Managed Care Operations Memorandum
General Operations
MCOPS Memo # 07/2022-006

Date: July 27, 2022

Subject: Utilization Review Criteria Assessment Process - Licensed Proprietary Product Review 2022

To: All Physical Health HealthChoices Managed Care Organizations (PH-MCOs) - Statewide

From: Sally A. Kozak, Deputy Secretary, Office of Medical Assistance Programs, on behalf of Gwendolyn Zander, Director, Bureau of Managed Care Operations

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Purpose:

To notify the HealthChoices PH-MCOs of the Utilization Review Criteria Assessment Process (URCAP) findings from the Department's review of Licensed Proprietary Products (LPPs) revision.

Background:

The PH-MCOs must annually submit all LPP decision making tools, including updates, revisions or changes made to utilization review criteria, and policies and procedures for the Department's review and approval prior to implementation.
The Department evaluates all utilization review criteria, including licensed proprietary products decision-making tools, utilized by the PH-MCOs to make determinations of medical necessity prior to PH-MCOs' implementation of the criteria.

Discussion:

LPPs contain nationally recognized clinical criteria utilized by the PH-MCOs as a utilization decision-making tool to approve a service or item for a member. LPPs may not be used to deny a service or item. The 2022 revisions of InterQual Criteria Guidelines, 26th edition Milliman Care Guidelines, 2022 eviCORE Imaging Guidelines, 2022 Magellan National Imaging Associates, 2022 Versant Vision Guidelines, 2022 HealthHelp Guidelines, and 2022 OPTUM National Comprehensive Cancer Network Guidelines were reviewed by the Department to ensure updates do not conflict with PA regulations, the HealthChoices Agreement, and the HealthChoices definition of medically necessary.

All licensed proprietary product revisions/updates that are approved are noted by as a "pass" may be implemented into the PH-MCO utilization decision-making tool. The LPP table lists categories and findings by the Department. The LPP table can be found in the following embedded table.

PH-MCO may not use LPPs for utilization management of Pharmaceutical injectable medications. PH-MCO Pharmaceutical injectable medications are required to have an individual policy submitted to the Department's Prior Authorization Review Panel (PARP) for approval.

Next Steps:

This information must be provided to all appropriate staff, particularly Utilization Management Directors and Medical Directors, within your organization. If you have any questions, please contact the Clinical Operations Unit Supervisor at 717-772-6156.

Obsolete:

This OPS Memo supersedes previously issued OPS Memo 12/2020-018 and remains in effect until further notice.

Attachment:

2022 MCO
LPP-Licensed Propriet

2022 Licensed Proprietary Product Review

2022 InterQual Criteria Guidelines Revisions

Licensed Proprietary Product Reviewed	Volume, Chapter, Section, or Major Category Identified by the Licensed Proprietary Product	Category Passed for MCO use	Guidelines must follow required notes
InterQual 2022 revisions reviewed	Level of Care: Procedures Revisions (April 2022)	Passed	None
	Level of Care: Long-term Acute Care Adult Revisions (March 2022)	Passed	See below #2
	Level of Care: Durable Medical Equipment Revisions (April 2022)	Passed	See below #1
	Level of Care: Acute Adult Clinical Revisions(April 2022)	Passed	See below #1
	Level of Care: Outpatient Rehabilitation and Chiropractic Revisions (March 2022)	Passed	See below #1 & #4
	Level of Care: Acute Pediatric Criteria (April 2022)	Passed	See below #1
	Level of Care: Acute Rehabilitation Revisions (March 2022)	Passed	See below #1
	Level of Care: Sub acute and SNF Clinical Revisions (April 2022)	Passed	See below #1
	Level of Care: Home Care Clinical Revisions (April 2022)	Passed (No changes from 2021)	None
	Level of Care: Imaging Revisions (April 2022)	Passed	None

** 1. Age determinations for services must meet EPSDT guidelines, determinations must be made based on HealthChoices definition of medical necessity
2. At the present time LTAC (long term acute care) is not a compensable service
3. Procedures must be determined as medical vs. dental based on the MA fee schedule
4. Chiropractic decisions are based on reaching functional plateau. This is in conflict with the HealthChoices definition of medical necessity and cannot be used in decision making.
**Results of URCAP/LPP review by the department does not constitute endorsement by OMAP/DHS of licensed proprietary products or utilization review policies, procedures or criteria within the licensed proprietary product.

