United Healthcare Community Plan

UnitedHealthcare Community Plan of Pennsylvania
Medical Policy Update Bulletin: June 2022

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.

In This Issue

Medical Policy Updates — Page

Updated

Revised

Medical Benefit Drug Policy Updates

Revised

Medical Policy Updates

Updated

Policy Title	Effective Date	Summary of Changes
Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes (for Pennsylvania Only)	Jul. 1, 2022	**Application** • Added language to indicate any requests for services that do not meet criteria set in the Prior Authorization Review Panel (PARP) will be evaluated on a case by case basis; refer to *Pennsylvania Exceptions, Pennsylvania Code, Title 55, Chapter 1101* **Applicable Codes** • Added HCPCS codes A4238 and E2102 **Supporting Information** • Updated *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information
Deep Brain and Cortical Stimulation (for Pennsylvania Only)	Jun. 1, 2022	**Application** • Added language to indicate any requests for services that do not meet criteria set in the Prior Authorization Review Panel (PARP) will be evaluated on a case-by-case basis; refer to *Pennsylvania Exceptions, Pennsylvania Code, Title 55, Chapter 1101* **Coverage Rationale** • Updated language to clarify responsive cortical stimulation is proven and medically necessary for treating *refractory* partial or focal seizure disorder • Removed reference to specific InterQual® release date; refer to the most current InterQual® criteria **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information
Gastrointestinal Pathogen Nucleic Acid Detection Panel Testing for Infectious Diarrhea (for Pennsylvania Only)	Jul. 1, 2022	**Application** • Added language to indicate any requests for services that do not meet criteria set in the Prior Authorization Review Panel (PARP) will be evaluated on a case by case basis; refer to *Pennsylvania Exceptions, Pennsylvania Code, Title 55, Chapter 1101* **Applicable Codes** • Removed CPT code 0097U
Mechanical Stretching Devices (for Pennsylvania Only)	Jul. 1, 2022	**Application** • Added language to indicate any requests for services that do not meet criteria set in the Prior Authorization Review Panel (PARP) will be evaluated on a case by case basis; refer to *Pennsylvania Exceptions, Pennsylvania Code, Title 55, Chapter 1101* **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information

Medical Policy Updates

Updated

Policy Title	Effective Date	Summary of Changes
Molecular Oncology Testing for Cancer Diagnosis, Prognosis, and Treatment Decisions (for Pennsylvania Only)	Jun. 1, 2022	**Application** • Added language to indicate any requests for services that do not meet criteria set in the Prior Authorization Review Panel (PARP) will be evaluated on a case-by-case basis; refer to *Pennsylvania Exceptions, Pennsylvania Code, Title 55, Chapter 1101* **Applicable Codes** • Added CPT codes 0306U, 0307U, 0313U, 0314U, and 0315U • Revised description for CPT codes 0022U and 0307U

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Cardiovascular Disease Risk Tests (for Pennsylvania Only)	Aug. 1, 2022	**Application** • Added language to indicate any requests for services that do not meet criteria set in the Prior Authorization Review Panel (PARP) will be evaluated on a case-by-case basis; refer to *Pennsylvania Exceptions, Pennsylvania Code, Title 55, Chapter 1101* **Coverage Rationale** • Added language to indicate multi-protein diagnostic biomarkers, 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, are unproven and not medically necessary **Applicable Codes** • Added CPT codes 0308U, 0309U,	The following are unproven and not medically necessary due to insufficient evidence of efficacy: • Arterial compliance testing, using waveform analysis as a method to determine risk for cardiovascular disease • Carotid intima-media thickness (CIMT) measurement as an effective screening tool for the management of cardiovascular disease • Advanced lipoprotein analysis (e.g., apolipoproteins, lipoprotein(a), subfractions or particle size) as method to determine risk for cardiovascular disease • Lipoprotein-associated phospholipase A2 (Lp-PLA2) enzyme and other human A2 phospholipases such as secretory phospholipase A2 (sPLA2-IIA) as method to determine risk for cardiovascular disease or ischemic stroke • Long-chain omega-3 fatty acids as method to determine risk for cardiovascular disease • Endothelial function assessment using tools such as peripheral arterial tonometry (PAT) or brachial artery pressure ultrasound as a prognostic indicator to determine risk of cardiovascular disease • 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

