United Healthcare Community Plan

UnitedHealthcare Community Plan of Indiana

Medical Policy Update Bulletin: May 2022

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InterQual® 2022 Clinical Criteria: Apr. 2022 Release

Effective May 1, 2022, the following Medical Policies, Coverage Determination Guidelines, and Utilization Review Guidelines have been updated to reflect the applicable InterQual® clinical criteria reference(s) associated with the Apr. 2022 Release:

Policy Title	Policy Type
Ablative Treatment for Spinal Pain (for Indiana Only)	Medical Policy
Articular Cartilage Defect Repairs (for Indiana Only)	Medical Policy
Blepharoplasty, Blepharoptosis, and Brow Ptosis Repair (for Indiana Only)	Coverage Determination Guideline
Breast Imaging for Screening and Diagnosing Cancer (for Indiana Only)	Medical Policy
Breast Reconstruction Post Mastectomy and Poland Syndrome (for Indiana Only)	Coverage Determination Guideline
Breast Repair/Reconstruction Not Following Mastectomy (for Indiana Only)	Coverage Determination Guideline
Chemotherapy Observation or Inpatient Hospitalization (for Indiana Only)	Utilization Review Guideline
Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes (for Indiana Only)	Medical Policy
Cosmetic and Reconstructive Procedures (for Indiana Only)	Coverage Determination Guideline
Deep Brain and Cortical Stimulation (for Indiana Only)	Medical Policy
Gastrointestinal Motility Disorders, Diagnosis and Treatment (for Indiana Only)	Medical Policy
Gender Dysphoria Treatment (for Indiana Only)	Medical Policy
Lower Extremity Invasive Diagnostic and Endovascular Procedures (for Indiana Only)	Medical Policy
Neurophysiologic Testing and Monitoring (for Indiana Only)	Medical Policy
Neuropsychological Testing Under the Medical Benefit (for Indiana Only)	Medical Policy
Obstructive and Central Sleep Apnea Treatment (for Indiana Only)	Medical Policy
Occipital Nerve Injections and Ablation (Including Occipital Neuralgia and Headache) (for Indiana Only)	Medical Policy
Patient Lifts (for Indiana Only)	Coverage Determination Guideline
Pectus Deformity Repair (for Indiana Only)	Coverage Determination Guideline
Pneumatic Compression Devices (for Indiana Only)	Medical Policy
Prosthetic Devices, Specialized, Microprocessor or Myoelectric Limbs (for Indiana Only)	Coverage Determination Guideline
Proton Beam Radiation Therapy (for Indiana Only)	Medical Policy
Surgery of the Elbow (for Indiana Only)	Medical Policy
Surgery of the Hip (for Indiana Only)	Medical Policy

Take Note

Policy Title	Policy Type
Surgery of the Knee (for Indiana Only)	Medical Policy
Surgery of the Shoulder (for Indiana Only)	Medical Policy
Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins (for Indiana Only)	Medical Policy
Surgical Treatment for Spine Pain (for Indiana Only)	Medical Policy
Transcatheter Heart Valve Procedures (for Indiana Only)	Medical Policy
Transcutaneous Electrical Nerve/Joint Stimulators (for Indiana Only)	Medical Policy
Video Electroencephalographic (vEEG) Monitoring and Recording (for Indiana Only)	Medical Policy

Policy Retirements

The following policies have been retired effective May 1, 2022, as the state of Indiana does not require clinical review for these services:

Policy Title	Policy Type
Abnormal Uterine Bleeding and Uterine Fibroids (for Indiana Only)	Medical Policy
Athletic Pubalgia Surgery (for Indiana Only)	Medical Policy
Attended Polysomnography for Evaluation of Sleep Disorders (for Indiana Only)	Medical Policy
Autologous Cellular Therapy for Certain Indications (for Indiana Only)	Medical Policy
Bronchial Thermoplasty (for Indiana Only)	Medical Policy
Cardiac Event Monitoring (for Indiana Only)	Medical Policy
Cardiovascular Disease Risk Tests (for Indiana Only)	Medical Policy
Carrier Testing for Genetic Diseases (for Indiana Only)	Medical Policy
Catheter Ablation for Atrial Fibrillation (for Indiana Only)	Medical Policy
Cell-Free Fetal DNA Testing (for Indiana Only)	Medical Policy
Collagen Crosslinks and Biochemical Markers of Bone Turnover (for Indiana Only)	Medical Policy
Computerized Dynamic Posturography (for Indiana Only)	Medical Policy
Corneal Collagen Crosslinking (for Indiana Only)	Medical Policy
Corneal Hysteresis and Intraocular Pressure Measurement (for Indiana Only)	Medical Policy
Cytological Examination of Breast Fluids for Cancer Screening or Diagnosis (for Indiana Only)	Medical Policy
Diagnostic Spinal Ultrasonography (for Indiana Only)	Medical Policy