2022 Milliman Care Guidelines Changes 26th edition

Licensed Proprietary Product Reviewed	Volume, Chapter, Section, or Major Category Identified by the Licensed Proprietary Product	Categories Passed for MCO use	Guidelines must follow required notes
**Milliman Care Guideline Clinical revisions/changes for the 26th edition ** **	Ambulatory Care	Passed	See Below 1-6
	Chronic Care	Passed	See Below 1-6
	General Recovery Care	Passed	See Below 1-6
	Home Care	Passed	See Below 1-6
	Inpatient Surgical Care	Passed	See Below 1-6
	Multiple Condition Management	Passed	See Below 1-6
	Recovery Facility Care	Passed	See Below 1-6
	Transition of Care	Passed	See Below 1-6

#1. Guidelines include use of homebound status to determine necessity of home care. Home bound status can not be considered in decision making. Additionally, home care services can not be denied because there is no skilled need. #2. Long term acute care was not reviewed.
#3. Transfer to SNF was not reviewed as placement is determined by OPTIONS assessment.
#4. Ambulatory Care Injectable and Pharmacologic Agents are not approved for use under MCG 2019 23rd edition or any previous year guideline and require PARP approval by DHS.

	#5. Use of discharge to custodial care is used in inpatient guidelines. Custodial care is not recognized and can not be used as alternative to inpatient care. #6. Age determinations for services must meet EPSDT guidelines, determinations must be made based on the Health Choices definition of medical necessity. ** Results of URCAP/LPP review by the department does not constitute endorsement by DHS or OMAP of licensed proprietary products or utilization review policies, procedures or criteria within the licensed proprietary product.

2022 eviCore Imaging Guidelines

Licensed Proprietary Product Reviewed	Volume, Chapter, Section, or Major Category Identified by the Licensed Proprietary Product	Categories Passed for MCO use	Guidelines must follow required notes
2022 eviCore Imaging Guidelines	Chiropractic Services	Passed	See 1-4, 6
	ABDOMEN Imaging Guidelines	Passed	See 1-4
	BREAST Imaging Policy	Passed	See 1-4
	CARDIAC imaging Policy	Passed	See 1-4
	CHEST Imaging Policy	Passed	See 1-4
	CARDIAC RHYTHM IMPLANTABLE DEVICE (CRID) Policy	Passed	See 1-4
	HEAD Imaging Policy	Passed	See 1-4
	MUSCULO SKELETAL Imaging Policy	Passed	See 1-4
	NECK Imaging policy	Passed	See 1-4
	ONCOLOGY Imaging Policy	Passed	See 1-4
	Oncology Medication Policy	Passed	See 1-4
	PELVIS Imaging Policy	Passed	See 1-4
	PERIPHERAL NERVE DISORDER (PND) Imaging Guidelines	Passed	See 1-4
	PERIPHERAL VASCULAR DISEASE (PVD) Imaging Guidelines	Passed	See 1-4
	SPINE Imaging Policy	Passed	See 1-4
	SLEEP APNEA & TREATMENT	Passed	See 1-4
	PEDIATRIC ABDOMEN Imaging Guidelines	Passed	See 1-4
	PEDIATRIC CARDIAC Imaging Guidelines	Passed	See 1-4
	PEDIATRIC CHEST Imaging Guidelines	Passed	See 1-4
	PEDIATRIC HEAD Imaging Guidelines	Passed	See 1-4
	PEDIATRIC MUSCULOSKELETAL Imaging Guidelines	Passed	See 1-4
	PEDIATRIC NECK Imaging Guidelines	Passed	See 1-4
	PEDIATRIC ONCOLOGY Imaging Guidelines	Passed	See 1-4
	PEDIATRIC PELVIS Imaging Guidelines	Passed	See 1-4
	PEDIATRIC PERIPHERAL NERVE DISORDERS (PND) Imaging Guidelines	Passed	See 1-4
	PEDIATRIC PERIPHERAL VASCULAR DISEASE (PVD) Imaging Guidelines	Passed	See 1-4
	PEDIATRIC SPINE IMAGING GUIDELINES	Passed	See 1-4
	PERIPHERAL SPINE Imaging Guidelines	Passed	See 1-4
	Interventional Pain - Sacroiliac Joint Injections (CMM 203)	Passed	See 1-4,7
	Interventional Pain - Trigger Point Injections (CMM 202)	Passed	See 1-4, 7
	Interventional Pain- Epidural Adhesiolysis (CMM 207)	Passed	See 1-4, 7
	Interventional Pain- Epidural Steroid Injections (CMM 200)	Passed	See 1-4, 7
	Interventional Pain- Facet Joint Injections (CMM 201)	Passed	See 1-4, 7
	Intervention Pain- Prolotherapy	Passed	See 1-4, 7
	Interventional Pain- Radiofrequency Joint Ablation_Denervation (CMM 208)	Passed	See 1-4
	Interventional Pain- Regional Sympathetic Blocks (CMM 209)	Passed	See 1-4,7
	Implantable Intrathecal Drug Delivery System (CMM 210)	Passed	See 1-4,7

