United Healthcare Community Plan

UnitedHealthcare Community Plan of North Carolina
Medical Policy Update Bulletin: July 2022

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Community Plan of North Carolina to Use National Policy Versions

Effective Jul. 1, 2022, Community Plan of North Carolina will no longer maintain state-specific Medical Policies, Coverage Determination Guidelines, or Utilization Review Guidelines for the following services; coverage guidelines for the state of North Carolina will now be provided in the Community Plan National policy versions listed below:

Policy Title	Policy Type
Ablative Treatment for Spinal Pain	Medical Policy
Abnormal Uterine Bleeding and Uterine Fibroids	Medical Policy
Articular Cartilage Defect Repairs, Knee	Medical Policy
Chemotherapy Observation or Inpatient Hospitalization	Utilization Review Guideline
Computed Tomographic Colonography	Medical Policy
Core Decompression for Avascular Necrosis	Medical Policy
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Intensity-Modulated Radiation Therapy	Medical Policy
Motorized Spinal Traction	Medical Policy
Nerve Graft to Restore Erectile Function During Radical Prostatectomy	Medical Policy
Pectus Deformity Repair	Coverage Determination Guideline
Percutaneous Vertebroplasty and Kyphoplasty	Medical Policy
Sensory Integration Therapy and Auditory Integration Training	Medical Policy
Surgery of the Elbow	Medical Policy
Surgery of the Hip	Medical Policy
Surgery of the Knee	Medical Policy
Surgery of the Shoulder	Medical Policy
Unicondylar Spacer Devices for Treatment of Pain or Disability	Medical Policy
Virtual Upper Gastrointestinal Endoscopy	Medical Policy

Medical Policy Updates

Updated

Policy Title	Effective Date	Summary of Changes
Gastrointestinal Pathogen Nucleic Acid Detection Panel Testing for Infectious Diarrhea (for North Carolina Only)	Jul. 1, 2022	Applicable Codes • Updated list of applicable CPT codes to reflect quarterly edits; removed 0097U
Vagus and External Trigeminal Nerve Stimulation (for North Carolina Only)	Jul. 1, 2022	Applicable Codes • Updated list of applicable CPT codes to reflect annual edits; revised description for 64568

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Attended Polysomnography for Evaluation of Sleep Disorders (for North Carolina Only)	Sep. 1, 2022	Coverage Rationale • Replaced references to "full-channel *nocturnal* polysomnography" with "full-channel polysomnography" • Added language to indicate the Multiple Sleep Latency Testing (MSLT) and Maintenance of Wakefulness Testing (MWT) may be performed during the night if necessary to match an individual's normal sleep pattern • Replaced language indicating: ○ "MWT is medically necessary for assessing response to treatment in individuals with *Narcolepsy or idiopathic Hypersomnia*" with "MWT is medically necessary for assessing response to treatment in individuals with	Diagnostic testing for Obstructive Sleep Apnea (OSA) should be performed in conjunction with a comprehensive sleep evaluation. **Home Sleep Apnea Testing** For medical necessity clinical coverage criteria, refer to North Carolina Medicaid Clinical Coverage Policy, Physician Clinical Coverage Policies, No.: 1A-20 Sleep Studies and Polysomnography Services. **Attended Full-Channel Nocturnal Polysomnography, Performed in a Healthcare Facility or Laboratory Setting** For medical necessity clinical coverage criteria, refer to North Carolina Medicaid Clinical Coverage Policy, Physician Clinical Coverage Policies, No.: 1A-20 Sleep Studies and Polysomnography Services. **Daytime Sleep Studies** Note: The following sleep studies may be performed during the night, if necessary, to match an individual's normal sleep pattern. Multiple Sleep Latency Testing (MSLT) is medically necessary when indicated by all of the following:

