United Healthcare Community Plan

UnitedHealthcare Community Plan of Louisiana

Medical Policy Update Bulletin: May 2022

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Medical Policy Updates

New

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
Abnormal Uterine Bleeding and Uterine Fibroids (for Louisiana Only)	Medical Policy
Catheter Ablation for Atrial Fibrillation (for Louisiana Only)	Medical Policy
Chemotherapy Observation or Inpatient Hospitalization (for Louisiana Only)	Utilization Review Guideline
Elbow Replacement Surgery (Arthroplasty) (for Louisiana Only)	Medical Policy
Hip Resurfacing and Replacement Surgery (Arthroplasty) (for Louisiana Only)	Medical Policy
Implanted Electrical Stimulator for Spinal Cord (for Louisiana Only)	Medical Policy
Knee Replacement Surgery (Arthroplasty), Total and Partial (for Louisiana Only)	Medical Policy
Obstructive Sleep Apnea Treatment (for Louisiana Only)	Medical Policy
Orthognathic (Jaw) Surgery (for Louisiana Only)	Coverage Determination Guideline
Pneumatic Compression Devices (for Louisiana Only)	Medical Policy
Surgery of the Shoulder (for Louisiana Only)	Medical Policy
Surgical Treatment for Spine Pain (for Louisiana Only)	Medical Policy
Temporomandibular Joint Disorders (for Louisiana Only)	Medical Policy

Medical Policy Updates

New

Policy Title	Effective Date	Coverage Rationale

Prostate Surgeries and Interventions (for Louisiana 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.
		
		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.

Medical Policy Updates

New		
Policy Title	**Effective Date**	**Coverage Rationale**
Prostate Surgeries and Interventions (for Louisiana Only) (continued)	Jun. 1, 2022	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

United Healthcare Community Plan

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