrophy (BMD) • Duchenne muscular dystrophy (DMD) in ambulatory patients < 4 years of age and ≥ 6 years of age • Duchenne muscular dystrophy (DMD) in patients at any age who are non-ambulatory
Simponi Aria® (Golimumab) Injection for Intravenous Infusion	Mar. 1, 2026	**Coverage Rationale** • Replaced references to "targeted immunomodulator" with "*systemic* targeted immunomodulator" • Revised coverage criteria for: ***Ankylosing Spondylitis*** ○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of ankylosing spondylitis with which the patient has been previously treated for initial therapy; added: ▪ Adalimumab ▪ Bimzelx (bimekizumab-bkzx) ▪ Cosentyx (secukinumab) ▪ Olumiant (baricitinib) ▪ Orencia (abatacept) ▪ Taltz (ixekizumab) ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving	**This policy refers only to Simponi Aria (golimumab) injection for intravenous infusion.** Simponi for self-administered subcutaneous injection is obtained under the pharmacy benefit, unless otherwise specified in the member's benefit plan documents. **Exception**: For members enrolled in UnitedHealthcare of California plans with a delegated provider group conducting the prior authorization review, the self-administered Simponi may be obtained under the medical benefit. Refer to the policy for complete details.

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Simponi Aria® (Golimumab) Injection for Intravenous Infusion (continued)	Mar. 1, 2026	in combination with Simponi Aria for treatment of the same indication; added: ▪ Bimzelx (bimekizumab-bkzx) ▪ Cosentyx (secukinumab) ▪ Taltz (ixekizumab) ***Psoriatic Arthritis*** ○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of psoriatic arthritis with which the patient has been previously treated for initial therapy: ▪ Added "Bimzelx (bimekizumab-bkzx)" ▪ Replaced: – "*Stelara* (ustekinumab)" with "ustekinumab" – "Xeljanz (tofacitinib)" with "Xeljanz/*Xeljanz XR* (tofacitinib)" ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with Simponi Aria for treatment of the same indication: ▪ Added "Bimzelx (bimekizumab-bkzx)" ▪ Removed "Olumiant (baricitinib)" ▪ Replaced:	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Simponi Aria® (Golimumab) Injection for Intravenous Infusion (continued)	Mar. 1, 2026	– "*Stelara* (ustekinumab)" with "ustekinumab" – "Xeljanz (tofacitinib)" with "Xeljanz/*Xeljanz XR* (tofacitinib)" ***Rheumatoid Arthritis*** ○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of rheumatoid arthritis with which the patient has been previously treated for initial therapy: ▪ Removed "Simponi (golimumab)" ▪ Replaced "Xeljanz (tofacitinib)" with "Xeljanz/*Xeljanz XR* (tofacitinib)" ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with Simponi Aria for treatment of the same indication; replaced "Xeljanz (tofacitinib)" with "Xeljanz/*Xeljanz XR* (tofacitinib)" ***Polyarticular Juvenile Idiopathic Arthritis*** ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Simponi Aria® (Golimumab) Injection for Intravenous Infusion (continued)	Mar. 1, 2026	in combination with Simponi Aria for treatment of the same indication for: ▪ Removed "Simponi (golimumab)" ▪ Replaced "Xeljanz (tofacitinib)" with "Xeljanz/*Xeljanz XR* (tofacitinib)" **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information	
Tocilizumab (Actemra®, Tofidence®, & Tyenne®) Injection for Intravenous Infusion	Mar. 1, 2026	**Coverage Rationale** ***Preferred Product*** • Added language to indicate any U.S. Food and Drug Administration approved tocilizumab product not listed by name in this policy will be considered non-preferred until reviewed by UnitedHealthcare ***Diagnosis-Specific Criteria*** • Replaced references to: ○ "Targeted immunomodulator" with "*systemic* targeted immunomodulator" ○ "*Biologic or* targeted *synthetic DMARD*" with "*systemic* targeted *immunomodulator*" • Revised coverage criteria: ○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of **rheumatoid arthritis** with which the patient has been	Refer to the Medical Benefit Drug Policy titled Oncology Medication Clinical Coverage for updated information based upon the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium® (NCCN Compendium®) for oncology indications. This policy refers to **Actemra (tocilizumab), Tofidence (tocilizumab-bavi), and Tyenne (tocilizumab-aazg) injection for intravenous infusion** only. Actemra (tocilizumab) and Tyenne (tocilizumab-aazg) for self-administered subcutaneous injection are obtained under the pharmacy benefit, unless otherwise specified in the member's benefit plan documents. **Exception**: For members enrolled in UnitedHealthcare of California plans with a delegated provider group conducting the prior authorization review, the available self-administered tocilizumab products may be obtained under the medical benefit. Refer to the policy for complete details.

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Tocilizumab (Actemra®, Tofidence®, & Tyenne®) Injection for Intravenous Infusion (continued)	Mar. 1, 2026	previously treated for initial therapy: ▪ Added: – Cimzia (certolizumab) – Enbrel (etanercept) – Orencia (abatacept) ▪ Replaced: – "*Humira* (adalimumab)" with "adalimumab" – "Xeljanz (tofacitinib)" with "Xeljanz/*Xeljanz XR* (tofacitinib)" ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with tocilizumab for treatment of the same indication for: Polyarticular Juvenile Idiopathic Arthritis, Rheumatoid Arthritis, *and* Systemic Juvenile Idiopathic Arthritis ▪ Replaced "Xeljanz (tofacitinib)" with "Xeljanz/*Xeljanz XR* (tofacitinib)" Giant Cell Arteritis ▪ Added "Kevzara (sarilumab)" ▪ Removed: – Adalimumab – Cimzia (certolizumab) – Enbrel (etanercept) – Olumiant (baricitinib)	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Tocilizumab (Actemra®, Tofidence®, & Tyenne®) Injection for Intravenous Infusion (continued)	Mar. 1, 2026	– Simponi (golimumab) – Xeljanz (tofacitinib) **Supporting Information** • Updated *CMS* and *References* sections to reflect the most current information	

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.

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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.