Medical Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Attended Polysomnography for Evaluation of Sleep Disorders (for North Carolina Only) (continued)	Sep. 1, 2022	*sleep disorders*" ○ "MSLT and MWT are not medically necessary for *evaluating* OSA, Insomnia or circadian rhythm disorders" with "MSLT and MWT are not medically necessary for *diagnosing* OSA, Insomnia or circadian rhythm disorders" **Definitions** • Removed definition of: ○ Chronic Opioid Medication Use ○ Medically Necessary • Updated definition of "Home Sleep Apnea Testing (HSAT)" • Replaced the term "Polysomnogram" with "Polysomnogram *(Attended)*" **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect the most current information	• Suspected narcolepsy or idiopathic Hypersomnia; and • Other causes of Excessive Sleepiness have been excluded by appropriate clinical assessment For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Sleep Studies. Click here to view the InterQual® criteria. Note: A diagnostic PSG or PAP-titration must be performed prior to an MSLT. HSAT and Split-night Polysomnography should not be performed in conjunction with the MSLT. Maintenance of Wakefulness Testing (MWT) is medically necessary for evaluating the following: • An individual who is unable to stay awake, resulting in a safety issue; or • Assessing response to treatment in individuals with sleep disorders For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Sleep Studies. Click here to view the InterQual® criteria. Note: A diagnostic PSG or PAP-titration may be performed prior to the MWT at the discretion of the ordering physician, however the MWT may also be performed as a stand-alone test. The following studies are not medically necessary due to insufficient evidence of efficacy: • Multiple Sleep Latency Testing (MSLT) for diagnosing OSA, Insomnia or circadian rhythm disorders • Maintenance of Wakefulness Testing (MWT) for diagnosing OSA, Insomnia or circadian rhythm disorders • PAP-Nap

Medical Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Attended Polysomnography for Evaluation of Sleep Disorders (for North Carolina Only) (continued)	Sep. 1, 2022		**Attended PAP Titration** When an individual meets the above criteria for an attended full-channel polysomnography sleep study, the following are medically necessary: • A split-night sleep study, performed in a healthcare facility or laboratory setting, for diagnosis and PAP titration • A full night study for PAP titration, when a split-night sleep study is inadequate or not feasible and the individual has a confirmed diagnosis of OSA **Attended Repeat Testing** For medical necessity clinical coverage criteria, refer to North Carolina Medicaid Clinical Coverage Policy No.: 1A-20 Sleep Studies and Polysomnography Services.
Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes (for North Carolina Only)	Sep. 1, 2022	Coverage Rationale • Removed coverage statements; refer to the North Carolina Medicaid (Division of Health Benefits) Clinical Coverage Policy for Medical Equipment, 5A-3, Nursing Equipment and Supplies for medical necessity clinical coverage criteria Applicable Codes • Added HCPCS code A4211 Supporting Information • Updated *FDA* and *References* sections to reflect the most current information • Removed *Description of Services* and *Clinical Evidence* sections	**Insulin Delivery** ***Adults Over the Age of 20 and Gestational Diabetes*** For medical necessity clinical coverage criteria, refer to the North Carolina Medicaid (Division of Health Benefits) Clinical Coverage Policy for Medical Equipment, 5A-3, Nursing Equipment and Supplies. ***Children Age 0-20*** For medical necessity clinical coverage criteria, refer to the North Carolina Medicaid (Division of Health Benefits) Clinical Coverage Policy for Medical Equipment, 5A-3, Nursing Equipment and Supplies. **Continuous Glucose Monitoring (CGM)** For medical necessity clinical coverage criteria, refer to North Carolina Medicaid (Division of Health Benefits) Clinical Coverage Policy for Medical Equipment, 5A-3, Nursing Equipment and Supplies.