Medical Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Cardiovascular Disease Risk Tests (for Pennsylvania Only) (continued)	Aug. 1, 2022	and 84999 **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect the most current information • Removed *CMS* section	
Epidural Steroid Injections for Spinal Pain (for Pennsylvania Only)	Aug. 1, 2022	**Application** • Added language to indicate any requests for services that do not meet criteria set in the Prior Authorization Review Panel (PARP) will be evaluated on a case-by-case basis; refer to *Pennsylvania Exceptions, Pennsylvania Code, Title 55, Chapter 1101* **Coverage Rationale** • Replaced language indicating "Epidural Steroid Injections (ESI) are proven and medically necessary *for treating* radicular pain *caused by spinal stenosis, disc herniation, degenerative changes in the vertebrae, or* for the short-term management of *spine* pain" with "Epidural Steroid Injections (ESI) are proven and medically necessary *when the injection is intended* for the short term management of *acute or subacute* radicular pain" • Revised coverage criteria: ○ Removed criterion requiring	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 **Epidural Steroid Injection Limitations** • A maximum of three (3) ESI sessions (per region, regardless of level, location, or side) per year ○ A session is defined as one date of service in which ESI(s) is performed ○ A region is defined by either the region of the cervical, thoracic, or lumbosacral spine ○ A year is defined as the 12-month period starting from the date of service of the first approved injection • Repeat ESIs may be provided only if: ○ The initial injection resulted in ≥ 50% pain relief is achieved for 3 or more months

Medical Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Epidural Steroid Injections for Spinal Pain (for Pennsylvania Only) (continued)	Aug. 1, 2022	the pain is associated with symptoms of nerve root irritation and/or spine pain due to disc extrusions and/or contained herniations ○ Replaced criterion requiring "the pain is unresponsive to Conservative Treatment, *including but not limited to* pharmacotherapy, exercise, or physical therapy" with "the *radicular* pain is unresponsive to Conservative Treatment: pharmacotherapy *such as NSAIDS or acetaminophen ≥ 3 weeks; activity modification ≥ 4 weeks (including but not limited to heavy lifting, bending, spinal torsion activities);* or physical therapy (PT) *or home* exercise *≥ 4 weeks*" *Epidural Steroid Injection Limitations* • Added language to indicate repeat ESIs may be provided only if: • Added language to indicate repeat ESIs may be provided only if: ○ The initial injection resulted in ≥ 50% pain relief achieved for 3 or more months ○ The initial injection resulted in a functional improvement as	○ The initial injection resulted in a functional improvement as measured by validated measurement tools, such as The Oswestry Disability Index ○ Repeat injections do not exceed 3 per year, per region

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Epidural Steroid Injections for Spinal Pain (for Pennsylvania Only) (continued)	Aug. 1, 2022	measured by validated measurement tools, such as the *Oswestry Disability Index* ○ Repeat injections do not exceed 3 per year, per region • Replaced language indicating: ○ "A maximum of three (3) ESI sessions (per region, regardless of level, location, or side) [may be provided] *in* a year *when criteria (indications for coverage) are met for each injection*" with "a maximum of three (3) ESI sessions (per region, regardless of level, location, or side) [may be provided] *per* year" ○ "A region is defined by either the region of the cervical or thoracic spine or the region of the lumbar or sacral spine" with "a region is defined by the region of the cervical, thoracic, or lumbosacral spine" **Definitions** • Added definition of "Oswestry Disability Index (also known as the Oswestry Low Back Pain Disability Questionnaire)" • Updated definition of "Epidural Steroid Injections (ESIs)" **Supporting Information** • Updated *Description of Services*,	

