United Healthcare Medicare Advantage

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Policy Guideline Update Bulletin: February 2023

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Policy Guideline Updates

New

Policy Title	Approval Date	Policy Summary
Spravato® (Esketamine)	Jan. 11, 2023	**Overview** SPRAVATO® is a non-competitive N-methyl D-aspartate (NMDA) receptor antagonist indicated, in conjunction with an oral antidepressant, for the treatment of treatment-resistant depression (TRD) in adults. **Guidelines** Drugs and biologicals must be determined to meet the statutory definition under the statue 1861(t) (1) Drugs and Biologicals. This guideline provides billing and coding guidance for the drug SPRAVATO® (esketamine) when administered at healthcare sites enrolled in the Food and Drug Administration (FDA) risk evaluation and mitigation strategies (REMS) program. Consistent with Title XVIII of the Social Security Act, Section 1861(t)(2)(B) the term "medically accepted indication", with respect to the use of a drug, includes any use which has been approved by the FDA for the drug, and includes another use of the drug if such use is supported by one or more citations which are included (or approved for inclusion) in one or more of the following compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluations, the United States Pharmacopoeia-Drug Information, and other authoritative compendia as identified by the Secretary. Prescribing medications for indications that are not approved by the FDA or are not supported in one of the compendia listed above may lead to revocation from the Medicare program consistent with CFR, Title 42, Chapter IV, Subchapter B, Part 424, Section 424.535.

Updated

Policy Title	Approval Date	Summary of Changes

Clinical Diagnostic Laboratory Services	Jan. 11, 2023	**Related Policies**
		• Removed reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled:
		  ○ *BRCA1 and BRCA2 Genetic Testing*
		  ○ *Genetic Testing for Lynch Syndrome*
		Applicable Codes
		• Removed CPT codes 0248U, 0306U, 0307U, 0313U, 0314U, 0315U, 0318U, 0319U, 0320U, 0323U, 0324U, 0325U, 0326U, 0327U, 0329U, 0330U, 0331U, 0332U, 0333U, 0334U, 0335U, 0336U, 0339U, 0340U, 0341U, 0343U, 0347U, 0348U, 0349U, 0350U, 0352U, and 0353U
		• Updated language pertaining to CPT code 86353:
		  ○ Added reference to the National Coverage Determination (NCD) for *Lymphocyte Mitogen Response Assays (NCD*

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Policy Title	Approval Date	Summary of Changes
Clinical Diagnostic Laboratory Services (continued)	Jan. 11, 2023	*190.8)* ○ Removed notation indicating this code is not covered when submitted with a screening diagnosis **Supporting Information** ● Updated *References* section to reflect the most current information
Human Tumor Stem Cell Drug Sensitivity Assays (NCD 190.7)	Jan. 11, 2023	**Applicable Codes** ● Added CPT codes 0248U, 0324U, and 0325U **Supporting Information** ● Updated *References* section to reflect the most current information

Revised

Policy Title	Approval Date	Summary of Changes
Coronary Fractional Flow Reserve Using Computed Tomography (FFR-ct)	Jan. 11, 2023	**Policy Summary** *Overview* ● Revised language to indicate noninvasive fractional flow reserve deduced from computed tomography (FFR-ct) involves computer-assisted processing of coronary computed tomography angiography (CCTA) images to estimate changes in blood pressure inside coronary arteries that have partial blockages, with the goal of determining how severely the blockages impede blood flow to the heart ○ FFR-ct is a post-processing software for the clinical quantitative and qualitative analysis of previously acquired computed tomography (CT) Digital Imaging and Communications in Medicine (DICOM) data for clinically stable symptomatic patients with coronary artery disease (CAD) ○ FFR-ct analysis is intended to support the functional evaluation of CAD; the results of this analysis are provided to support qualified clinicians to aid in the evaluation and assessment of coronary arteries *Guidelines* ● Revised language to indicate: ○ FDA-approved FFR-ct technology may be considered reasonable and necessary in the management of patients with: ▪ Intermediate-risk patients with acute or stable chest pain and with no known history coronary artery stenosis with finding of 40-90% in proximal or middle coronary artery on CCTA; or ▪ Intermediate-risk patients with acute chest pain and known non-obstructive (< 50%) CAD coronary artery stenosis with finding of 40-90% stenosis in proximal or middle coronary artery on CCTA; or ▪ Stable nonobstructive coronary artery disease (< 50% stenosis) with persistent symptoms requiring further test, and finding of 40-90% stenosis on CCTA; and ▪ Not in conjunction with stress testing (unless CCTA was not sufficient quality for FFR-ct, and an alternative

