United Healthcare Oxford

UnitedHealthcare Oxford
Policy Update Bulletin: December 2022

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Take Note

Annual CPT® and HCPCS Code Updates

Beginning Jan. 1, 2023, all applicable Clinical and Administrative Policies will be updated to reflect the 2023 Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) code additions, revisions, and deletions. Refer to the following sources for information on the code updates:

- American Medical Association. Current Procedural Terminology: CPT®
- Centers for Medicare & Medicaid Services. Healthcare Common Procedure Coding System: HCPCS Level II

Complete details on impacted policies and corresponding code edits will be provided in the January 2023 edition of the Oxford Policy Update Bulletin.

Prior Authorization Requirement Changes

Effective Jan. 1, 2023, the information pertaining to prior authorization requirements will be removed from UnitedHealthcare Oxford Clinical and Administrative Policies. The complete list of impacted policies is provided below for your reference.

The new *Oxford Health Plans Prior Authorization Requirements* document, available at UHCprovider.com > Advance Notification and Clinical Submission Requirements, will now provide a comprehensive list of all procedure codes requiring prior authorization for our commercial Oxford contracted network providers. Refer to the UnitedHealthcare news article titled Oxford prior authorization requirement changes for additional information.

Impacted Policies

- Ablative Treatment for Spinal Pain
- Abnormal Uterine Bleeding and Uterine Fibroids
- Airway Clearance Devices
- Apheresis
- Articular Cartilage Defect Repairs
- Attended Polysomnography for Evaluation of Sleep Disorders
- Balloon Sinus Ostial Dilation
- Bariatric Surgery
- Beds and Mattresses
- Breast Imaging for Screening and Diagnosing Cancer
- Breast Reconstruction
- Breast Reduction Surgery
- Brow Ptosis and Eyelid Repair
- Cardiac Event Monitoring
- Cardiology Procedures for eviCore healthcare Arrangement
- Carrier Testing for Genetic Diseases
- Catheter Ablation for Atrial Fibrillation
- Cell-Free Fetal DNA Testing
- Chelation Therapy for Non-Overload Conditions
- Chromosome Microarray Testing (Non-Oncology Conditions)
- Clinical Trials
- Cochlear Implants
- Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes
- Core Decompression for Avascular Necrosis
- Cosmetic and Reconstructive Procedures
- Deep Brain and Cortical Stimulation
- Elective Inpatient Services
- Electric Tumor Treatment Field Therapy
- Electrical and Ultrasound Bone Growth Stimulators
- Electrical Stimulation and Electromagnetic Therapy for Wounds
- Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation
- Epidural Steroid Injections for Spinal Pain
- Facet Joint and Medial Branch Block Injections for Spinal Pain
- Fecal Calprotectin Testing
- Functional Endoscopic Sinus Surgery (FESS)
- Gastrointestinal Motility Disorders, Diagnosis and Treatment

Take Note

- Gastrointestinal Pathogen Nucleic Acid Detection Panel Testing for Infectious Diarrhea
- Gender Dysphoria Treatment
- Genetic Testing for Cardiac Disease
- Genetic Testing for Hereditary Cancer
- Genetic Testing for Neuromuscular Disorders
- Genitourinary Pathogen Nucleic Acid Detection Panel Testing
- Glaucoma Surgical Treatments
- Gynecomastia Surgery
- Hearing Aids and Devices Including Wearable, Bone-Anchored and Semi-Implantable
- Home Health Care
- Home Hemodialysis
- Hyperbaric Oxygen Therapy and Topical Oxygen Therapy
- Hysterectomy
- Implantable Beta-Emitting Microspheres for Treatment of Malignant Tumors
- Implanted Electrical Stimulator for Spinal Cord
- Implanted Spinal Drug Delivery Systems
- Infertility Diagnosis, Treatment and Fertility Preservation
- Inhaled Nitric Oxide Therapy
- Intensity-Modulated Radiation Therapy
- Intraoperative Hyperthermic Intraperitoneal Chemotherapy (HIPEC)
- Intrauterine Fetal Surgery
- Left Atrial Appendage Closure (Occlusion)
- Light and Laser Therapy
- Liposuction for Lipedema
- Lower Extremity Endovascular Procedures
- Lyme Disease
- Macular Degeneration Treatment Procedures
- Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Scan – Site of Service
- Manipulation Under Anesthesia
- Manipulative Therapy
- Manual Wheelchairs
- Mechanical Stretching Devices
- Meniscus Implant and Allograft
- Minimally Invasive Procedures for Gastroesophageal Reflux Disease (GERD) and Achalasia
- Molecular Oncology Testing for Cancer Diagnosis, Prognosis, and Treatment Decisions
- Negative Pressure Wound Therapy
- Neurophysiologic Testing and Monitoring
- Neuropsychological Testing Under the Medical Benefit
- Obstetrical Ultrasonography
- Obstructive and Central Sleep Apnea Treatment
- Occipital Nerve Injections and Ablation (Including Occipital Neuralgia and Headache)
- Office Based Procedures – Site of Service
- Orthognathic (Jaw) Surgery
- Otoacoustic Emissions Testing
- Outpatient Physical and Occupational Therapy
- Outpatient Surgical Procedures – Site of Service
- Oxford's Outpatient Imaging Self-Referral
- Panniculectomy and Body Contouring Procedures
- Patient Lifts
- Pectus Deformity Repair
- Pediatric Gait Trainers and Standing Systems
- Pediatric Outpatient Intensive Feeding Programs
- Percutaneous Neuroablation for Pancreatic Cancer Pain, Severe Cancer Pain and Trigeminal Neuralgia
- Percutaneous Patent Foramen Ovale (PFO) Closure
- Percutaneous Vertebroplasty and Kyphoplasty
- Pharmacogenetic Testing
- Plagiocephaly and Craniosynostosis Treatment
- Pneumatic Compression Devices
- Power Mobility Devices
- Preimplantation Genetic Testing and Related Services
- Preventive Care Services
- Private Duty Nursing Services
- Prostate Surgeries and Interventions
- Prosthetic Devices, Wigs, Specialized, Microprocessor or Myoelectric Limbs
- Proton Beam Radiation Therapy

