MECHANICAL CIRCULATORY SUPPORT DEVICE (MCSD)

Guideline Number: MMG081.G  Effective Date: February 1, 2018

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INSTRUCTIONS FOR USE

This Medical Management Guideline provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document [e.g., Evidence of Coverage (EOC) and Schedule of Benefits (SOB)] may differ greatly from the standard benefit plan upon which this Medical Management Guideline is based. In the event of a conflict, the member specific benefit plan document supersedes this Medical Management Guideline. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this Medical Management Guideline. Other Policies and Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary. This Medical Management Guideline is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Member benefit coverage and limitations may vary based on the member's benefit plan Health Plan coverage provided by or through UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare Benefits of Texas, Inc., or UnitedHealthcare of Washington, Inc.

BENEFIT CONSIDERATIONS

Essential Health Benefits for Individual and Small Group

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the member specific benefit plan document to determine benefit coverage.

APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

The below table represents CPT codes that require prior authorization by OptumHealth. The list is not meant to provide a coverage determination. Coverage will be determined based upon further review of members benefit, UnitedHealthcare Policies and OptumHealth's Clinical Guidelines. Clinical Guidelines may be found at:
CPT Code | Description
--- | ---
33975 | Insertion of ventricular assist device; extracorporeal, single ventricle
33976 | Insertion of ventricular assist device; extracorporeal, biventricular
33979 | Insertion of ventricular assist device, implantable, intracorporeal, single ventricle
33981 | Replacement of extracorporeal ventricular assist device, single or biventricular, pump(s), single or each pump
33982 | Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass
33983 | Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, with cardiopulmonary bypass

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DESCRIPTION OF SERVICES

UnitedHealthcare has engaged OptumHealth to perform reviews for prior authorization requests for the use of long term, durable mechanical circulatory devices. UnitedHealthcare continues to be responsible for decisions regarding coverage determinations and for appeals. Optum has established an infrastructure to support the review, development, and implementation of comprehensive clinical guidelines. The evidence-based clinical guidelines are available at: UHCProvider.com > Menu > Policies and Protocols > Clinical Guidelines > Mechanical Circulatory Support Device (MCSD) Clinical Guideline.

All prior authorization requests are handled by OptumHealth. To prior authorize a procedure related to mechanical circulatory devices; please call OptumHealth at 888-936-7246.

GUIDELINE HISTORY/REVISION INFORMATION

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/01/2018</td>
<td>Updated policy header to reflect the most current UnitedHealthcare West branding; modified list of applicable products to encompass new benefit plans effective Jan. 1, 2019</td>
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<tr>
<td>02/01/2018</td>
<td>Routine review; no content changes, Archived previous policy version MMG081.F</td>
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