Take Note

Policy Title	Policy Type
Electrical Bioimpedance for Cardiac Output Measurement (for Indiana Only)	Medical Policy
Embolization of the Ovarian and Iliac Veins for Pelvic Congestion Syndrome (for Indiana Only)	Medical Policy
Emergency Services (for Indiana Only)	Coverage Determination Guideline
Epidural Steroid Injections for Spinal Pain (for Indiana Only)	Medical Policy
Epiduroscopy, Epidural Lysis of Adhesions, and Discography (for Indiana Only)	Medical Policy
Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions and Soft Tissue Wounds (for Indiana Only)	Medical Policy
Facet Joint Injections for Spinal Pain (for Indiana Only)	Medical Policy
Fecal Calprotectin Testing (for Indiana Only)	Medical Policy
Genetic Testing for Neuromuscular Disorders (for Indiana Only)	Medical Policy
Genitourinary Pathogen Nucleic Acid Detection Panel Testing (for Indiana Only)	Medical Policy
Gynecomastia Treatment (for Indiana Only)	Coverage Determination Guideline
Hepatitis Screening (for Indiana Only)	Medical Policy
Home Hemodialysis (for Indiana Only)	Medical Policy
Home Traction Therapy (for Indiana Only)	Medical Policy
Implantable Beta-Emitting Microspheres for Treatment of Malignant Tumors (for Indiana Only)	Medical Policy
Inhaled Nitric Oxide Therapy (for Indiana Only)	Medical Policy
Intraoperative Hyperthermic Intraperitoneal Chemotherapy (HIPEC) (for Indiana Only)	Medical Policy
Intrauterine Fetal Surgery (for Indiana Only)	Medical Policy
Laser Interstitial Thermal Therapy (for Indiana Only)	Medical Policy
Lithotripsy for Salivary Stones (for Indiana Only)	Medical Policy
Macular Degeneration Treatment Procedures (for Indiana Only)	Medical Policy
Manipulation Under Anesthesia (for Indiana Only)	Medical Policy
Manipulative Therapy (for Indiana Only)	Medical Policy
Minimally Invasive Procedures for Gastroesophageal Reflux Disease (GERD) and Achalasia (for Indiana Only)	Medical Policy
Motorized Spinal Traction (for Indiana Only)	Medical Policy
Nerve Graft to Restore Erectile Function During Radical Prostatectomy (for Indiana Only)	Medical Policy

Take Note

Policy Title	Policy Type
Otoacoustic Emissions Testing (for Indiana Only)	Medical Policy
Percutaneous Patent Foramen Ovale (PFO) Closure (for Indiana Only)	Medical Policy
Percutaneous Vertebroplasty and Kyphoplasty (for Indiana Only)	Medical Policy
Prolotherapy and Platelet Rich Plasma Therapies (for Indiana Only)	Medical Policy
Skin and Soft Tissue Substitutes (for Indiana Only)	Medical Policy
Transcranial Magnetic Stimulation (for Indiana Only)	Medical Policy
Transpupillary Thermotherapy (for Indiana Only)	Medical Policy
Umbilical Cord Blood Harvesting and Storage for Future Use (for Indiana Only)	Medical Policy
Unicondylar Spacer Devices for Treatment of Pain or Disability (for Indiana Only)	Medical Policy
Visual Information Processing Evaluation and Orthoptic and Vision Therapy (for Indiana Only)	Medical Policy

Medical Policy Updates

New

Policy Title	Effective Date	Coverage Rationale

Prostate Surgeries and Interventions (for Indiana Only)	Jun. 1, 2022	Transurethral ablation of the prostate is proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® 2022, Apr. 2022 Release, CP: Procedures, Prostatectomy, Transurethral Ablation.
		
		Click here to view the InterQual® criteria.
		
		Cryoablation of the prostate is proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® 2022, Apr. 2022 Release, CP: Procedures, Cryoablation, Prostate.
		
		Click here to view the InterQual® criteria.
		
		Surgical prostatectomy is proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® 2022, Apr. 2022 Release, CP: Procedures Prostatectomy, Radical.
		
