Cardiovascular Diagnostic and Therapeutic Procedures

Policy Number: MCS013.12
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Instructions for Use

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Related Medicare Advantage Policy Guidelines

- Biomarkers in Cardiovascular Risk Assessment
- Long-Term Wearable Electrocardiographic Monitoring
- Percutaneous Coronary Interventions

Coverage Guidelines

Cardiovascular diagnostic and therapeutic procedures are covered when Medicare coverage criteria are met.

Note: Cardiology imaging prior authorization programs exist for some plans. Reference materials are available at UHCprovider.com > Cardiology Prior Authorization and Notification.

Electrocardiographic Services

Electrocardiographic services, including electrocardiogram ambulatory electrocardiography (AECG) (Holter monitor or real-time EKG), cardiac event monitor or event recorders are covered when specific criteria are met. Refer to the NCD for Electrocardiographic Services (20.15).

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at https://www.cms.gov/medicare-coverage-database/search.aspx.

Note: Where the NCD or LCDs/LCAs is silent on coverage criteria for implantable loop recorders (CPT code 33285, HCPCS code E0616), refer to the UnitedHealthcare Commercial Medical Policy titled Cardiac Event Monitoring for clinical coverage guidance.
(Accessed March 4, 2024)

Cardiac Computed Tomography (CCT) and Coronary Computed Tomography Angiography (CCTA)

Refer to the Coverage Summary for Radiologic Diagnostic Procedures.

Arterial Compliance Testing, Using Waveform Analysis (CPT Code 93050)

Medicare does not have a National Coverage Determination (NCD) for arterial compliance testing, using waveform analysis. Local Coverage Determinations (LCDs)/Local Coverage Article (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Cardiovascular Disease Risk Tests.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines. (Accessed March 4, 2024)

Lower Extremity Stenting, Atherectomy, and/or Angioplasty (CPT Codes 37220, 37221, 37224, 37225, 37226, 37227, 37228, 37229, 37230, and 37231)

Medicare does not have a National Coverage Determination (NCD) for lower extremity endovascular interventions. Local Coverage Determinations (LCDs)/Local Coverage Article (LCAs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at https://www.cms.gov/medicare-coverage-database/new-search/search.aspx.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Lower Extremity Endovascular Procedures.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines. (Accessed March 4, 2024)

Catheter Ablation

Treatment of Atrial Fibrillation (CPT Codes 93653 and 93656)

Medicare does not have a National Coverage Determination (NCD) for catheter ablation for treatment of atrial fibrillation. Local Coverage Determinations (LCDs)/Local Coverage Article (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Catheter Ablation for Atrial Fibrillation.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines. (Accessed March 4, 2024)

Treatment of Other Indications (e.g., Atrial Flutter) (CPT Codes 93653 and 93656)

Medicare does not have a National Coverage Determination (NCD) for catheter ablation for treatment of for other atrial flutter. Local Coverage Determinations (LCDs)/Local Coverage Article (LCAs) do not exist.

For coverage guidelines, refer to the InterQual® CP: Procedures, Electrophysiology (EP) Testing +/- Radiofrequency (RFA) or Cryothermal Ablation, Cardiac.

Click here to view the InterQual® criteria.

Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the InterQual® criteria referenced above for coverage guidelines.

Policy History/Revision Information

Date	Summary of Changes

04/10/2024	**Coverage Guidelines**
	• Removed content/language addressing:
	  ○ Computerized tomography (CT scan)
	  ○ Aquapheresis (ultrafiltration) [CPT code 37799 when used to report aquapheresis (ultrafiltration)]; refer to the UnitedHealthcare Medicare Advantage Coverage Summary titled *Omnibus Codes* for applicable coverage guidelines
	  ○ Peripheral vascular angiography (CPT codes 75710 and 75716)
	• Revised notation pertaining to prior authorization requirements to indicate cardiology imaging prior authorization programs exist for some plans for cardiac imaging; reference materials are available at UHCprovider.com > Cardiology Prior Authorization and Notification

Date	Summary of Changes
	• Removed notation pertaining to members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements **Administrative** • Archived previous policy version MCS013.11

Instructions for Use

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member's Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member's EOC/SB, the member's EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing the items or services in this coverage summary have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, UnitedHealthcare applies internal coverage criteria in the UnitedHealthcare commercial policies referenced in this coverage summary. The coverage criteria in these commercial policies was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.