Take Note

- Radiation Therapy: Fractionation, Image-Guidance, and Special Services
- Radiology Procedures for eviCore healthcare Arrangement
- Radiopharmaceuticals and Contrast Media
- Rhinoplasty and Other Nasal Surgeries
- Routine Foot Care
- Sacroiliac Joint Injections
- Screening Colonoscopy Procedures – Site of Service
- Skin and Soft Tissue Substitutes
- Speech Generating Devices
- Speech Therapy and Early Intervention
- Spinal Fusion and Bone Healing Enhancement Products
- Stereotactic Body Radiation Therapy and Stereotactic Radiosurgery
- Surgery of the Ankle
- Surgery of the Elbow
- Surgery of the Foot
- Surgery of the Hand or Wrist
- Surgery of the Hip
- Surgery of the Knee
- Surgery of the Shoulder
- Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins
- Surgical Treatment for Spine Pain
- Surgical Treatment of Lymphedema
- Sympathetic Blockade
- Temporomandibular Joint Disorders
- Total Artificial Disc Replacement for the Spine
- Total Artificial Heart and Ventricular Assist Devices
- Transcatheter Heart Valve Procedures
- Transpupillary Thermotherapy
- Vagus and External Trigeminal Nerve Stimulation
- Video Electroencephalographic (vEEG) Monitoring and Recording
- Visual Information Processing Evaluation and Orthoptic and Vision Therapy
- Walkers
- Wheelchair Options and Accessories
- Wheelchair Seating
- Whole Exome and Whole Genome Sequencing
- Wigs

Clinical Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale

Cardiology Procedures for eviCore healthcare Arrangement	Jan. 1, 2023	**Title Change**
		• Previously titled *Cardiology Procedures Requiring Prior Authorization for eviCore healthcare Arrangement*
		Coverage Rationale
		• Added language to indicate:
		  ○ This policy assumes board certification by an American Board of Medical Specialties (ABMS) recognized in the provider specialties listed [in the policy]
		  ○ A notification/authorization number is valid for 45 calendar days; it is specific to the advanced outpatient imaging procedure requested, to be performed one time, and for one date of service within the 45-day period
		• Revised accreditation requirement for participating providers to perform cardiac services; updated list of applicable certification sources:
		Cardiac CT Scan, Cardiac PET, Cardiac MRI
		  ○ Added "RadSite"
		Nuclear Medicine
		  ○ Added:
		  ▪ American College of Radiology (ACR)
			Oxford has engaged eviCore healthcare to perform initial reviews of requests for prior authorization that may include a site of service review (Oxford continues to be responsible for decisions to limit or deny coverage and for appeals). Refer to the Clinical Policy titled Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Scan – Site of Service.
			
			All prior authorization requests are handled by eviCore healthcare. To obtain prior authorization for a cardiology procedure, please contact eviCore healthcare via one of the three options below:
			• Providers can call 1-877-PRE-AUTH (1-877-773-2884); or
			• Providers can send a fax to 1-888-622-7369; or
			• Providers can log onto the eviCore website using the Prior Authorization and Notification App.
			
			eviCore healthcare has established correct coding and evidence-based criteria to determine the medical necessity and appropriate billing of cardiology services. These criterions have been carefully researched and are continually updated in order to be consistent with the most current evidence-based criteria.
			
			Oxford has engaged eviCore healthcare to manage the accreditation process for our provider network. Accreditations should be submitted directly to the eviCore healthcare website. To ensure prompt handling of the accreditation, ensure that all applicable facility and physician information is included. This policy assumes board certification by an American Board of Medical Specialties (ABMS) recognized in the provider specialty listed below.
			
			The cardiology evidence-based criteria and management criteria are available on the eviCore healthcare website using the Prior Authorization and Notification App.
			
			Treating Cardiology providers may be asked to submit a clinical submission form. The following information/documentation may be required:
			• Copies of office notes and treatment planning documents.
			• Results of key diagnostic studies and/or office notes.

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Cardiology Procedures for eviCore healthcare Arrangement (continued)	Jan. 1, 2023	▪ Intersocietal Accreditation Commission (IAC) ▪ RadSite ○ Removed: ▪ American Board of Radiology (ABR) ▪ American Board of Nuclear Medicine (ABNM) ▪ American Osteopathic Board of Nuclear Medicine (AOBNM) ▪ Certification Board of Nuclear Cardiology (CBNC) **Applicable Codes** • Added language to indicate prior authorization is no longer required for CPT codes 93303 and 93304 ***Echocardiogram and Stress Echocardiogram Crosswalk*** • Updated list of CPT codes that are interchangeable for prior authorization; removed 93303 and 93304 **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information • Removed *Prior Authorization Requirements* section	In conjunction with board certified cardiologists and radiologists, eviCore healthcare staff will evaluate the submitted treatment and billing plans. Providers will be informed, in writing, as to which services have been approved for payment. Where provided by state regulations, a board-certified cardiologist will be available to discuss the payment decision with the treating provider. **Privileging and Accreditation Requirements** Participating providers will be reimbursed for radiology and cardiology services rendered in the office or in an outpatient setting. The following is a list of services that are payable to participating physicians based on their specialty as well as accreditation/certification requirements are required. Prior authorization is required. Note: Hospitals are currently excluded from the privileging and accreditation requirements below. Exception: Radiologists and cardiologists who are currently participating in the Oxford network or wish to participate in the Oxford network and perform Coronary CT Angiography (CCTA) are required to complete the physician application from eviCore healthcare. Documents can be sent to a provider upon request or obtained on the eviCore healthcare website using the Prior Authorization and Notification App. Privileging requirement for participating providers to perform cardiac services: **Modality**: Nuclear Medicine, Cardiac CT Scan, PET, and MRI **Privileged**: • Radiologist • Radiology center/facility • Certified cardiologist • Cardiovascular disease specialists