Medical Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Epidural Steroid Injections for Spinal Pain (for Pennsylvania Only) (continued)	Aug. 1, 2022	*Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	
Facet Joint and Medial Branch Block Injections for Spinal Pain (for Pennsylvania Only)	Aug. 1, 2022	**Title Change** • Previously titled *Facet Joint Injections for Spinal Pain* **Application** • Added language to indicate any requests for services that do not meet criteria set in the Prior Authorization Review Panel (PARP) will be evaluated on a case-by-case basis; refer to *Pennsylvania Exceptions, Pennsylvania Code, Title 55, Chapter 1101* **Coverage Rationale** • Revised language to indicate: ○ Diagnostic Facet Joint/Medial Branch Block injections of the cervical, thoracic, and lumbar levels of the spine are proven and medically necessary in certain circumstances; for medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Facet Joint Injection ○ Therapeutic Facet Joint/Medial Branch Block Injections at the cervical, thoracic, and lumbar levels of the spine are	Diagnostic Facet Joint/Medial Branch Block injections of the cervical, thoracic and lumbar levels of the spine are proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures Facet Joint Injection. Click here to view the InterQual® criteria. Therapeutic Facet Joint/Medial Branch Block Injections at the cervical, thoracic and lumbar levels of the spine are unproven and not medically necessary due to insufficient evidence of efficacy and safety.

Medical Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Facet Joint and Medial Branch Block Injections for Spinal Pain (for Pennsylvania Only) (continued)	Aug. 1, 2022	unproven and not medically necessary due to insufficient evidence of efficacy and safety • Removed ICD-10 diagnosis codes G89.18, G89.28, G97.82, M41.20, M41.22, M41.23, M41.24, M41.25, M41.26, M41.27, M43.00, M43.01, M43.02, M43.03, M43.04, M43.05, M43.06, M43.07, M43.08, M43.09, M43.10, M43.11, M43.12, M43.13, M43.14, M43.15, M43.16, M43.17, M43.18, M43.19, M46.90, M46.91, M46.92, M46.93, M46.94, M46.95, M46.96, M46.97, M46.98, M46.99, M47.011, M47.012, M47.013, M47.014, M47.015, M47.016, M47.019, M47.021, M47.022, M47.029, M47.11, M47.12, M47.13, M47.14, M47.15, M47.16, M47.20, M47.21, M47.22, M47.23, M47.24, M47.25, M47.26, M47.27, M47.28, M47.811, M47.818, M47.891, M47.898, M48.50XA, M48.51XA, M48.52XA, M48.53XA, M48.54XA, M48.55XA, M48.56XA, M48.57XA, M48.58XA, M51.14, M51.15, M51.16, M51.17, M51.26, M51.27, M80.0AXA, M80.08XA, M80.8AXA, M80.88XA, M84.48XA, M84.58XA, M84.68XA, M96.1, S12.000A, S12.001A, S12.01XA, S12.02XA, S12.030A, S12.031A, S12.040A, S12.041A, S12.090A, S12.091A,	

Medical Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Facet Joint and Medial Branch Block Injections for Spinal Pain (for Pennsylvania Only) (continued)	Aug. 1, 2022	S12.100A, S12.101A, S12.110A, S12.111A, S12.112A, S12.120A, S12.121A, S12.130A, S12.131A, S12.14XA, S12.150A, S12.151A, S12.190A, S12.191A, S12.200A, S12.201A, S12.230A, S12.231A, S12.24XA, S12.250A, S12.251A, S12.290A, S12.291A, S12.300A, S12.301A, S12.330A, S12.331A, S12.34XA, S12.350A, S12.351A, S12.390A, S12.391A, S12.400A, S12.401A, S12.430A, S12.431A, S12.44XA, S12.450A, S12.451A, S12.490A, S12.491A, S12.500A, S12.501A, S12.530A, S12.531A, S12.54XA, S12.550A, S12.551A, S12.590A, S12.591A, S12.600A, S12.601A, S12.630A, S12.631A, S12.64XA, S12.650A, S12.651A, S12.690A, S12.691A, S12.9XXA, S22.000A, S22.001A, S22.002A, S22.008A, S22.009A, S22.010A, S22.011A, S22.012A, S22.018A, S22.019A, S22.020A, S22.021A, S22.022A, S22.028A, S22.029A, S22.030A, S22.031A, S22.032A, S22.038A, S22.039A, S22.040A, S22.041A, S22.042A, S22.048A, S22.049A, S22.050A, S22.051A, S22.052A, S22.058A, S22.059A, S22.060A, S22.061A, S22.062A, S22.068A, S22.069A, S22.070A, S22.071A, S22.072A, S22.078A,	

