United Healthcare Community Plan

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

In This Issue

Take Note

Medical Policy Updates

Updated

Revised

United Healthcare Community Plan

Take Note

InterQual® Release Dates Removed

Effective Jun. 1, 2022, all references to specific InterQual® release dates will be removed from the Medical Policies, Coverage Determination Guidelines, and Utilization Review Guidelines which contain language pertaining to InterQual® criteria; refer to the most current version of the InterQual® criteria, when applicable.

Community Plan of North Carolina to Use National Policy Versions

Effective Jun. 1, 2022, Community Plan of North Carolina will no longer maintain state-specific Medical Policies 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:

- Apheresis
- Athletic Pubalgia Surgery
- Autologous Cellular Therapy
- Bronchial Thermoplasty
- Catheter Ablation for Atrial Fibrillation
- Chelation Therapy for Non-Overload Conditions
- Cognitive Rehabilitation
- Computer-Assisted Surgical Navigation for Musculoskeletal Procedures
- Computerized Dynamic Posturography
- Corneal Hysteresis and Intraocular Pressure Measurement
- Cytological Examination of Breast Fluids for Cancer Screening or Diagnosis
- Diagnostic Spinal Ultrasonography
- Electric Tumor Treatment Field Therapy
- Electrical Bioimpedance for Cardiac Output Measurement
- Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation
- Epiduroscopy, Epidural Lysis of Adhesions and Discography
- Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions and Soft Tissue Wounds
- Fecal Calprotectin Testing
- Gastrointestinal Motility Disorders, Diagnosis and Treatment
- Glaucoma Surgical Treatments
- Hepatitis Screening
- Implantable Beta-Emitting Microspheres for Treatment of Malignant Tumors
- Intraoperative Hyperthermic Intraperitoneal Chemotherapy (HIPEC)
- Intrauterine Fetal Surgery
- Laser Interstitial Thermal Therapy
- Light and Laser Therapy
- Lithotripsy for Salivary Stones
- Lower Extremity Invasive Diagnostic and Endovascular Procedures
- Macular Degeneration Treatment Procedures
- Mechanical Stretching Devices
- Meniscus Implant and Allograft
- Minimally Invasive Procedures for Gastroesophageal Reflux Disease (GERD) and Achalasia
- Occipital Nerve Injections and Ablation (Including Occipital Neuralgia and Headache)
- Percutaneous Patent Foramen Ovale (PFO) Closure
- Prolotherapy and Platelet Rich Plasma Therapies
- Prostate Surgeries and Interventions
- Stereotactic Body Radiation Therapy and Stereotactic Radiosurgery
- Surgery of the Foot
- Surgery of the Hand or Wrist
- Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins
- Thermography
- Transcranial Magnetic Stimulation
- Transpupillary Thermotherapy
- Umbilical Cord Blood Harvesting and Storage for Future Use
- Vertebral Body Tethering for Scoliosis
- Visual Information Processing Evaluation and Orthoptic and Vision Therapy
- Warming Therapy and Ultrasound Therapy for Wounds

Medical Policy Updates

Updated

Policy Title	Effective Date	Summary of Changes
Cardiovascular Disease Risk Tests (for North Carolina Only)	Aug. 1, 2022	**Coverage Rationale** • Revised list of indications that are unproven and not medically necessary; added "multi-protein diagnostic biomarker, such as 3 proteins (high sensitivity [hs] troponin, adiponectin, and kidney injury molecule-1 [KIM-1]) or 4 proteins (NT-proBNP, osteopontin, tissue inhibitor of metalloproteinase-1 [TIMP-1], and KIM-1) with algorithm and reported as a risk score" **Applicable Codes** • Added CPT code 84999 • Removed CPT codes 0308U and 0309U **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect the most current information
Functional Endoscopic Sinus Surgery (FESS) (for North Carolina Only)	Aug. 1, 2022	**Applicable Codes** • Removed CPT code 31239