Medical Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale

Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation (for North Carolina Only)	Sep. 1, 2022	**Related Policies**
		• Added reference link to the:
		  ○ Coverage Determination Guideline titled *Durable Medical Equipment, Orthotics, medical Supplies and Repairs/Replacements (for North Carolina Only)*
		  ○ Medical Policy titled *Occipital Nerve Injections and Ablation (including Occipital Neuralgia and Headache)*
		Coverage Rationale
		• Added language to indicate:
		  ○ Neuromuscular electrical stimulation (NMES) is proven and medically necessary when used as part of a comprehensive lower limb rehabilitation program following total knee arthroplasty
		  ○ Translingual stimulation (TS) for gait rehabilitation is unproven and not medically necessary
		• Replaced language indicating:
		  ○ "Functional electrical stimulation (FES) is proven and medically necessary as a component of a comprehensive rehabilitation program in members with lower limb paralysis due to
			Functional electrical stimulation (FES) is proven and medically necessary as a component of a comprehensive ambulation rehabilitation program in members with lower limb paralysis due to spinal cord injury (SCI) when all of 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 three minutes
			• Demonstration of hand and finger function to manipulate controls
			• Post-recovery from SCI and restorative surgery of at least six months
			• Absence of hip and knee degenerative disease
			• Absence of history of long bone fracture secondary to osteoporosis
			
			Neuromuscular electrical stimulation (NMES) is proven and medically necessary for treating 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 including but not limited to casting, splinting or contractures
			• When used as part of a comprehensive lower limb rehabilitation program following total knee arthroplasty
			• To improve upper extremity function in persons with partial paralysis following stroke when used as part of a comprehensive rehabilitation program
			
			The following are unproven and not medically necessary due to insufficient

Medical Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation (for North Carolina Only) (continued)	Sep. 1, 2022	spinal cord injury (SCI) when all the [listed] criteria are met" with "FES is proven and medically necessary as a component of a comprehensive *ambulation* rehabilitation program in members with lower limb paralysis due to spinal cord injury (SCI) when all the [listed] criteria are met" ○ "NMES is proven and medically necessary to improve *wrist and finger* function *and prevent or correct shoulder subluxation* in persons with partial paralysis following stroke" with "NMES is proven and medically necessary to improve *upper extremity* function in persons with partial paralysis following stroke *when used as part of a comprehensive rehabilitation program*" • Removed language indicating dorsal root ganglion (DRG) stimulation is unproven and not medically necessary • Added reference link to the Medical Policy titled *Implanted Electrical Stimulator for Spinal Cord (for North Carolina Only)* for	evidence of efficacy: • FES for treating any other indication not listed above • 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) • NMES for treating any other indication not listed above • Percutaneous electrical nerve stimulation (PENS), percutaneous electrical nerve field stimulation (PENFS) or percutaneous neuromodulation therapy (PNT) • Percutaneous peripheral nerve stimulation (PNS)* • Peripheral subcutaneous field stimulation (PSFS) or peripheral nerve field stimulation (PNFS) • Pulsed electrical stimulation (PES) • Scrambler Therapy (ST) • Translingual Stimulation for gait rehabilitation (TS) *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 Spinal Cord (for North Carolina Only).

Medical Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation (for North Carolina Only) (continued)	Sep. 1, 2022	information regarding dorsal root ganglion (DRG) stimulation **Applicable Codes** • Removed CPT code 64566 • Updated list of functional electrical stimulation (FES) devices verified by the Centers for Medicare & Medicaid Services (CMS) Pricing, Data Analysis and Coding (PDAC) to be reported with HCPCS code E0770; added "Deluxe Digital Electronic Muscle Stimulator (Drive medical)" **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	
Implanted Electrical Stimulator for Spinal Cord (for North Carolina Only)	Sep. 1, 2022	**Coverage Rationale** • Replaced coverage guidelines for implanted electrical spinal cord stimulators with instruction to refer to the *North Carolina Medicaid (Division of Health Benefits) Clinical Coverage Policy for Physician 1A-25, Spinal Cord Stimulation* for medical necessity clinical coverage criteria • Added language to indicate: ○ Dorsal root ganglion (DRG) stimulation is proven and medically necessary for treating refractory complex regional pain syndrome	For implanted electrical spinal cord stimulators medical necessity clinical coverage criteria, refer to the to the North Carolina Medicaid (Division of Health Benefits) Clinical Coverage Policy for Physician 1A-25, Spinal Cord Stimulation. Dorsal root ganglion (DRG) stimulation is proven and medically necessary for treating refractory complex regional pain syndrome (CRPS I, CPRS II) in certain circumstances when performed according to U.S. Food and Drug Administration (FDA) labeled indications, contraindications, warnings and precautions. Dorsal root ganglion (DRG) stimulation is unproven and not medically necessary for treating all other indications due to insufficient evidence of efficacy. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Spinal Cord Stimulator (SCS) Insertion.