Medical Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Facet Joint and Medial Branch Block Injections for Spinal Pain (for Pennsylvania Only) (continued)	Aug. 1, 2022	S22.079A, S22.080A, S22.081A, S22.082A, S22.088A, S22.089A, S32.000A, S32.001A, S32.002A, S32.008A, S32.009A, S32.010A, S32.011A, S32.012A, S32.018A, S32.019A, S32.020A, S32.021A, S32.022A, S32.028A, S32.029A, S32.030A, S32.031A, S32.032A, S32.038A, S32.039A, S32.040A, S32.041A, S32.042A, S32.048A, S32.049A, S32.050A, S32.051A, S32.052A, S32.058A, S32.059A, S32.10XA, S32.110A, S32.111A, S32.112A, S32.119A, S32.120A, S32.121A, S32.122A, S32.129A, S32.130A, S32.131A, S32.132A, S32.139A, S32.14XA, S32.15XA, S32.16XA, S32.17XA, S32.19XA, and S32.2XXA **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	
Negative Pressure Wound Therapy (for Pennsylvania Only)	Jul. 1, 2022	**Application** • Added language to indicate any requests for services that do not meet criteria set in the Prior Authorization Review Panel (PARP) will be evaluated on a case-by-case basis; refer to *Pennsylvania Exceptions, Pennsylvania Code, Title 55, Chapter 1101*	Notes: • The proven and medically necessary coverage statements in this policy apply to the use of negative pressure wound therapy (NPWT) in the outpatient setting. • The unproven and not medically necessary coverage statements in this policy apply to all settings. NPWT, in an outpatient setting or upon discharge from an inpatient setting, is proven and medically necessary for treating individuals who have

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale

Negative Pressure Wound Therapy (for Pennsylvania Only) (continued)	Jul. 1, 2022	**Coverage Rationale**
		• Revised list of indications and devices that are unproven and not medically necessary:
		  ○ Added "negative pressure wound therapy (NPWT) systems with instillation"
		  ○ Replaced "NPWT for treating closed surgical *wounds*" with "NPWT for treating closed surgical *incisions*"
		Definitions
		• Updated definition of "National Pressure Injury Advisory Panel (NPIAP) Staging System"
		Applicable Codes
		• Removed instruction to refer to the Coverage Determination Guideline titled *Durable Medical Equipment, Orthotics, Medical Supplies and Repairs/Replacements* (for Pennsylvania Only) for use of HCPCS codes K0743-K0746
		Supporting Information
		• Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect the most current information
			undergone a complete wound therapy program and meet indication-specific criteria as noted below.
			
			A complete wound therapy program, meeting the following criteria, must have been tried or considered and ruled out prior to initiation of NPWT:
			• Documentation of evaluation, care and wound measurements; and
			• Application of dressings to maintain a moist wound environment; and
			• Debridement of necrotic tissue, if present; and
			• Evaluation of and provision for adequate nutritional status; and
			• Documentation, by provider, of indication for NPWT; and
			• Documentation that open wound has not responded to conventional treatment after 30 days
			
			Indications
			• Pressure ulcer (Stage III or IV) with documentation of the following:
			  ○ Complete wound therapy program, as outlined above; and
			  ○ Appropriate turning and positioning; and
			  ○ Use of a pressure-reducing support surface; and
			  ○ Moisture and incontinence management
			• Neuropathic ulcer (e.g., Diabetic ulcer) with documentation of the following:
			  ○ Complete wound therapy program, as outlined above; and
			  ○ Comprehensive diabetic management program; and
			  ○ Reduction in pressure on ulcer
			• Venous insufficiency ulcer with documentation of the following:
			  ○ Complete wound therapy program, as outlined above; and
			  ○ Compression bandages and/or garments have been used consistently, for at least 30 days; and
			  ○ Leg elevation and ambulation
			• Open surgical wound with documentation of the following:
			  ○ Post-operative dehiscence (separation of a previously closed surgical incision) with documentation of a complete wound therapy program, as outlined above; or
			  ○ Open, non-healing amputation site in diabetics; or