	Interventional Pain- Spinal Cord and Implantable Peripheral Nerve Stimulators (CMM 211)	Passed	See 1-4
	Interventional Pain- Thermal Intradiscal Procedures (CMM 308)	Passed	See 1-4
	Large Joint Services - Knee Arthroscopic (CMM 312)	Passed	See 1-4
	Large Joint Services - Shoulder Arthroplasty_Arthrodesis (CMM 318)	Passed	See 1-4
	Large Joint Services - Shoulder Surgery - Arthroscopic (CMM 315)	Passed	See 1-4
	Large Joint Services- Hip Arthroplasty-Total_Partial (CMM 313)	Passed	See 1-4
	Large Joint Services- Hip Surgery_Arthroscopic and Open (CMM 314)	Passed	See 1-4
	Large Joint Services- Knee Arthroplasty-Total_Partial (CMM 311)	Passed	See 1-4
	Manipulation Under Anesthesia (CMM 310)	Passed	See 1-4,7
	Physical and Occupational Therapy Guidelines	Passed	See 1-5
	Sleep Guidelines	Passed	See 1-4
	Speech Therapy Guidelines	Passed	See 1-5
	Discography (CMM 401)	Passed	See 1-4,7
	Anesthesia Services for Interventional Pain Procedures (CMM 400)	Passed	See 1-4,7
	Spine Surgery Guidelines (CMM-600)-12 Guidelines	Passed	See 1-4,7
	#1. Utilization determination for services must meet EPSDT guidelines and services or items not on the MA Fee Schedule must be considered under the exception process by a medical director for medical necessity under EPSDT. #2. Medical Necessity is determined using the Pennsylvania HealthChoices definition of medical necessity and not by the PH-MCO Licensed Proprietary Product. #3. In cases where Licensed Proprietary Products decision making criteria is more restrictive than Medicaid Fee For Service program services or can not be Passed by a clinical reviewer, the request for services or item will be determined by the PH-MCO medical director. #4. The Physical Medicine category and listed procedures would be subject to the Health Choices program Technology Assessment Group decisions with all experimental and investigation procedures being determined on a case by case basis using the Health Choices definition of medical necessity. #5. In case of Habilitation Physical and Occupational therapy where ongoing treatment is not appropriate state of sensorimotor functioning has yielded no measurable functional progress is not recognized criteria to make a determination for medical necessity and is in conflict with the Health Choices Definition of medical necessity which is to maintain the functional status of the member. #6. Chiropractic decisions are based on reaching functional plateau. This is in conflict with the HealthChoices definition of medical necessity and cannot be used in decision making. #7. Injectable medications for procedures cannot be approved in any edition and must be approved via the Department's PARP process.		

2022 Magellan Healthcare Subsidiary (National Imaging Associates),

Licensed Proprietary Product Reviewed	Volume, Chapter, Section, or Major Category Identified by the Licensed Proprietary Product	Categories Passed for MCO use	Guidelines must follow required notes
	MRI Temporomandibular Joint (TMJ)	Passed	None
	CT Head/Brain	Passed	None
	CT Temporal, Bone, Mastoid, Orbit	Passed	None
	CT Maxillofacial/Sinus	Passed	None
	CT Soft Tissue Neck	Passed	None
	CT Angiography, Head	Passed	None
	CT Angiography, Neck	Passed	None
	MRI Orbit (Face or Neck)	Passed	None
	MRI Angiography, Head/Brain	Passed	None
	MRI Angiography, Neck	Passed	None
	MRI Brain (includes Internal Auditory Canal)	Passed	None
	Functional MRI Brain	Passed	None
	CT Chest (thorax)	Passed	None
	Low Dose CT for Lung Cancer Screening	Passed	See #2 below
	CT Angiography, Chest (non coronary)	Passed	None