		Click here to view the InterQual® criteria.
		
		Prostatic urethral lift (PUL) is proven and medically necessary when performed according to the following U.S. Food and Drug Administration (FDA) labeled indication:
		• Treating symptoms due to urinary outflow obstruction secondary to benign prostatic hyperplasia (BPH), including lateral and median lobe hyperplasia; in men 45 years of age or older, and
		• The following are not present:
		  ○ Prostate volume of > 100 cc
		  ○ A urinary tract infection
		  ○ Urethra conditions that may prevent insertion of delivery system into bladder
		  ○ Urinary incontinence due to incompetent sphincter
		  ○ Current gross hematuria
		
		High-energy water vapor thermotherapy for the treatment of malignant prostate tissue is unproven and not medically necessary due to insufficient evidence of safety and/or efficacy.
		
		The transperineal placement of biodegradable material, peri-prostatic (via needle) is proven and medically necessary for use with radiotherapy for treating prostate cancer.

Medical Policy Updates

New		
Policy Title	**Effective Date**	**Coverage Rationale**
Prostate Surgeries and Interventions (for Indiana Only) (continued)	Jun. 1, 2022	The transperineal placement of biodegradable material, peri-prostatic (via needle) is unproven and not medically necessary for all other indications due to insufficient evidence of safety and/or efficacy. The following procedures are unproven and not medically necessary due to insufficient evidence of safety and/or efficacy: • Transurethral waterjet ablation of the prostate (aquablation) • Focal laser ablation • Insertion of a temporary prostatic urethral stent • Vascular embolization

Medical Benefit Drug Policy Updates

New		
Policy Title	**Effective Date**	**Coverage Rationale**
Enjaymo (for Indiana Only)	Jun. 1, 2022	Enjaymo is medically necessary for the treatment of cold agglutinin disease (CAD) in patients who meet all of the following criteria: • For initial therapy, all of the following: ○ Diagnosis of CAD by, or in consultation with, a hematologist with expertise in the diagnosis of CAD; and ○ Confirmation of the CAD diagnosis based on all of the following: ▪ Evidence of chronic hemolysis [e.g. elevated lactated dehydrogenase (LDH), decreased haptoglobin, increased indirect bilirubin, increased reticulocyte count]; and ▪ Positive polyspecific direct antiglobin test (DAT); and ▪ Positive monospecific DAT specific for C3d; and ▪ Immunoglobulin G (IgG) DAT ≤ 1+; and ▪ Cold agglutinin titer ≥ 64 at 4°C and ○ Cold agglutinin syndrome secondary to other factors has been ruled out (e.g. infection, rheumatologic disease, systemic lupus erythematosus, overt hematologic malignancy, other autoimmune disorders); and ○ Patient has a baseline hemoglobin level ≤ 10 g/dL; and ○ Enjaymo is prescribed by a hematologist; and ○ Enjaymo dosing is in accordance with the United States Food and Drug Administration approved labeling; and ○ Patient is not receiving Enjaymo in combination with a complement inhibitor [e.g., Soliris (eculizumab), Ultomiris (ravilizumab-cwzb), Empaveli (pegcetacoplan)]; and ○ Initial authorization will be for no more than 6 months. • For continuation of therapy, all of the following: ○ Documentation of positive clinical response to therapy (e.g., increase in hemoglobin, decreased transfusion requirements, decreased markers of hemolysis, improvement in anemia-related symptoms); and ○ Enjaymo is prescribed by, or in consultation with, a hematologist; and ○ Enjaymo dosing is in accordance with the United States Food and Drug Administration (FDA) approved labeling; and ○ Patient is not receiving Enjaymo in combination with a complement inhibitor [e.g., Soliris (eculizumab), Ultomiris (ravilizumab-cwzb), Empaveli (pegcetacoplan)]; and ○ Reauthorization will be for no more than 12 months.