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Cardiology Procedures for eviCore healthcare Arrangement (continued)	Jan. 1, 2023		Diagnostic Cardiac Heart Catheterizations: • Cardiovascular disease • Cardiology group • Pediatric cardiology • Cardiology • Clinical cardiac electro physician • Cardiac electrophysiology Accreditation requirement for participating providers to perform cardiac services: **Modality**: Cardiac CT Scan, Cardiac PET, Cardiac MRI, and Nuclear Medicine — **Certification Required**: ACR (American College of Radiology), IAC (Intersocietal Accreditation Commission), RadSite, or The Joint Commission (TJC) **Payment Guidelines** • The notification/authorization number is valid for 45 calendar days. It is specific to the advanced outpatient imaging procedure requested, to be performed one time, for one date of service within the 45-day period. • Current Procedural Terminology (CPT) codes that are not subject to TC/PC component may be reimbursed to both the physician and facility when billed for the same date of service (DOS). • ECG, diagnostic studies, and injection procedures must be billed in conjunction with an authorized cardiac catheterization code in order to be reimbursed on the same date of service. When billed in conjunction with an authorized cardiac catheterization, no separate authorization will be required in addition to the catheterization code for these services.
Catheter Ablation for Atrial Fibrillation	Jan. 1, 2023	Coverage Rationale • Added language to indicate this policy does not apply to members ages < 18 years or to arrhythmias other than atrial fibrillation	Note: This policy does not apply to members ages < 18 years or to arrhythmias other than atrial fibrillation. Catheter ablation for atrial fibrillation is proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Catheter Ablation for Atrial Fibrillation (continued)	Jan. 1, 2023	• Revised language pertaining to medical necessity clinical coverage criteria; replaced reference to the "InterQual® CP: Procedures, Electrophysiology (EP) Testing +/- Radiofrequency Ablation (RFA), Cardiac" with "InterQual® CP: Procedures, Electrophysiology (EP) Testing +/- Radiofrequency Ablation (RFA) *or Cryothermal Ablation*, Cardiac" **Documentation Requirements** • Added list of applicable CPT codes **Supporting Information** • Removed *Prior Authorization Requirements* section	the InterQual® CP: Procedures, Electrophysiology (EP) Testing +/- Radiofrequency Ablation (RFA) or Cryothermal Ablation, Cardiac. Click here to view the InterQual® criteria.
Gender Dysphoria Treatment	Jan. 1, 2023	**Coverage Rationale** • Revised list of indications for surgical treatment for Gender Dysphoria; replaced "breast surgery" with "*mastectomy/* breast *reduction* surgery" • Revised criteria that must be documented in the written psychological assessment for genital surgery; replaced criterion requiring an individual must: ○ "Complete at least 12 months of successful continuous full-time real-life *experience* in the *desired* gender" with "complete at least 12 months of successful continuous full-	Notes: This Clinical Policy does not apply to individuals with ambiguous genitalia or disorders of sexual development. Surgical treatment for Gender Dysphoria may be indicated for individuals who provide the following documentation: • For mastectomy/breast reduction surgery, a written psychological assessment from at least one Qualified Behavioral Health Provider experienced in treating Gender Dysphoria*, is required. The assessment must document that an individual meets all of the following criteria: ○ Persistent, well-documented Gender Dysphoria ○ Capacity to make a fully informed decision and to consent for treatment ○ Must be at least 18 years of age (age of majority) ○ Favorable psychosocial-behavioral evaluation to provide screening and identification of risk factors or potential postoperative challenges • For genital surgery, a written psychological assessment from at least two Qualified Behavioral Health Provider experienced in treating Gender Dysphoria*, who have independently assessed the individual, is required.

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Gender Dysphoria Treatment (continued)	Jan. 1, 2023	time real-life *involvement* in the *experienced* gender" ○ "Complete 12 months of continuous *cross-sex* hormone therapy appropriate for the *desired* gender (unless medically contraindicated)" with "complete 12 months of continuous hormone therapy appropriate for the *experienced* gender (unless medically contraindicated *or not indicated for gender*)" • Added language for plans that specifically provide coverage for breast augmentation, thyroid cartilage reduction, and/or voice modification surgery (e.g., laryngoplasty, glottoplasty, or shortening of the vocal cords) to indicate a written psychological assessment from at least one Qualified Behavioral Health Provider experienced in treating Gender Dysphoria is required; the assessment must document that an individual meets all of the following criteria: ○ Persistent, well-documented Gender Dysphoria ○ Capacity to make a fully informed decision and to consent for treatment ○ Must be at least 18 years of	The assessment must document that an individual meets all of the following criteria: ○ Persistent, well-documented Gender Dysphoria ○ Capacity to make a fully informed decision and to consent for treatment ○ Must be at least 18 years of age (age of majority) ○ Favorable psychosocial-behavioral evaluation to provide screening and identification of risk factors or potential postoperative challenges ○ Complete at least 12 months of successful continuous full-time real-life involvement in the experienced gender ○ Complete 12 months of continuous hormone therapy appropriate for the experienced gender (unless medically contraindicated) or not indicated for gender • Treatment plan that includes ongoing follow-up and care by a Qualified Behavioral Health Provider experienced in treating Gender Dysphoria*. • For plans that specifically provide coverage for breast augmentation, thyroid cartilage reduction, and/or voice modification surgery (e.g., laryngoplasty, glottoplasty or shortening of the vocal cords), a written psychological assessment from at least one Qualified Behavioral Health Provider experienced in treating Gender Dysphoria is required. The assessment must document that an individual meets all of the following criteria: ○ Persistent, well-documented Gender Dysphoria ○ Capacity to make a fully informed decision and to consent for treatment ○ Must be at least 18 years of age (age of majority) ○ Favorable psychosocial-behavioral evaluation to provide screening and identification of risk factors or potential postoperative challenges ○ For breast augmentation, completion of 12 months of continuous hormone therapy prior to the breast procedure is required When the above criteria are met, the following surgical procedures to treat Gender Dysphoria are medically necessary and covered as a proven benefit: • Bilateral mastectomy or breast reduction • Clitoroplasty (creation of clitoris) • Hysterectomy (removal of uterus) • Labiaplasty (creation of labia)

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Gender Dysphoria Treatment (continued)	Jan. 1, 2023	age (age of majority) ○ Favorable psychosocial-behavioral evaluation to provide screening and identification of risk factors or potential postoperative challenges ○ For breast augmentation, completion of 12 months of continuous hormone therapy prior to the breast procedure is required • Removed notation pertaining to completion of hormone therapy prior to the breast procedure when bilateral mastectomy or breast reduction is performed as a stand-alone procedure, without genital reconstruction procedures • Added instruction for fully insured group policies in New York to refer to the *Benefit Considerations* section of the policy for more information • Added notation to clarify that some plans may provide coverage for specific ancillary procedures otherwise considered cosmetic; refer to the *Benefit Considerations* section of the policy, as member specific benefit plan language may vary Documentation Requirements • Added list of applicable CPT codes	• Laser or electrolysis hair removal in advance of genital reconstruction prescribed by a physician for the treatment of Gender Dysphoria • Metoidioplasty (creation of penis, using clitoris) • Orchiectomy (removal of testicles) • Penectomy (removal of penis) • Penile prosthesis • Phalloplasty (creation of penis) • Salpingo-oophorectomy (removal of fallopian tubes and ovaries) • Scrotoplasty (creation of scrotum) • Testicular prostheses • Urethroplasty (reconstruction of female urethra) • Urethroplasty (reconstruction of male urethra) • Vaginectomy (removal of vagina) • Vaginoplasty (creation of vagina) • Vulvectomy (removal of vulva) Certain ancillary procedures, including but not limited to the following, are considered cosmetic and not medically necessary, when performed as part of surgical treatment for Gender Dysphoria: Refer to the Benefit Considerations section of this policy as member specific benefit plan document language may vary. Note: For fully insured group policies in New York, refer to the Benefit Considerations section of this policy for more information. • Abdominoplasty – also refer to the Clinical Policy titled Panniculectomy and Body Contouring Procedures • Blepharoplasty – also refer to Clinical Policy titled Brow Ptosis and Eyelid Repair • Body contouring (e.g., fat transfer, lipoplasty, panniculectomy) – also refer to the Clinical Policy titled Panniculectomy and Body Contouring Procedures • Breast enlargement, including augmentation mammaplasty and breast implants • Brow lift