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Coronary Fractional Flow Reserve Using Computed Tomography (FFR-ct) (continued)	Jan. 11, 2023	study is needed) ○ FFR-ct is not considered reasonable in the following clinical circumstances: ▪ Prior placement of prosthetic valves ▪ Prior placement of grafts in coronary bypass surgery ▪ Suspicion of acute coronary syndrome (where MI or unstable angina have not been ruled out) ▪ Intracoronary metallic stent ▪ Status post-heart transplantation ▪ Recent MI (30 days or less) ▪ Prior pacemaker or defibrillator lead placement ▪ Newly diagnosed systolic heart failure, with no prior left heart catheterization ▪ Non-obstructing stenosis (< 50% of all major epicardial vessels) on CTA or catheterization in the past twelve months, in the absence of a new symptom complex ▪ If turnaround times may impact prompt clinical care decisions ○ This service should be performed in patients with stable coronary symptoms ▪ It should not be performed until after the base study (CCTA) has been completed and interpreted ▪ If higher grade stenoses (i.e., greater than 90%) are present, this study is not medically necessary, as the patient should proceed to catheterization ▪ Similarly, low-grade stenoses (less than 40%) do not require additional confirmatory data ▪ This should be performed as an alternative to stress testing **Documentation Requirements** ● Revised language to indicate: ○ The patient's medical record must document all of the following: ▪ The clinical findings that led to the initial performance of the CCTA, and the CCTA must be fully reviewed before the performance of FFRCT (as evidenced by the submission of the Coronary Computed Tomographic Angiography Report) ▪ Description of symptoms consistent with stable ischemic heart disease ▪ Fractional Flow Reserve analysis report ○ As this service constitutes post-procedure analysis of a previously performed study (CCTA), the name and NPI of the referring/ordering physician that submitted imaging data for FFR-ct review must be reported on the claim **Applicable Codes** ● Added notation to indicate ICD-10 diagnosis codes C38.0, C45.2, C79.89, D15.1, I20.0, I20.8, I20.9, I24.0, I25.10, I25.110, I25.111, I25.118, I25.119, I25.2, I25.3, I25.41, I25.42, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751,