Magellan Healthcare (National Imaging Associates), revisions/changes for 2021 & 2022 review **	MRI Chest (Thorax)	Passed	None
	MRA Chest	Passed	None
	CT Cervical Spine	Passed	None
	CT Thoracic Spine	Passed	None
	CT Lumbar Spine	Passed	None
	MRI Cervical Spine	Passed	None
	MRI Thoracic Spine	Passed	None
	MRI Lumbar Spine	Passed	None
	MRI Angiography Spinal Canal	Passed	None
	CT Angiography Pelvis	Passed	None
	CT Pelvis	Passed	None
	MRI Pelvis	Passed	None
	MRI angiography, Pelvis	Passed	None
	CT Upper Extremity	Passed	None
	CT Angiography, Upper Extremity	Passed	None
	MRI Upper Extremity	Passed	None
	MR Angiography Upper Extremity	Passed	None
	CT Lower Extremity (ankle, foot, hip or knee)	Passed	None
	CT Angiography, Lower Extremity	Passed	None
	MRI Lower Extremity	Passed	None
	MR Angiography, Lower Extremity	Passed	None
	CT Abdomen	Passed	None
	CT Angiography, Abdomen and Pelvis	Passed	None
	CT Angiography, Abdomen	Passed	None
	CT Angiography, Abdomen and Pelvis combo	Passed	None
	MRI MRCP Abdomen	Passed	None
	MR Angiography, Abdomen	Passed	None
	CT colonoscopy Diagnostics (Virtual)	Passed	None
	MRI Heart	Passed	None
	Electron Beam Tomography (EBCT)	Passed	None
	CT Heart	Passed	None
	CT Heart congenital studies	Passed	None
	CTA Coronary Arteries (CCTA)	Passed	None
	CT Angiography, Abdominal Arteries	Passed	None
	MR Spectroscopy	Passed	None
	Unlisted CT Procedure	Passed	None
	MRI Breast	Passed	None
	CT Bone Density Study	Passed	None
	MRI Bone Marrow	Passed	None
	Heart PET Scan with CT for Attenuation	Passed	None
	Myocardial Perfusion Imaging (Nuclear Cardiac)	Passed	None
	PET Scan, Heart (Cardiac)	Passed	None
	MUGA Scan	Passed	None
	PET Scan Brain	Passed	None
	Radiopharmaceutical Tumor Localization (SPECT), Singel Area	Passed	None
	Pet Scans with CT attenuation	Passed	None
	Tumor Imaging PET	Passed	None
	Low Field MRI	Passed	None
	1. In cases where Licensed Proprietary Products decision making criteria is more restrictive than Medicaid Fee For Service program services or can not be Passed by a clinical reviewer, the request for services or item will be determined by the PH-MCO medical director. 2. Magellan (NIA) updated guidelines do not meet the Departments InterQual guidelines; therefore, MCO must use InterQual medical necessity criteria of a 20 – 30 pack year		

	smoker and one selection below (USPSTF is 30 pack-year AND the below): o COPD with fev1 <70% o Environmental or occupational exposure to known carcinogens (ex. Asbestos, radon) o Prior history of cancer o Family history of lung cancer 3. In case of Habilitation Physical and Occupational therapy where ongoing treatment is not appropriate state of sensorimotor functioning has yielded no measurable functional progress is not recognized criteria to make a determination for medical necessity and is in conflict with the Health Choices Definition of medical necessity which is to maintain the functional status of the member. 4. In cases of Lumbar Spinal Surgery a program exception must be considered under the Health choices program. 5. In cases of Preventative Care, Maintenance, Corrective care are applicable to physicians and not chiropractic and determinations of medical necessity must be made according to the Health choices definition of medical necessity. 6. The Physical Medicine category and listed procedures would be subject to the Health Choices program Technology Assessment Group decisions with all experimental and investigation procedures being determined on a case by case basis using the Health Choices definition of medical necessity. **Results of URCAP/LPP review by the department does not constitute endorsement by OMAP/DHS of licensed proprietary products or utilization review policies, procedures or criteria within the licensed proprietary product.