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Gender Dysphoria Treatment (continued)	Jan. 1, 2023	Supporting Information • Updated *Benefit Considerations*, *Clinical Evidence*, and *References* sections to reflect the most current information at the time of review • Removed *Prior Authorization Requirements* section • Updated reference link to the Clinical Policy titled *Outpatient Physical and Occupational Therapy*	• Calf implants • Cheek, chin and nose implants • Injection of fillers or neurotoxins – also refer to the Medical Benefit Drug Policy titled Botulinum Toxins A and B • Face/forehead lift and/or neck tightening • Facial bone remodeling for facial feminization • Laser or electrolysis hair removal not related to genital reconstruction • Hair transplantation • Lip augmentation • Lip reduction • Liposuction (suction-assisted lipectomy) – also refer to the Clinical Policy titled Panniculectomy and Body Contouring Procedures • Mastopexy • Pectoral implants for chest masculinization • Rhinoplasty – also refer to the Clinical Policy titled Rhinoplasty and Other Nasal Surgeries • Skin resurfacing (e.g., dermabrasion, chemical peels, laser) • Thyroid cartilage reduction/reduction thyroid chondroplasty/trachea shave (removal or reduction of the Adam's apple) • Voice modification surgery (e.g., laryngoplasty, glottoplasty or shortening of the vocal cords) • Voice lessons and voice therapy *Some plans may provide coverage for these services. Refer to the Benefit Considerations section of this policy as member specific benefit plan document language may vary.
Obstetrical Ultrasonography	Jan. 1, 2023	Coverage Rationale • Added language to indicate: ○ A notification/authorization number is valid for 45 calendar days; it is specific to the advanced outpatient imaging procedure requested, to be performed one time, and for	This policy has three components: 1. Utilization Management Up to three ultrasounds will be reimbursed per member, per pregnancy, without prior authorization as outlined in section 2. and 3. of this policy. The fourth and subsequent obstetrical ultrasound procedure per member per pregnancy performed by a participating provider as outlined are subject to utilization review (prior authorization) by eviCore healthcare. Payment of these ultrasounds will be

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Obstetrical Ultrasonography (continued)	Jan. 1, 2023	one date of service within the 45-day period ○ This policy assumes board certification by an American Board of Medical Specialties (ABMS) recognized in the provider specialties listed [in the policy] ● Replaced language indicating "*Board Certified Pediatric Cardiologists with the American Board of Pediatrics and Cardiology* laboratories accredited by the Intersocietal Accreditation Commission for Echocardiography may perform the [listed] ultrasound CPT codes" with "laboratories accredited by the Intersocietal Accreditation Commission for Echocardiography may perform the [listed] ultrasound CPT codes" **Supporting Information** ● Removed *Benefit Considerations* and *Prior Authorization Requirements* sections	based upon provider contract, provider specialty and applicable payment rules. Oxford has engaged eviCore healthcare to perform initial reviews of requests for prior authorization and Medical necessity reviews. To pre-authorize a radiology procedure, please call eviCore healthcare at 1-877-PRE-AUTH (1-877-773-2884) or log on to the eviCore healthcare web site using the Prior Authorization and Notification App. eviCore healthcare has established an infrastructure to support the review, development, and implementation of comprehensive outpatient imaging criteria. The radiology evidence-based guidelines and management criteria are available on the eviCore healthcare web site using the Prior Authorization and Notification App. The notification/authorization number is valid for 45 calendar days. It is specific to the advanced outpatient imaging procedure requested, to be performed one time, for one date of service within the 45-day period. 2 & 3. Payment by Specialty & Accreditation/Certification Requirements Oxford has engaged eviCore healthcare to manage the accreditation process for our provider network. Accreditations should be submitted directly to the eviCore healthcare website. To ensure prompt handling of the accreditation, ensure that all applicable facility and physician information is included. Specialists will be reimbursed for radiology services rendered in the office, outpatient or home setting. Services are payable to participating physicians based on their specialty. In addition, certain ultrasounds may not be reimbursed unless the providers hold a particular accreditation. This policy assumes board certification by an American Board of Medical Specialties (ABMS) recognized in the provider specialty listed below. ● Reproductive Endocrinologists may perform the following ultrasound CPT codes; prior authorization for the fourth and subsequent procedures per member per pregnancy is required: ○ 76815, 76816, 76817

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Obstetrical Ultrasonography (continued)	Jan. 1, 2023		*In addition to the codes listed above, a Reproductive Endocrinologist with an AIUM/ACR accreditation may perform the following studies; prior authorization for the fourth and subsequent procedure per member per pregnancy is required: ○ 76801, 76802, 76805, 76810, 76811, 76812, 76813, 76814, 76818, 76819, 76820, 76821, 76825, 76826, 76827, 76828 • Obstetricians/Gynecologists may perform the following ultrasound CPT codes; prior authorization for the fourth and subsequent procedure per member per pregnancy is required: ○ 76815, 76816, 76817 *In addition to the codes listed above, an Obstetrician/Gynecologist with an AIUM or ACR accreditation may perform the following studies; prior authorization for the fourth and subsequent procedure per member per pregnancy is required: ○ 76801, 76802, 76805, 76810, 76811, 76812, 76813, 76814, 76818, 76819, 76820, 76821, 76825, 76826, 76827, 76828 • Maternal Fetal Medicine and Perinatal Neonatal Medicine specialists may perform the following ultrasound CPT codes; prior authorization for the fourth and subsequent procedure per member per pregnancy is required: ○ 76815, 76816, 76817 *In addition to the codes listed above, a Maternal Fetal Medicine and Perinatal Neonatal Medicine specialist with an AIUM or ACR accreditation may perform the following studies; prior authorization for the fourth and subsequent procedure per member per pregnancy is required: ○ 76801, 76802, 76805, 76810, 76811, 76812, 76813, 76814, 76818, 76819, 76820, 76821, 76825, 76826, 76827, 76828 • Laboratories accredited by the Intersocietal Accreditation Commission for Echocardiography may perform the following ultrasound CPT codes; prior authorization for the fourth and subsequent procedure per member per pregnancy is required: ○ 76820, 76821, 76825, 76826, 76827, 76828