Medical Policy Updates

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Implanted Electrical Stimulator for Spinal Cord (for North Carolina Only) (continued)	Sep. 1, 2022	(CRPS I, CPRS II) in certain circumstances when performed according to U.S. Food and Drug Administration (FDA) labeled indications, contraindications, warnings, and precautions ○ Dorsal root ganglion (DRG) stimulation is unproven and not medically necessary for treating all other indications due to insufficient evidence of efficacy ● Removed instruction to refer to the Medical Policy titled *Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation (for North Carolina Only)* for Dorsal Root Ganglion (DRG) stimulation Supporting Information ● Updated *Clinical Evidence* and *References* sections to reflect the most current information	Click here to view the InterQual® criteria. Note: Coverage of a replacement battery/generator for a previously implanted electrical stimulator is appropriate when the individual's existing battery/generator is malfunctioning, cannot be repaired, and is no longer under warranty.
Obstructive and Central Sleep Apnea Treatment (for North Carolina Only)	Sep. 1, 2022	Coverage Rationale *Nonsurgical Treatment* ● Revised list of services/devices that are unproven and not medically necessary for treating Obstructive Sleep Apnea (OSA); added: ○ Non-surgical electrical muscular training ○ Morning repositioning devices *Surgical Treatment*	**Nonsurgical Treatment** Removable Oral Appliances are proven and medically necessary for treating Obstructive Sleep Apnea (OSA) as documented by a sleep study (e.g., polysomnography or Home Sleep Apnea Testing). Refer to the Medical Policy titled Attended Polysomnography for Evaluation of Sleep Disorders (for North Carolina Only) for further information. For many individuals, oral appliance therapy (OAT) may be an effective alternative to failed continuous positive airway pressure (CPAP) therapy. Documentation of the following is required: ● A patient presenting with symptoms of OSA be seen in a face-to-face

Medical Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Obstructive and Central Sleep Apnea Treatment (for North Carolina Only) (continued)	Sep. 1, 2022	• Revised coverage criteria for implantable hypoglossal nerve stimulation: ○ Added criterion requiring total AHI < 25% for central + mixed apneas ○ Replaced reference to "polysomnography" with "Polysomnography *(Attended)*" • Revised list of surgical procedures that are unproven and not medically necessary for treating Obstructive Sleep Apnea (OSA); added "distraction osteogenesis for maxillary expansion (DOME)" **Definitions** • Added definition of "Polysomnogram (Attended)" **Applicable Codes** • Added CPT/HCPCS codes 21142 and E1399 • Added notation to indicate HCPCS code E0486 applies to the custom fabricated oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable and includes fitting and adjustment **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	evaluation with a qualified physician (MD or DO) trained in sleep medicine or with an Advanced Practice Provider working under the direct supervision of a sleep medicine physician prior to beginning treatment for OAT (AASM and AADSM, Dec. 2012, AAO-HNS, Nov. 2019) • A treating physician (MD or DO) or an Advanced Practice Provider must diagnose OSA and recommend course of treatment (AAO-HNS, Nov. 2019) • If the patient refuses CPAP therapy, documentation of the refusal from the patient's treating physician (MD or DO) or an Advanced Practice Provider must be supplied For medical necessity clinical coverage criteria, refer to the InterQual® CP: Durable Medical Equipment, Noninvasive Airway Assistive Devices. Click here to view the InterQual® criteria. 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 • Removable Oral Appliances for treating Central Sleep Apnea • Prefabricated Oral Appliance/Device • Non-surgical electrical muscular training • Morning repositioning devices **Surgical Treatment** The following surgical procedures are proven and medically necessary for treating OSA as documented by polysomnography. For medical necessity clinical coverage criteria, refer to the InterQual® Client Defined CP: Procedures: • Mandibular Osteotomy (Custom) – UHG • Maxillomandibular Osteotomy and Advancement (Custom) - UHG • Uvulopalatopharyngoplasty (UPPP) (Custom) - UHG Click here to view the InterQual® criteria.