Transcatheter Heart Valve Procedures (for North Carolina Only)	Aug. 1, 2022	**Coverage Rationale**
		• Added instruction to refer to the following sources for additional information pertaining to Volume Requirements consistent with the Centers for Medicare and Medicaid Services (CMS):
		  ○ CMS National Coverage Determination 20.32: *Transcatheter Aortic Valve Replacement (TAVR)*
		  ○ Society of Thoracic Surgeons/American College of Cardiology (STS/ACC) *Transcatheter Valve Therapy (TVT) Registry*
		Definitions
		• Updated definition of "CMS Volume Requirements for Transcatheter Aortic Heart Valve Replacement (TAVR)"
		Supporting Information
		• Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Cell-Free Fetal DNA Testing (for North Carolina Only)	Aug. 1, 2022	**Coverage Rationale** • Removed coverage statement (refer to the North Carolina (Division of Health Benefits) Clinical Coverage	For medical necessity clinical coverage criteria refer to North Carolina Medicaid Clinical Coverage Policy No.: 1S-4, Genetic Testing.

Medical Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Cell-Free Fetal DNA Testing (for North Carolina Only) (continued)	Aug. 1, 2022	Policy No.: 1S-4, Genetic Testing for applicable details) Applicable Codes • Removed ICD-10 diagnosis codes G91.2, Q90.0, Q90.1, Q90.2, Q90.9, Q91.0, Q91.1, Q91.2, Q91.3, Q91.4, Q91.5, Q91.6, Q91.7, Q92.0, Q92.1, Q92.2, Q92.5, Q92.61, Q92.62, Q92.7, Q92.8, Q92.9, Z36.84, Z36.85, Z36.86, Z36.87, and Z36.88	
Epidural Steroid Injections for Spinal Pain (for North Carolina Only)	Aug. 1, 2022	Coverage Rationale *Proven and Medically Necessary* • Revised language to indicate Epidural Steroid Injections (ESI) are proven and medically necessary when the following criteria are met: ○ The injection is intended for the short term management of acute or subacute radicular pain and; ○ The radicular pain is unresponsive to Conservative Treatment: ▪ Pharmacotherapy such as NSAIDS or acetaminophen ≥ 3 weeks or; ▪ Activity modification ≥ 4 weeks (including but not limited to heavy lifting, bending, spinal torsion activities) or; ▪ PT or home exercise ≥ 4 weeks	Epidural Steroid Injections (ESI) are proven and medically necessary when the following criteria are met: • The injection is intended for the short-term management of acute or subacute radicular pain and; • The radicular pain is unresponsive to Conservative Treatment: ○ Pharmacotherapy such as NSAIDS or acetaminophen ≥ 3 weeks or; ○ Activity modification ≥ 4 weeks (including but not limited to heavy lifting, bending, spinal torsion activities) or; ○ PT or home exercise ≥ 4 weeks The following are unproven and not medically necessary due to insufficient evidence of efficacy: • The use of ultrasound guidance for ESIs • ESI for all other indications of the spine not included above

Medical Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Epidural Steroid Injections for Spinal Pain (for North Carolina Only) (continued)	Aug. 1, 2022	**Definitions** • Added definition of "Oswestry Disability Index (also known as the Oswestry Low Back Pain Disability Questionnaire)" • Updated definition of "Epidural Steroid Injections (ESIs)" **Applicable Codes** • Added CPT codes 62324, 62325, 62326, and 62327 **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	
Neurophysiologic Testing and Monitoring (for North Carolina Only)	Aug. 1, 2022	**Coverage Rationale** • Revised list of known or suspected disorders for which nerve conduction studies with or without late responses (e.g., F-wave and H-reflex tests) and neuromuscular junction testing when performed in conjunction with needle electromyography are proven and medically necessary: ○ Added: ▪ Peripheral neuropathy/polyneuropathy (e.g., inherited, metabolic, traumatic, entrapment syndromes) ▪ Treatment guidance (e.g., muscle localization for	**Nerve Conduction Studies** The following are proven and medically necessary: • Nerve conduction studies with or without late responses (e.g., F-wave and H-reflex tests) and neuromuscular junction testing when performed in conjunction with needle electromyography for any of the following known or suspected disorders: ○ Peripheral neuropathy/polyneuropathy (e.g., inherited, metabolic, traumatic, entrapment syndromes) ○ Plexopathy ○ Neuromuscular junction disorders (e.g., myasthenia gravis) ○ Myopathy ○ Motor neuron disease ○ Radiculopathy (cervical, thoracic or lumbosacral) ○ Treatment guidance (e.g., muscle localization for botulinum toxin injections, when required to identify affected muscles warranting injection) • Nerve conduction studies with or without late responses (e.g., F-wave and H-reflex tests) when performed without needle electromyography for