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Oxford's Outpatient Imaging Self-Referral	Jan. 1, 2023	Coverage Rationale • Added language to indicate a notification/authorization number is valid for 45 calendar days; it is specific to the advanced outpatient imaging procedure requested, to be performed one time, and for one date of service within the 45-day period • Revised list of accreditations/certifications required for: *General Surgeons, Surgical Oncologists – Breast* ○ Added language to indicate ultrasound and ultrasound guided needle placement of the breast requires accreditation by The Joint Commission (TJC) ○ Removed language indicating ultrasound and ultrasound guided needle placement of the breast requires accreditation by the American Society of Breast Surgeons (ASBS) in breast ultrasound *Cardiologists – Nuclear Medicine* ○ Removed language indicating nuclear studies require nuclear medicine certification by the American Board of Radiology (ABR), the American Board of Nuclear Medicine (ABNM), the American Osteopathic Board of Nuclear Medicine (AOBNM), the American Osteopathic Board of Radiology (AOBR), Certification Board for Nuclear Cardiology (CBNC), Royal College of Physicians and Surgeons of Canada (RCPSC), or Le college des Medicine du Quebec (LMQ) *Cardiologists – Pediatric Only* ○ Removed language indicating: ▪ Nuclear studies require certification by ABR, ABNM, AOBNM, AOBR, CBNC, RCPSC, or LMQ ▪ Echocardiography studies require board certification in pediatric cardiology *Endocrinologists; Pediatric Endocrinologists* ○ Removed language indicating CPT codes 76536 and 76942 require American Association of Clinical Endocrinologists (AACE) accreditation *Reproductive Endocrinologists* and *Reproductive Endocrinologists – Infertility Specialists Practicing within an Infertility Clinic* ○ Removed language indicating ultrasound of the breast requires accreditation by the American Society of Breast Surgeons (ASBS) in breast ultrasound *OB/GYNs* and *Maternal and Fetal Medicine and Neonatal/Perinatal Medicine* ○ Added language to indicate ultrasound of the breast requires accreditation by The Joint Commission (TJC) ○ Removed language indicating ultrasound and ultrasound guided needle placement of the breast requires accreditation by the American Society of Breast Surgeons (ASBS) in breast ultrasound

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Policy Title	**Effective Date**	**Summary of Changes**
Oxford's Outpatient Imaging Self-Referral (continued)	Jan. 1, 2023	*Nuclear Medicine* ○ Removed language indicating nuclear medicine studies require physicians certified by the ABR, ABNM, RCPSC, or LMQ *Orthopedists/Orthopedic Surgeons (including Pediatric Orthopedists)* ○ Replaced language indicating "CPT codes 76881, 76882, and 76942 require an AIUM accreditation in musculoskeletal ultrasound" with "CPT codes 76881, 76882, and 76942 require an AIUM accreditation in musculoskeletal ultrasound *or accreditation by The Joint Commission (TJC)*" *Rheumatologists* ○ Replaced language indicating "CPT code 76942 requires an AIUM accreditation in musculoskeletal ultrasound" with "CPT code 76942 requires an AIUM accreditation in musculoskeletal ultrasound *or accreditation by The Joint Commission (TJC)*" Supporting Information ● Updated *Background* section to reflect the most current information Refer to the policy for complete details.
Preventive Care Services	Jan. 1, 2023	Frequently Asked Questions (FAQ) ● Removed FAQ #14 pertaining to maternal depression screening Applicable Codes *Preventive Care Services* Hepatitis B Virus Infection Screening ● Updated service description; added Jul. 2022 Bright Futures guideline to indicate Bright Futures recommends screening between the ages 0-21 years [perform risk assessment for hepatitis B virus (HBV) infection] ● Updated lists of applicable codes; added: ○ CPT code 87467 ○ ICD-10 diagnosis codes Z00.121 and Z00.129 Statin Use for the Primary Prevention of Cardiovascular Disease in Adults - Cholesterol Screening (Lipid Disorders Screening) ● Updated service description: ○ Removed Nov. 2016 USPSTF rating "B" ○ Added Aug. 2022 USPSTF rating "B" to indicate the USPSTF recommends clinicians prescribe a statin for the primary prevention of CVD for adults aged 40 to 75 years who have 1 or more CVD risk factor (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year risk of a cardiovascular event of 10% or greater

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Preventive Care Services (continued)	Jan. 1, 2023	**Colorectal Cancer Screening**
		• Updated list of applicable CPT codes *Code Group 5: Pre-Op/Consultation* to reflect annual edits; removed 99241
		Screening for Depression in Adults
		• Updated list of applicable CPT codes; added 96161
		• Updated preventive benefit instructions; added language to indicate the diagnosis codes listed for this service are not required for CPT code 96161
		Depression in Children and Adolescents (Screening)
		• Updated service description:
		  ○ Removed Feb. 2016 USPSTF "B" rating
		  ○ Added Oct. 2022 USPSTF "B" rating to indicate the USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12-18 years
		• Updated list of applicable CPT codes; added 96161
		• Updated preventive benefit instructions; added language to indicate the diagnosis codes listed for this service are not required for CPT code 96161
		Screening for Anxiety in Children and Adolescents *(new to policy)*
		• Added service description for the Oct. 2022 USPSTF "B" rating to indicate the USPSTF recommends screening for anxiety in children and adolescents aged 8 to 18 years
		• Added instruction to refer to the *Screening for Anxiety (HRSA)*, *Screening for Depression in Adults (USPSTF)*, *Perinatal Depression – Preventive Interventions (Counseling) (USPSTF)*, and *Depression and Suicide Risk Screening (Bright Futures)* sections of the policy for additional information
		• Added CPT code 96127
		• Added ICD-10 diagnosis code Z13.39
		• Added preventive benefit instruction to indicate CPT code 96127 requires diagnosis code Z13.39
		Fluoride Application in Primary Care
		• Updated service description:
		  ○ Removed Apr. 2017 Bright Futures guideline
		  ○ Added Jul. 2022 Bright Futures guideline to indicate Bright Futures adopted the May 2014 recommendation of the USPSTF and further recommends, once teeth are present, [to] apply fluoride varnish to all children every 3 to 6 months in the primary care or dental office, based on caries risk
		Behavioral/Social/Emotional Screening (Bright Futures)
		• Updated service description:
		  ○ Removed Apr. 2017 Bright Futures guideline