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**

Obstructive and Central Sleep Apnea Treatment (for North Carolina Only) (continued)	Sep. 1, 2022		Implantable hypoglossal nerve stimulation is proven and medically necessary in an adult patient with moderate to severe OSA when all the following criteria are met:
			• Body Mass Index (BMI) of less than or equal to 32kg/m^2; and
			• Apnea Hypopnea Index (AHI) of ≥ 20 and ≤ 65 as determined with Polysomnography (Attended); and
			• Total AHI < 25% for central + mixed apneas; and
			• Absence of complete concentric collapse at the soft palate level; and
			• Failure or intolerance of Positive Airway Pressure (PAP) treatments (such as continuous positive airway pressure [CPAP] or bi-level positive airway pressure [BPAP] machines)
			  ○ PAP failure is defined as an inability to eliminate OSA (AHI of greater than 20 despite PAP usage) and PAP intolerance is defined as:
			  ▪ Inability to use PAP (greater than 5 nights per week of usage; usage defined as greater than 4 hours of use per night); or
			  ▪ Unwillingness to use PAP (for example, a patient returns the PAP system after attempting to use it)
			
			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.
			
			The following surgical procedures are unproven and not medically necessary for treating OSA due to insufficient evidence of efficacy:
			• Laser-assisted uvulopalatoplasty (LAUP)
			• Lingual suspension – Also referred to as tongue stabilization, tongue stitch or tongue fixation
			• Palatal implants
			• Radiofrequency ablation of the soft palate and/or tongue base
			• Transoral robotic surgery (TORS)
			• Distraction osteogenesis for maxillary expansion (DOME)
			
			Respiratory Devices for the Treatment of Obstructive Sleep Apnea

Medical Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Obstructive and Central Sleep Apnea Treatment (for North Carolina Only) (continued)	Sep. 1, 2022		Bilevel and CPAP devices are proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to North Carolina Medicaid (Division of Health Benefits) Clinical Coverage Policy for Medical Equipment, 5A-2, Respiratory Equipment and Supplies.
Out-of-State Services (for North Carolina Only)	Sep. 1, 2022	**Template Update** • Changed policy type classification from "Utilization Review Guideline" to "Medical Policy" **Coverage Rationale** • Replaced language with instruction to refer to the North Carolina (Division of Health Benefits) Clinical Coverage Policy for Facility Services, 2A-3, Out-of-State Services (OOS) for medical necessity clinical coverage criteria **Definitions** • Removed definition of: ○ Emergency Medical Condition ○ Medically Necessary Services and Supplies ○ Out-of-State Providers	For medical necessity clinical coverage criteria, refer to the North Carolina (Division of Health Benefits) Clinical Coverage Policy for Facility Services, 2A-3, Out-of-State Services (OOS).