2022 Versant Vision Guidelines

Licensed Proprietary Product Reviewed	Volume, Chapter, Section, or Major Category Identified by the Licensed Proprietary Product	Categories Passed for MCO use	Guidelines must follow required notes
2022 Versant Vision Guidelines	Contact Lenses 1309.00 policy	Passed	See 1-2
	#1. Age determinations for services must meet EPSDT guidelines, determinations must be made based on the Health Choices definition of medical necessity. * #2 Versant Vision Guidelines must use the HealthChoices program definition of medical necessity for corrective vision request from providers. Medically Necessary — A service or benefit that is compensable under the MA Program and if it meets any one of the following standards: The service, item, procedure or level of care will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability. The service, item, procedure or level of care will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability. The service, item, procedure or level of care will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age. **Results of URCAP/LPP review by the department does not constitute endorsement by DHS or OMAP of licensed proprietary products or utilization review policies, procedures or criteria within the licensed proprietary product		

2022 HealthHelp Guidelines

Licensed Proprietary Product Reviewed	Volume, Chapter, Section, or Major Category Identified by the Licensed Proprietary Product	Categories Passed for MCO use	Guidelines must follow required notes
	Cardiology Services (7376 individual guidelines)	Passed	See below #1-3
	Radiology Services (112 individual guidelines)	Passed	See below #1-3

2022 HealthHelp Guidelines	Cervical Lumbar Spine Surgery	Passed	See below #1-3
	Hip Arthroplasty	Passed	See below #1-3
	Hip Arthroscopy Open	Passed	See below #1-3
	Knee Arthroplasty	Passed	See below #1-3
	Knee Arthroscopy Open	Passed	See below #1-3
	Other MSK (Other Procedures: Hip, Knee, Shoulder, Spine)	Passed	See below #1-3
	Shoulder Arthroplasty	Passed	See below #1-3
	Shoulder Arthroplasty Open	Passed	See below #1-3
	Interventional Pain management: Spine Epidural Injection	Passed	See #5 below
	Interventional Pain management: Spine Facet Block	Passed	See #5 below
	Interventional Pain management: Spine Facet Radio Frequency Neurolysis	Passed	See #5 below
	Interventional Pain management: Spine Sacroiliac Joint Injection	Passed	See #5 below
	#1. Utilization determination for services must meet EPSDT guidelines and services or items not on the MA Fee Schedule must be considered under the exception process by a medical director for medical necessity under EPSDT. #2. Medical Necessity is determined using the Pennsylvania HealthChoices definition of medical necessity and not by the PH-MCO Licensed Proprietary Product. As of 2021, Health Help has adopted, for use in review of Highmark Wholecare, DBA Gateway, DHS defintion of Medical Necessity per policy submitted to Docushare #3. The Physical Medicine category and listed procedures would be subject to the Health Choices program Technology Assessment Group decisions with all experimental and investigation procedures being determined on a case by case basis using the Health Choices definition of medical necessity. #4. In case of Habilitation Physical and Occupational therapy where ongoing treatment is not appropriate state of sensorimotor functioning has yielded no measurable functional progress is not recognized criteria to make a determination for medical necessity and is in conflict with the Health Choices Definition of medical necessity which is to maintain the functional status of the member. Note * Results of URCAP/LPP review by the departments bureau of managed care operations does not constitute endorsement by OMAP/DHS of licensed proprietary products or utilization review policies, procedures or criteria within the licensed proprietary product. #5. Injectable medications for procedures cannot be approved in any edition and must be approved via the Department's PARP process. Note * Results of URCAP/LPP review by the departments bureau of managed care operations does not constitute endorsement by OMAP/DHS of licensed proprietary products or utilization review policies, procedures or criteria within the licensed proprietary product.		

2022 OPTUM National Comprehensive Cancer Network (NCCN) Guidelines

Licensed Proprietary Product Reviewed	Volume, Chapter, Section, or Major Category Identified by the Licensed Proprietary Product	Categories Passed for MCO use	Guidelines must follow required notes
	Acute Lymphoblastic Leukemia	Passed	see 1-4 below
	Acute Myeloid Leukemia	Passed	see 1-4 below
	Anal Carcinoma	Passed	see 1-4 below
	Basal Cell Skin Cancer	Passed	see 1-4 below
	B-Cell Lymphomas	Passed	see 1-4 below
	Bladder Cancer	Passed	see 1-4 below
	Bone Cancer	Passed	see 1-4 below
	Breast cancer	Passed	see 1-4 below
	Central Nervous System Cancers	Passed	see 1-4 below
	Cervical Cancer	Passed	see 1-4 below
	Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma	Passed	see 1-4 below
	Chronic Myeloid Leukemia	Passed	see 1-4 below
	Colon Cancer	Passed	see 1-4 below
	Primary Cutaneous B-Cell Lymphomas	Passed	see 1-4 below
	Dermatofibrosarcoma Protuberans	Passed	see 1-4 below
	Esophageal & Esophagogastric Junction Cancer	Passed	see 1-4 below
	Gastric Cancer	Passed	see 1-4 below
	Gastrointestinal Stromal Tumors (GIST)	Passed	see 1-4 below
	Gestational Trophoblastic Neoplasia	Passed	see 1-4 below
	Hairy Cell Leukemia	Passed	see 1-4 below