Revised		
Policy Title	**Effective Date**	**Summary of Changes**
Preventive Care Services (continued)	Jan. 1, 2023	○ Added Jul. 2022 Bright Futures guideline to indicate Bright Futures recommends behavioral/social/emotional screening annually from newborn to 21 years ● Added instruction to refer to the *Screening for Anxiety (HRSA)*, *Screening for Depression in Adults (USPSTF)*, *Perinatal Depression – Preventive Interventions (Counseling) (USPSTF)*, and *Depression and Suicide Risk Screening (Bright Futures)* sections of the policy for additional information **Depression and Suicide Risk Screening (Bright Futures)** ● Updated service description: ○ Removed Apr. 2017 Bright Futures guideline ○ Added Jul. 2022 Bright Futures guideline to indicate Bright Futures recommends screening adolescents age 12-21 years for depression and suicide risk, making every effort to preserve confidentiality of the adolescent **Sudden Cardiac Arrest (SCA) and Sudden Cardiac Death (SCD) – Risk Assessment and ECG Screening (Bright Futures)** ***(new to policy)*** ● Added service description for the Jul. 2022 Bright Futures guideline to indicate Bright Futures recommends all children should be evaluated for conditions predisposing to SCA and SCD in the course of routine health care: ○ A thorough and detailed history, family history, and physical examination are necessary to begin assessing SCA and SCD risk ○ The ECG should be the first test ordered when there is a concern for SCA risk ○ The ECG should be interpreted by a physician trained in recognizing electrical heart disease (i.e., a pediatric cardiologist or pediatric electrophysiologist) ● Added lists of applicable codes: ○ Added CPT codes 93000, 93005, and 93010 ○ Added ICD-10 diagnosis codes for: ▪ At least one required for screening: – Adult: Z00.00 and Z00.01 – Child: Z00.121 and Z00.129 ▪ Additional (at least one) required: I42.0, I42.1, I42.2, I45.81, I49.8, I49.9, R55, R06.00, R06.09, R53.83, R00.2, R01.0, R01.1, R03.0, Q87.40, Q87.410, Q87.418, Q87.42, Q87.43, Z82.41, Z84.81, and Z82.49 ● Added language to indicate a risk assessment is included in the code for a wellness examination visit; refer to the codes in the *Wellness Examinations* section of the policy ● Added preventive benefit instructions to indicate ECG screening for those at risk: ○ Is limited to ages 11 years to 21 years (ends on 22nd birthday) ○ Requires one of the screening diagnosis codes and one of the additional diagnosis codes listed for this service

Revised

Policy Title	Effective Date	Summary of Changes

Preventive Care Services (continued)	Jan. 1, 2023	*Preventive Vaccines (Immunizations)*
		Pneumococcal Conjugate
		• Revised language to indicate CPT code 90671 applies to both pediatric and adult age groups (no age benefit limit)
		Measles, Mumps, Rubella (MMR)
		• Revised list of trade names associated with CPT code 90707; added "Priorix®"
		Expanded Women's Preventive Health
		Well-Woman Preventive Visits
		• Replaced references to "prenatal care" with "prenatal care *(antepartum)*"
		• Added CPT code 59430 for postpartum care visits (outpatient)
		• Added preventive benefit instruction to indicate:
		  ○ CPT code 99078 requires a pregnancy diagnosis code listed in the policy
		  ○ Postpartum care visits (outpatient) do not have diagnosis code requirements for the preventive benefit to apply
		Contraceptive Methods (Including Sterilizations)
		• Added service notation to indicate coverage includes member reimbursement for the cost of FDA-approved, cleared, or granted mobile device applications for use as contraception consistent with the FDA-approved, cleared, or granted indication
		• Added lists of applicable codes for *Code Group 7* for:
		  ○ *Related Visits: Related Evaluation and Management Office/Outpatient Visits for Contraception or Sterilization*: Added CPT/HCPCS codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99417, and G0463
		  ○ *Related Pregnancy Tests: Pregnancy Tests When Related to Contraception or Sterilization*: Added CPT codes 81025, 84702, and 84703
		  ○ *Tubal Ligation Status*: Added ICD-10 diagnosis code Z98.51
		  ○ *Sterilization*: Added ICD-10 diagnosis code Z30.2
		  ○ *Contraceptive Management*: Added ICD-10 diagnosis codes Z30.012, Z30.013, Z30.014, Z30.017, Z30.018, Z30.019, Z30.09, Z30.40, Z30.42, Z30.430, Z30.431, Z30.432, Z30.433, Z30.46, Z30.49, Z30.8, and Z30.9
		• Added instruction to refer to the coding in the *Wellness Examinations* section of the policy
		• Added preventive benefit instructions to indicate the CPT codes in *Code Group 7* require one of the *Code Group 7* diagnosis codes
		Breastfeeding Services and Supplies
		• Updated list of applicable CPT codes to reflect annual edits; removed 99241 and 99343
		
		Refer to the policy for complete details.

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Radiation Therapy: Fractionation, Image-Guidance, and Special Services	Jan. 1, 2023	Coverage Rationale *Radiation Therapy Fractionation* • Replaced language indicating: ○ "When providing external beam radiation therapy (EBRT) for the treatment of a bone metastasis the [listed services] are medically necessary" with "when providing *palliative* external beam radiation therapy (EBRT) for the treatment of a bone metastasis the [listed services] are medically necessary" ○ "When providing EBRT, with or without chemotherapy, for locally advanced non-small cell lung cancer, delivery of greater than *30* fractions is not medically necessary" with "when providing EBRT, with or without chemotherapy, for locally advanced non-small cell lung cancer, delivery of greater than *35* fractions is not medically necessary" • Revised list of medically necessary services for: Bone Metastases ○ Removed "single fraction of radiation therapy" ○ Replaced "delivery of up to 10 fractions *for treatment of one of the following: a weight*	**Radiation Therapy Fractionation** ***Bone Metastases*** When providing palliative external beam radiation therapy (EBRT) for the treatment of a bone metastasis the following are medically necessary: • Delivery of up to 10 fractions of radiation therapy • Delivery of greater than 10 fractions for: ○ The treatment of a site that has previously received radiation therapy ***Breast Adenocarcinoma*** When providing EBRT for breast adenocarcinoma the following are medically necessary: • Delivery of up to 21 fractions (inclusive of a boost to the tumor bed) • Delivery of up to 33 fractions (inclusive of a boost to the tumor bed) is medically necessary when any of the following criteria are met: ○ Treatment of supraclavicular and/or internal mammary lymph nodes; or ○ Post-mastectomy radiation therapy; or ○ Individual has received previous thoracic radiation therapy; or ○ Individual has a connective tissue disorder such as lupus or scleroderma When providing EBRT for breast cancer, delivery of greater than 33 fractions (inclusive of a boost to the tumor bed) is not medically necessary. ***Locally Advanced Non-Small Cell Lung Cancer*** When providing EBRT, with or without chemotherapy, for locally advanced non-small cell lung cancer the following is medical necessary: • Delivery of up to 35 fractions When providing EBRT, with or without chemotherapy, for locally advanced non-small cell lung cancer, delivery of greater than 35 fractions is not medically necessary.