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Negative Pressure Wound Therapy (for Pennsylvania Only) (continued)	Jul. 1, 2022		○ Post-sternotomy infection (mediastinitis); or ○ Delayed healing or non-healing of skin graft is likely due to irregularly contoured or inadequate blood flow of the graft bed • High-risk open fracture (Gustilo Grade III) The following indications and devices are unproven and not medically necessary due to insufficient evidence of efficacy: • NPWT for treating all other indications, including but not limited to: ○ Closed surgical incisions ○ Pilonidal disease • Disposable/single-use NPWT systems • NPWT systems with instillation **Contraindications to NPWT** • Active bleeding or exposed vasculature in wound • Eschar or necrotic tissue present in wound • Exposed bone, nerves or organs in vicinity of wound • Malignancy present in wound • Uncontrolled soft tissue infection or osteomyelitis within vicinity of wound • Presence of an open fistula to body organs or cavities within vicinity of wound NPWT should be discontinued when any of the following criteria are present: • Documentation of weekly assessment of the wound's dimensions and characteristics by the provider indicate failure of progressive wound healing (i.e., wound is not diminishing in size [either surface area or depth] within 30 days); or • The depth of the wound is 1 mm or less; or • Uniform granulation tissue has been obtained
Obstructive and Central Sleep Apnea Treatment (for Pennsylvania Only)	Jul. 1, 2022	Application • Added language to indicate any requests for services that do not meet criteria set in the Prior	**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).

Medical Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Obstructive and Central Sleep Apnea Treatment (for Pennsylvania Only) (continued)	Jul. 1, 2022	Authorization Review Panel (PARP) will be evaluated on a case by case basis; refer to *Pennsylvania Exceptions, Pennsylvania Code, Title 55, Chapter 1101* **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* • 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	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 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, December 2012, AAO-HNS, November 2019) • A treating physician (MD or DO) or an Advanced Practice Provider must diagnose OSA and recommend course of treatment (AAO-HNS, November 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 information on snoring and Oral Appliances, refer to the Coverage Determination Guideline titled *Durable Medical Equipment, Orthotics, Medical Supplies and Repairs/Replacements (for Pennsylvania Only).* For medical necessity clinical coverage criteria for removable oral appliances, refer to the InterQual® Release, 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

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Obstructive and Central Sleep Apnea Treatment (for Pennsylvania Only) (continued)	Jul. 1, 2022	"Polysomnogram (Attended)" Applicable Codes • Added CPT/HCPCS codes 21142, E1399, K1028, and K1029 • 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 ○ Dental services (e.g., HCPCS codes D9947, D9948, and D9949) are excluded from coverage under the medical plan; the member specific benefit plan document must be referenced prior to determining any coverage decision Supporting Information • Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	**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. Implantable hypoglossal nerve stimulation is proven and medically necessary in an adult patient with moderate to severe OSA when all of the following criteria are met: • Body Mass Index of (BMI) 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

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Obstructive and Central Sleep Apnea Treatment (for Pennsylvania Only) (continued)	Jul. 1, 2022		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)
Skin and Soft Tissue Substitutes (for Pennsylvania Only)	Aug. 1, 2022	Application • Added language to indicate any requests for services that do not meet criteria set in the Prior Authorization Review Panel (PARP) will be evaluated on a case-by-case basis; refer to *Pennsylvania Exceptions, Pennsylvania Code, Title 55, Chapter 1101* Coverage Rationale • Revised list of skin and soft tissue substitutes that are unproven and not medically necessary for any indication; added: ○ AmnioBind ○ Enverse ○ Human Health Factor 10 Amniotic Patch (HHF10-P) ○ Innovamatrix FS ○ MLG-Complete ○ Relese ○ Supra SDRM ○ Suprathel Applicable Codes • Added HCPCS codes A2011,	Refer to the policy for complete details.

Medical Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Skin and Soft Tissue Substitutes (for Pennsylvania Only) (continued)	Aug. 1, 2022	A2012, A2013, A4100, Q4224, Q4225, Q4256, Q4257, and Q4258 • Revised description for HCPCS code Q4176 **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information	

Medical Benefit Drug Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Complement Inhibitors (Soliris® & Ultomiris®)	Jul. 1, 2022	Coverage Rationale • Removed language indicating Soliris is proven and medically necessary for initial therapy for treatment of generalized Myasthenia Gravis when the patient is currently on a stable dose (at least two months) of immunosuppressive therapy	This policy refers to the following complement inhibitor drug products: • Soliris® (eculizumab) • Ultomiris® (ravulizumab-cwvz) Refer to the policy for complete details.

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