Medical Benefit Drug Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Vyvgart™ (Efgartigimod Alfa-Fcab) (for Indiana Only)	Jun. 1, 2022	Coverage Rationale • Revised coverage criteria for continuation of therapy; replaced criterion requiring "improvement and/or maintenance of at least a *3* point improvement (reduction in score) in the MG-ADL score from pre-treatment baseline" with "improvement and/or maintenance of at least a *2* point improvement (reduction in score) in the MG-ADL score from pre-treatment baseline"	**Myasthenia Gravis** Vyvgart is proven and medically necessary when the following criteria are met: • Initial Therapy: ○ Submission of medical records (e.g., chart notes, laboratory values, etc.) to support the diagnosis of generalized myasthenia gravis (gMG) by a neurologist or in consultation with a neurologist confirming all of the following: ▪ Patient has not failed a previous course of Vyvgart therapy; and ▪ Positive serologic test for anti-AChR antibodies; and ▪ One of the following: – History of abnormal neuromuscular transmission test demonstrated by single-fiber electromyography (SFEMG) or repetitive nerve stimulation – History of positive anticholinesterase test, e.g., edrophonium chloride test – Patient has demonstrated improvement in MG signs on oral cholinesterase inhibitors, as assessed by the treating neurologist and ▪ Patient has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of class II, III, or IV at initiation of therapy; and ▪ Patient has a Myasthenia Gravis-specific Activities of Daily Living scale (MG-ADL) total score ≥ 5 at initiation of therapy and ○ Both of the following: ▪ History of failure of at least two immunosuppressive agents over the course of at least 12 months (e.g., azathioprine, methotrexate, cyclosporine, mycophenylate, etc.); and ▪ Patient has required 2 or more courses of plasmapheresis/plasma exchanges and/or intravenous immune globulin for at least 12 months without symptom control and

Medical Benefit Drug Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Vyvgart™ (Efgartigimod Alfa-Fcab) (for Indiana Only) (continued)	Jun. 1, 2022		○ Patient is currently on a stable dose (at least 2 months) of immunosuppressive therapy; and ○ Patient is not receiving Vyvgart in combination with Soliris (eculizumab); and ○ Vyvgart is initiated and titrated according to the U.S. Food and Drug Administration (FDA) labeled dosing for gMG, up to a maximum of 1,200 mg per dose; and ○ Prescribed by, or in consultation with, a neurologist; and ○ Initial authorization will be for no more than 6 months. • Continuation of Therapy: ○ Patient has previously been treated with Vyvgart; and ○ Submission of medical records (e.g., chart notes, laboratory tests) to demonstrate a positive clinical response from baseline as demonstrated by all of the following: ▪ Improvement and/or maintenance of at least a 2 point improvement (reduction in score) in the MG-ADL score from pre-treatment baseline. ▪ Reduction in signs and symptoms of myasthenia gravis ▪ Maintenance, reduction, or discontinuation of dose(s) of baseline immunosuppressive therapy (IST) prior to starting Vyvgart. Note: Add on, dose escalation of IST, or additional rescue therapy from baseline to treat myasthenia gravis or exacerbation of symptoms while on Vyvgart therapy will be considered as treatment failure. and ○ Patient is not receiving Vyvgart in combination with Soliris (eculizumab); and ○ Vyvgart is dosed according to the U.S. Food and Drug Administration (FDA) labeled dosing for gMG: up to a maximum of 1,200 mg per dose; and ○ Prescribed by, or in consultation with, a neurologist; and ○ Reauthorization will be for no more than 12 months.

Utilization Review Guideline Updates

Retired		
Policy Title	**Effective Date**	**Summary of Changes**
Propranolol Treatment for Infantile Hemangiomas: Inpatient Protocol (for Indiana Only)	May 1, 2022	• Policy retired; propranolol treatment for infantile hemangiomas in the inpatient setting no longer requires clinical review

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 UnitedHealthcare Community Plan of Indiana Medical Policy, Medical Benefit Drug Policy, Coverage Determination Guideline, and Utilization Review Guideline updates. When information in this bulletin conflicts with applicable state and/or federal law, UnitedHealthcare follows such applicable federal and/or state law.

Policy Update Classifications

New

New clinical coverage criteria have been adopted for a health service (e.g., test, drug, device or procedure)

Updated

An existing policy has been reviewed and changes have not been made to the clinical coverage criteria; however, items such as the clinical evidence, FDA information, and/or list(s) of applicable codes may have been updated

Revised

An existing policy has been reviewed and revisions have been made to the clinical coverage criteria

Replaced

An existing policy has been replaced with a new or different policy

Retired

The health service(s) addressed in the policy are no longer being managed or are considered to be proven/medically necessary and are therefore not excluded as unproven/not medically necessary services, unless coverage guidelines or criteria are otherwise documented in another policy

The complete library of UnitedHealthcare Community Plan of Indiana Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, and Utilization Review Guidelines is available at UHCprovider.com/Indiana > Medicaid (Community Plan) > Current Policies and Clinical Guidelines > UnitedHealthcare Community Plan of Indiana Medical & Drug Policies and Coverage Determination Guidelines.