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Radiation Therapy: Fractionation, Image-Guidance, and Special Services (continued)	Jan. 1, 2023	*bearing bone such as femur, a bone that has previously undergone surgical stabilization, or spinal cord compression*" with "delivery of up to 10 fractions *of radiation therapy*" Locally Advanced Non-Small Cell Lung Cancer ○ Replaced "delivery of up to *30* fractions" with "delivery of up to *35* fractions" Prostate Adenocarcinoma ○ Removed "delivery of up to 45 fractions for localized prostate cancer when EBRT is being delivered in combination with brachytherapy" *Image-Guided Radiation Therapy (IGRT)* • Replaced language indicating: ○ "When the criteria [listed in the policy] are not met, IGRT is not medically necessary to align bony landmarks without implanted fiducials" with "when the criteria [listed in the policy] are not met, IGRT is not medically necessary to align bony landmarks without implanted fiducials *(e.g., during palliative radiation therapy)*"	***Prostate Adenocarcinoma*** When providing EBRT for prostate adenocarcinoma the following are medically necessary: • Delivery of up to 20 fractions for definitive treatment in an individual with Limited Metastatic Disease • Delivery of up to 28 fractions for localized prostate cancer • Delivery of up to 45 fractions for localized prostate cancer when any of the following criteria are met: ○ Individual with high-risk prostate cancer is undergoing radiation treatment to pelvic lymph nodes; or ○ Radiation therapy is delivered post-prostatectomy; or ○ Individual has a history of inflammatory bowel disease such as ulcerative colitis or Crohn's disease; or ○ Individual has received previous pelvic radiation therapy When providing EBRT for localized prostate cancer, delivery greater than 45 fractions is not medically necessary. **Image-Guided Radiation Therapy (IGRT)** Image guidance for radiation therapy is medically necessary under any of the following circumstances: • When used with intensity modulated radiation therapy (IMRT) (e.g. prostate cancer); or • When used with proton beam radiation therapy (PBRT); or • When the target has received prior radiation therapy or abuts previously irradiated area; or • When implanted fiducial markers are being used for target localization; or • During definitive treatment using 3D-CRT for the following: ○ Breast cancer and any of the following: ▪ Accelerated partial breast irradiation ▪ Breast boost with the use of photons ▪ Hypofractionated radiation therapy delivered over five fractions to the whole breast or chest wall

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Radiation Therapy: Fractionation, Image-Guidance, and Special Services (continued)	Jan. 1, 2023	○ "Special services include the need for special dosimetry, special medical physics consultation, and special treatment procedure; refer to the *Coding Clarification* [section of the policy]" with "*for the use of IGRT for brachytherapy, SRS, SBRT, and* special services (*i.e.,* dosimetry, medical physics consultation, and treatment procedure), refer to the *Coding Clarification* [section of the policy]" • Revised list of medically necessary indications: ○ Added: ▪ During definitive treatment using 3D-CRT for: – Breast cancer and any of the following: • Accelerated partial breast irradiation • Breast boost with the use of photons • Hypofractionated radiation therapy delivered over five fractions to the whole breast or chest wall	▪ Left breast cancer and deep inspiration breath hold (DIBH) technique is being used ▪ Patient is being treated in prone position ○ During boost treatment of rectal and bladder cancer ○ Esophageal cancer ○ Gastric cancer ○ Head and neck cancer ○ Hepatobiliary cancer ○ Lung Cancer ○ Pancreatic cancer ○ Soft tissue sarcoma When the above criteria are not met, IGRT is not medically necessary including but not limited to any of the following circumstances: • Brachytherapy • Stereotactic body radiation therapy (SBRT)* • Stereotactic radiosurgery (SRS)* • Superficial treatment of skin cancer including superficial radiation therapy or electronic brachytherapy • To align bony landmarks without implanted fiducials (e.g. during palliative radiation therapy) Note: For the use of IGRT for brachytherapy, SRS, SBRT, and special services (i.e. dosimetry, medical physics consultation, and treatment procedure) refer to Coding Clarification in this policy.

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Radiation Therapy: Fractionation, Image-Guidance, and Special Services (continued)	Jan. 1, 2023	• Left breast cancer and deep inspiration breath hold (DIBH) technique is being used • Patient is being treated in prone position – During boost treatment of rectal and bladder cancer – Gastric cancer – Hepatobiliary cancer – Lung cancer – Pancreatic cancer – Soft tissue sarcoma ○ Removed: ▪ For left sided breast cancer with the use of: – Deep inspiration breath hold (DIBH) technique – Prone technique ▪ During definitive treatment using 3D-CRT for: – Central nervous system tumors – Mediastinal tumors – Prostate cancer – Individuals who are severely obese (BMI ≥ 35) and are being treated for abdominal and pelvic tumors	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Radiation Therapy: Fractionation, Image-Guidance, and Special Services (continued)	Jan. 1, 2023	– Tumors with significant respiratory motion and motion assessment and management techniques are being utilized (e.g., 4D CT scan) ○ Replaced: ▪ "When used with intensity modulated radiation therapy (IMRT)" with "when used with intensity modulated radiation therapy (IMRT) *(e.g., prostate cancer)*" ▪ "*Primary* head and neck cancer" with "head and neck cancer" **Definitions** ● Added definition of "Limited Metastatic Disease" **Applicable Codes** ● Added notation to indicate IGRT codes should not be used for imaging performed during brachytherapy; verification of applicator position should be reported using simple simulation CPT code 77280 ● Updated notation pertaining to special medical radiation physics consultation (CPT code 77370); replaced reference to "implanted	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Radiation Therapy: Fractionation, Image-Guidance, and Special Services (continued)	Jan. 1, 2023	*pacemaker or defibrillator* device" with "implanted *cardiac* devices" Supporting Information • Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect the most current information • Removed *Prior Authorization Requirements* section	
Radiology Procedures for eviCore healthcare Arrangement	Jan. 1, 2023	Title Change • Previously titled *Radiology Procedures Requiring Prior Authorization for eviCore healthcare Arrangement* Coverage Rationale • Added language to indicate: ○ A notification/authorization number is valid for 45 calendar days; it is specific to the advanced outpatient imaging procedure requested, to be performed one time, and for one date of service within the 45-day period ○ Ultrasound studies must be performed on an American College of Radiology (ACR), American Institute of Ultrasound in Medicine (AIUM), Intersocietal Accreditation Commission (IAC), RadSite, or The Joint Commission (TJC) accredited unit or at accredited	Oxford has engaged eviCore healthcare to perform initial reviews of requests for prior authorization and medical necessity reviews that may include a site of service review. (Oxford continues to be responsible for decisions to limit or deny coverage and for appeals). Refer to the Clinical Policy titled Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Scan – Site of Service. All prior authorization requests are handled by eviCore healthcare. To prior authorize a radiology procedure, contact eviCore healthcare via one of the two options listed below: • Providers can call eviCore healthcare at 1-877-PRE-AUTH (1-877-773-2884); or • Providers can log onto the eviCore healthcare web page using the Prior Authorization and Notification App. Note: It is eviCore healthcare's policy not to accept prior authorization requests from persons or entities other than referring physicians. The notification/authorization number is valid for 45 calendar days. It is specific to the advanced outpatient imaging procedure requested, to be performed one time, for one date of service within the 45-day period. eviCore healthcare has established an infrastructure to support the review, development, and implementation of comprehensive outpatient imaging criteria. The radiology evidence-based guidelines and management criteria are available