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Revised		
Policy Title	**Approval Date**	**Summary of Changes**
Coronary Fractional Flow Reserve Using Computed Tomography (FFR-ct) (continued)	Jan. 11, 2023	I25.758, I25.759, I25.760, I25.761, I25.768, I25.790, I25.791, I25.798, I25.799, I25.810, I25.811, I25.812, I25.89, I25.9, I27.0, I31.0, I31.1, I31.2, I31.3, I31.4, I31.8, I31.9, I34.0, I34.1, I34.2, I34.8, I34.9, I35.0, I35.1, I35.2, I35.8, I35.9, I48.0, I48.11, I48.19, I48.20, I48.21, I48.3, I48.4, I48.91, I48.92, I49.01, I49.02, I71.01, I71.1, I71.2, Q20.1, Q20.2, Q20.3, Q20.4, Q20.5, Q20.6, Q20.8, Q20.9, Q21.0, Q21.1, Q21.2, Q21.3, Q21.4, Q21.8, Q21.9, Q22.0, Q22.1, Q22.2, Q22.3, Q22.4, Q22.5, Q22.6, Q22.8, Q22.9, Q23.0, Q23.1, Q23.2, Q23.3, Q23.4, Q23.8, Q23.9, Q24.0, Q24.1, Q24.2, Q24.3, Q24.4, Q24.5, Q24.8, Q24.9, Q25.0, Q25.1, Q25.3, Q25.5, Q25.6, Q25.71, Q25.72, Q25.79, Q25.8, Q25.9, Q26.0, Q26.1, Q26.2, Q26.3, Q26.4, Q26.8, Q26.9, R07.2, R07.82, R07.89, R07.9, R94.39, Z45.010, and Z45.018 were “deleted Mar. 31, 2022” • Removed ICD-10 diagnosis codes C79.9, I20.1, I25.769, I42.0, I42.5, I42.8, I42.9, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.810, I50.811, I50.812, I50.813, I50.814, I50.82, I50.83, I50.84, I50.89, I50.9, Q25.21, Q25.29, Q25.40, Q25.41, Q25.42, Q25.43, Q25.44, Q25.45, Q25.46, Q25.47, Q25.48, Q25.49, R06.02, R06.03, and R94.30 **Supporting Information** • Updated *References* section to reflect the most current information

Mobility Devices (Non-Ambulatory) and Accessories	Jan. 11, 2023	**Related Policies**
		• Added reference link to the UnitedHealthcare Medicare Advantage Policy Guideline titled *Durable Medical Equipment Reference List*
		Policy Summary
		Power Operated Vehicle
		• Removed language pertaining to coverage for temporary replacement for patient owned equipment being repaired
		Power Wheelchair
		• Removed language pertaining to:
		  ○ The elimination of the lump sum purchase payment for standard wheelchairs
		  ○ Coverage for temporary replacement for patient owned equipment being repaired
		Applicable Codes
		• Removed modifier code EY
		Supporting Information
		• Updated *References* section to reflect the most current information

Policy Guideline Updates

Retired

The following Policy Guidelines have been retired effective Jan. 11, 2023:

- Delivery of IMRT/SRS/SBRT
- Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds (NCD 270.1)
- Treatment of Actinic Keratosis (NCD 250.4)

General Information

This bulletin provides a list of new, updated, revised, replaced and/or retired UnitedHealthcare Medicare Advantage Policy Guidelines to reflect the most current clinical coverage rules and guidelines developed by the Centers for Medicare & Medicaid Services (CMS). The inclusion of a health service (e.g., test, drug, device or procedure) in this bulletin indicates only that UnitedHealthcare has recently adopted a new policy and/or updated, revised, replaced or retired an existing policy; it does not imply that UnitedHealthcare provides coverage for the health service. In the event of an inconsistency or conflict between the information provided in this bulletin and the posted policy, the provisions of the posted policy will prevail. 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.

UnitedHealthcare respects the expertise of the physicians, health care professionals, and their staff who participate in our network. Our goal is to support you and your patients in making the most informed decisions regarding the choice of quality and cost-effective care, and to support practice staff with a simple and predictable administrative experience. The Policy Update Bulletin was developed to share important information regarding UnitedHealthcare Medicare Advantage Policy Guideline updates. When information in this bulletin conflicts with applicable state and/or federal law, UnitedHealthcare follows such applicable federal and/or state law.

Policy Update Classifications

New

New coverage guidelines 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 coverage guidelines; however, items such as the definitions or references may have been updated

Revised

An existing policy has been reviewed and revisions have been made to the coverage guidelines

Replaced

An existing policy has been replaced with a new or different policy

Retired

An existing policy has been retired

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 CMS, federal, or state regulatory requirements. Additionally, UnitedHealthcare reserves the right to review the clinical evidence supporting the safety and effectiveness of a medical technology prior to rendering a coverage determination.

The complete library of UnitedHealthcare Medicare Advantage Policy Guidelines is available at UHCprovider.com > Policies and Protocols > Medicare Advantage Policies > Policy Guidelines.