2022 OPTUM National Comprehensive Cancer Network (NCCN) Guidelines			
	Head and Neck Cancers	Passed	see 1-4 below
	Hepatobiliary Cancers	Passed	see 1-4 below
	Histiocytic Neoplasms	Passed	see 1-4 below
	Hodgkin Lymphoma	Passed	see 1-4 below
	Kaposi Sarcoma	Passed	see 1-4 below
	Kidney Cancer	Passed	see 1-4 below
	Malignant Peritoneal Mesothelioma	Passed	see 1-4 below
	Malignant Pleaural Mesothelioma	Passed	see 1-4 below
	Management of Immunotherapy-Related Toxicities	Passed	see 1-4 below
	Melanoma: Cutaneous	Passed	see 1-4 below
	Melanoma: Uveal	Passed	see 1-4 below
	Merkel Cell Carcinoma	Passed	see 1-4 below
	Multiple Myeloma	Passed	see 1-4 below
	Myelodysplastic Syndromes	Passed	see 1-4 below
	Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Fusion	Passed	see 1-4 below
	Myeloproliferative Neoplasms	Passed	see 1-4 below
	Neuroendocrine and Adrenal Tumors	Passed	see 1-4 below
	Non-small Cell Lung Cancer	Passed	see 1-4 below
	Occult Primary	Passed	see 1-4 below
	Ovarian Cancer/Fallopian Tube Cancer Primary Peritoneal Cancer	Passed	see 1-4 below
	Pancreatic Adenocarcinoma	Passed	see 1-4 below
	Pediatric Acute Lymphoblastic Leukemia	Passed	see 1-4 below
	Pediatric Aggressive Mature B-Cell Lymphomas	Passed	see 1-4 below
	Pediatric Hodgkin Lymphoma	Passed	see 1-4 below
	Penile Cancer	Passed	see 1-4 below
	Primary Cutaneous B-Cell Lymphomas	Passed	see 1-4 below
	Prostate Cancer	Passed	see 1-4 below
	Rectal Cancer	Passed	see 1-4 below
	Small Bowel Adenocarcinoma	Passed	see 1-4 below
	Small Cell Lung Cancer	Passed	see 1-4 below
	Soft Tissue Sarcoma	Passed	see 1-4 below
	Squamous Cell Skin Cancer	Passed	see 1-4 below
	Systemic Light Chain Amyloidosis	Passed	see 1-4 below
	Systemic Mastocytosis	Passed	see 1-4 below
	T-Cell Lymphomas	Passed	see 1-4 below
	Testicular Cancer	Passed	see 1-4 below
	Thymomas And Thymic Carcinomas	Passed	see 1-4 below
	Thyroid Carcinoma	Passed	see 1-4 below
	Uterine Neoplasms	Passed	see 1-4 below
	Vulvar Cancer (Squamous Cell Carcinoma)	Passed	see 1-4 below
	Waldenstrom Macroglobulinemia/ Lymphasmacytic Lymphoma	Passed	see 1-4 below
	Wils Tumor (Nephroblastoma)	Passed	see 1-4 below
	#1. Medical Necessity is determined using the Pennsylvania HealthChoices definition of medical necessity and not by the PH-MCO Licensed Proprietary Product. #2. In cases where Licensed Proprietary Products decision making criteria is more restrictive than Medicaid Fee For Service program services or can not be Passed by a clinical reviewer, the request for services or item w+B321:D349ill be determined by the PH-MCO medical director. #3. The Physical Medicine category and listed procedures would be subject to the Health Choices program Technology Assessment Group decisions with all experimental and investigation procedures being determined on a case by case basis using the Health Choices definition of medical necessity. #4. Injectable medications for procedures cannot be approved in any edition and must be approved via the Department's PARP process. * Results of URCAP/LPP review by the departments bureau of managed care operations does not constitute endorsement by OMAP/DHS of licensed proprietary products or utilization review policies, procedures or criteria within the licensed proprietary product.		