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Radiology Procedures for eviCore healthcare Arrangement (continued)	Jan. 1, 2023	facilities ● Revised list of accreditations required for units/facilities where MRI, PET, and CT studies must be performed; added American Institute of Ultrasound in Medicine (AIUM) ● Revised list of accreditations required for units/facilities where nuclear medicine studies must be performed: ○ Added: ▪ American Institute of Ultrasound in Medicine (AIUM) ▪ RadSite ▪ The Joint Commission (TJC) ○ Removed Intersocietal Commission for the Accreditation of Nuclear Medicine (ICANL) ● Removed certification requirements for cardiologists that perform certain nuclear medicine procedures **Applicable Codes** ● Revised list of CPT codes requiring prior authorization; added 0697T, 0698T, 0710T, 0711T, 0712T, and 0713T **Supporting Information** ● Removed *Prior Authorization Requirements* section	on the eviCore healthcare web site using the Prior Authorization and Notification App. Accreditation Requirements for Participating Providers Note: Hospitals are currently excluded from the accreditation requirements listed below. All MRI, PET, CT, nuclear medicine, and ultrasound studies must be performed on an American College of Radiology (ACR), American Institute of Ultrasound in Medicine (AIUM), Intersocietal Accreditation Commission (IAC), RadSite, or The Joint Commission (TJC) accredited unit or at accredited facilities. Refer to the Administrative Policy titled Accreditation Requirements for Radiology Services. Oxford has engaged eviCore healthcare to manage the accreditation process for our provider network. Accreditations should be submitted directly to the eviCore healthcare website. To ensure prompt handling of the accreditation, ensure that all applicable facility and physician information is included. The Oxford Radiology Prior Notification/Authorization Crosswalk Table contains a list of CPT® codes that are interchangeable for prior authorization. If a provider obtains prior authorization for a procedure that corresponds with the Crosswalk Table, then the substitution is appropriate.

Administrative Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Accreditation Requirements for Radiology Services	Jan. 1, 2023	**Definitions** • Removed definition of ASBS **Policy** • Removed language indicating radiology facilities require accreditation from the American Society of Breast Surgeons (ASBS) for breast ultrasound or stereotactic breast biopsy procedures • Removed notation pertaining to reimbursement limitations for nuclear medicine procedures **Procedures and Responsibilities** • Added language to indicate this policy assumes board certification by an American Board of Medical Specialties (ABMS) recognized in the provider specialties listed [in the policy]	In diagnostic imaging, accreditation programs have emerged as key initiatives to advance the quality and safety of imaging studies. It is important that Members receive services from facilities whose equipment, technologists, and physicians are in compliance with established accreditation performance standards. All freestanding facilities and physician offices performing outpatient radiology advanced imaging studies in the eviCore imaging network are required to obtain and maintain accreditation as a condition for reimbursement for the below services. Radiologists seeking reimbursement for advanced imaging must have the laboratory/facility accreditation on file.

Provider Specialty	Accreditation in Appropriate Module	Modality/Procedure
Radiology Facilities	ACR	MRI, Breast MRI, CT, Nuclear Medicine, PET, Ultrasound, Breast Ultrasound, Mammography, Stereotactic Biopsy
	AIUM	Ultrasound, Breast Ultrasound
	IAC	MRI, CT, Nuclear Medicine, PET, Ultrasound
	RadSite (except cardiac procedures)	MRI, CT, Nuclear Medicine (SPECT), PET
	TJC	MRI, CT, Nuclear Medicine, PET, Ultrasound, X-ray, Breast Ultrasound, Stereotactic Breast Biopsy

Refer to the Clinical Policy titled Radiology Procedures for eviCore healthcare Arrangement for applicable CPT codes requiring Prior Authorization.

Oxford has engaged eviCore healthcare to manage the accreditation process for our provider network. Accreditations should be submitted directly to the eviCore

Administrative Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Accreditation Requirements for Radiology Services (continued)	Jan. 1, 2023		healthcare website. To ensure prompt handling of the accreditation, ensure that all applicable facility and physician information is included. If you have specific questions about the application process for accreditation, contact the ACR or IAC on their websites or by phone. For questions about Oxford's accreditation requirements, call 1-800-666-1353. In addition to accreditation, all radiologists and radiology centers in New York (NY) and New Jersey (NJ), who are interested in participating in the Oxford network and/or radiologists and radiology centers that already participate in the Oxford network and want to add a modality to their practice must also be credentialed. Refer to the Administrative Policy titled Credentialing Guidelines: Participation in the eviCore healthcare Network for additional information. Exceptions: • Radiologists and radiology centers performing outpatient radiology imaging studies in Connecticut (CT) are excluded from credentialing requirements (accreditation requirements are applicable). • Hospitals performing outpatient radiology imaging studies are excluded from the accreditation requirements. All radiology centers and cardiologists in NY, NJ, and CT who are currently participating in the Oxford network or wish to participate in the Oxford network and perform Coronary CT Angiography (CCTA) must also be credentialed. Refer to the Administrative Policy titled Credentialing Guidelines: Participation in the eviCore Healthcare Network for additional information.

General Information

The inclusion of a health service (e.g., test, drug, device or procedure) in this bulletin indicates only that UnitedHealthcare Oxford® is adopting a new policy and/or updated, revised, replaced or retired an existing policy; it does not imply that UnitedHealthcare Oxford® 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 Oxford® reserves the right to review the clinical evidence supporting the safety and effectiveness of a medical technology prior to rendering a coverage determination.

UnitedHealthcare Oxford® 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 Policy Update Bulletin was developed to share important information regarding UnitedHealthcare Oxford® Clinical, Administrative, and Reimbursement Policy updates. When information in this bulletin conflicts with applicable state and/or federal law, UnitedHealthcare Oxford® 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 Oxford® Clinical and Administrative Policies is available at UHCprovider.com > Policies and Protocols > Commercial Policies > UnitedHealthcare Oxford Clinical and Administrative Policies.