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Neurophysiologic Testing and Monitoring (for North Carolina Only) (continued)	Aug. 1, 2022	botulinum toxin injections, when required to identify affected muscles warranting injection) ○ Removed: ▪ Peripheral nerve entrapment syndromes ▪ Generalized neuropathies ▪ Hereditary, metabolic, or degenerative polyneuropathy ▪ Spine disorder with nerve root impingement symptoms ▪ Guidance for botulinum toxin injection for spasmodic dysphonia or segmental dystonia when it is difficult to isolate affected muscles ▪ Traumatic nerve lesions ○ Replaced: ▪ "Plexopathy *(acquired disorder in tissue along nerves that causes motor and sensory dysfunction)*" with "plexopathy" ▪ "Neuromuscular junction disorders" with "neuromuscular junction disorders *(e.g., myasthenia gravis)*" ▪ "Myopath*ies*" with "myopath*y*"	individuals who have any of the above known or suspected disorders with any of the following clinical indications: ○ Individuals treated with anticoagulants; or ○ Individuals with lymphedema; or ○ Individuals being evaluated for carpal tunnel syndrome The following are unproven and not medically necessary due to insufficient evidence of efficacy: ● Nerve conduction studies for all conditions other than those listed above as proven. ● Non-invasive automatic, portable, or automated point of care nerve conduction monitoring systems (e.g., the NC-stat® System, the Brevio® NCS-Monitor, and the Advance™ System) that test only distal motor latencies and conduction velocities for the purpose of electrodiagnostic testing. **Other Neurophysiological Testing** The following are unproven and not medically necessary due to insufficient evidence of efficacy: ● Surface electromyography (SEMG) ● SEMG based seizure monitoring systems ● Macroelectromyography (macro-EMG) testing ● Physiologic recording of movement disorder symptoms, including bradykinesia, dyskinesia, and tremor using wearable devices with accelerometers or gyroscopes ● Quantitative sensory testing, including monofilament testing, pressure-specified sensory testing, computer assisted sensory examinations, and current perception threshold (CPT) testing ● Visual evoked potential testing for diagnosing and evaluating glaucoma This policy does not address intraoperative neurophysiologic testing.

Medical Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Neurophysiologic Testing and Monitoring (for North Carolina Only) (continued)	Aug. 1, 2022	▪ "Cervical, thoracic, *and/or* lumbosacral radiculopathy" with "radiculopathy (cervical, thoracic, *or* lumbosacral)" Supporting Information • Updated *References* section to reflect the most current information	
Personal Care Services (for North Carolina Only)	Aug. 1, 2022	Coverage Rationale • Removed coverage statement (refer to the North Carolina (Division of Health Benefits) Clinical Coverage Policy for Community Based Services, 3L, State Plan Personal Care Services (PCS) for applicable details) Supporting Information • Updated *FDA* and *References* sections to reflect the most current information	For medical necessity clinical coverage criteria, refer to the North Carolina (Division of Health Benefits) Clinical Coverage Policy for Community Based Services, 3L, State Plan Personal Care Services (PCS).
Skin and Soft Tissue Substitutes (for North Carolina Only)	Aug. 1, 2022	Coverage Rationale • Removed coverage statement (refer to the North Carolina Medicaid (Division of Health Benefits) Clinical Coverage Policy for Burn Treatment and Skin Substitutes, 1G-2. Skin Substitutes for applicable details)	For medical necessity clinical coverage criteria, refer to North Carolina Medicaid (Division of Health Benefits) Clinical Coverage Policy for Burn Treatment and Skin Substitutes, 1G-2. Skin Substitutes.

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.