Retired

Policy Title	Effective Date	Summary of Changes
Corneal Collagen Crosslinking (for North Carolina Only)	Jul. 1, 2022	• Policy retired; corneal collagen crosslinking no longer requires clinical review
Lung Volume Reduction Surgery (for North Carolina Only)	Jul. 1, 2022	• Policy retired; lung volume reduction surgery no longer requires clinical review

Medical Policy Updates

Retired		
Policy Title	**Effective Date**	**Summary of Changes**
Otoacoustic Emissions Testing (for North Carolina Only)	Jul. 1, 2022	• Policy retired; otoacoustic emissions testing no longer requires clinical review

Coverage Determination Guideline Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rational**
Ambulance Services (for North Carolina Only)	Sep. 1, 2022	Coverage Rationale • Removed coverage statement; refer to the North Carolina Medicaid (Division of Health Benefits) Clinical Coverage Policy for Ambulance Services, 15. Ambulance Services for clinical coverage criteria Applicable Codes • Revised description for modifiers E, I, J, P, and X	For clinical coverage criteria, refer to the North Carolina Medicaid (Division of Health Benefits) Clinical Coverage Policy for Ambulance Services, 15. Ambulance Services.

Utilization Review Guideline Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rational
Outpatient Surgical Procedures – Site of Service (for North Carolina Only)	Sep. 1, 2022	**Coverage Rationale** • Removed list of documentation requirements **Supporting Information** • Updated *References* section to reflect the most current information	UnitedHealthcare members may choose to receive surgical procedures in an ambulatory surgical center (ASC) or other locations. We are conducting site of service medical necessity reviews; however, to determine whether the outpatient hospital department is medically necessary, in accordance with the terms of the member's benefit plan. Certain planned surgical procedures performed in a hospital outpatient department are considered medically necessary for an individual who meets any of the following criteria: • Advanced liver disease (MELD Score > 8) • Advance surgical planning determines an individual requires overnight recovery and care following a surgical procedure • Anticipated need for transfusion • Bleeding disorder requiring replacement factor or blood products or special infusion products to correct a coagulation defect • Cardiac arrhythmia (symptomatic arrhythmia despite medication) • Chronic obstructive pulmonary disease (COPD) (FEV1 < 50%) • Coronary artery disease ([CAD]/peripheral vascular disease [PVD]) (ongoing cardiac ischemia requiring medical management or recently placed [within one year] drug eluting stent) • Developmental stage or cognitive status warranting use of a hospital outpatient department • End stage renal disease ([hyperkalemia above reference range] receiving peritoneal or hemodialysis) • History of cerebrovascular accident (CVA) or transient ischemic attack (TIA) (recent event [< 3 months]) • History of myocardial infarction (MI) (recent event [< 3 months]) • Individuals with drug eluting stents (DES) placed within one year or bare metal stents (BMS) or plain angioplasty within 90 days unless acetylsalicylic acid and antiplatelet drugs will be continued by agreement of surgeon, cardiologist, and anesthesia • Ongoing evidence of myocardial ischemia • Poorly Controlled asthma (FEV1 < 80% despite medical management) • Pregnancy

Utilization Review Guideline Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rational**
Outpatient Surgical Procedures – Site of Service (for North Carolina Only) (continued)	Sep. 1, 2022		• Prolonged surgery (> 3 hours) • Resistant hypertension (Poorly Controlled) • Severe valvular heart disease • Sleep apnea (moderate to severe Obstructive Sleep Apnea (OSA) • Uncompensated chronic heart failure (CHF) (NYHA class III or IV) • Uncontrolled diabetes with recurrent diabetic ketoacidosis (DKA) or severe hypoglycemia • Under 21 years of age A planned surgical procedure performed in a hospital outpatient department is considered medically necessary if there is an inability to access an ambulatory surgical center for the procedure due to any one of the following: • There is no geographically accessible ambulatory surgical center that has the necessary equipment for the procedure; or • There is no geographically accessible ambulatory surgical center available at which the individual's physician has privileges; or • An ASC's specific guideline regarding the individual's weight or health conditions that prevents the use of an ASC **Planned Surgical Procedures List** Site of service medical necessity reviews will be conducted for certain surgical procedures only when performed in an outpatient hospital setting. For the complete list of surgical procedure codes requiring prior authorization for each state, refer to the UnitedHealthcare Community Plan Prior Authorization List.

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