Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease

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Instructions for Use

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Related Policies
None

Coverage Rationale

Overview

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.

CMS National Coverage Determinations (NCDs)

Medicare does not have an NCD for Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease.

CMS Local Coverage Determinations (LCDs) and Articles

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the coverage rationale below.

This service should be performed in clinically stable symptomatic patients with coronary artery disease. FFR-ct should not be used for patients with unstable coronary syndromes, or in patients where urgent and timely workup and evaluation is critical.

This service 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.

FDA-approved FFR-ct technology is reasonable and necessary when all of the following criteria are met:

- FFR-ct technology is used in the management of patients with:
  - No prior coronary disease and acute (anginal) chest pain, FFR-ct is indicated in intermediate risk patients (troponin elevation) after a coronary artery stenosis finding on CCTA of 40-90% in a proximal or middle coronary artery; **or**
  - Known coronary artery disease and acute (anginal) chest pain, FFR-ct is indicated for intermediate risk patients (troponin elevation) after a coronary artery stenosis finding on CCTA of 40-90% in a proximal or middle coronary artery; **or**
  - No prior coronary disease and stable (anginal) chest pain, FFR-ct is indicated for intermediate risk patients* after a coronary artery stenosis finding on CCTA of 40-90% in proximal or middle coronary artery; **or**
  - Known coronary disease and persistent stable (anginal) chest pain, FFR-ct is indicated after any 40-90% stenosis finding on CCTA.

  and
- FFR-ct technology is not used in conjunction with stress testing (unless CCTA was not sufficient quality for FFR-ct, and an alternative study is needed); **and**
- None of the following clinical circumstances are present:
  - 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.

*Intermediate and high-risk as defined in the 2021 AHA/ACC/ASE/CHEST/SAEM/SCCT/SCMR Guideline for the Evaluation and Diagnosis of Chest Pain.

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 policy does not imply that the service described by the code is a covered or non-covered health service; however, language may be included in the listing below to indicate if a code is non-covered. 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.

CPT Code	Description
75580	Noninvasive estimate of coronary fractional flow reserve (FFR) derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional

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Diagnosis Code	Description
R93.1	Abnormal findings on diagnostic imaging of heart and coronary circulation

Centers for Medicare and Medicaid Services (CMS) Related Documents

After checking the table below and searching the Medicare Coverage Database, if no NCD, LCD or LCA is found refer to the criteria as noted in the Coverage Rationale section above.

NCD	LCD	Article	Contractor Type	Contractor Name
Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease				
N/A	L38771 Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease	A58359 Billing and Coding: Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease	Part A and B MAC	CGS
	L39075 Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease	A58814 Billing and Coding: Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease	Part A and B MAC	NGS
	L38613 Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease	A58095 Billing and Coding: Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease	Part A and B MAC	Noridian
	L38615 Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease	A58097 Billing and Coding: Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease	Part A and B MAC	Noridian
	L38278 Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease	A58406 Billing and Coding: Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease	Part A and B MAC	Palmetto**
	L38839 Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease	A58473 Billing and Coding: Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease	Part A and B MAC	WPS*

Medicare Administrative Contractor (MAC) With Corresponding States/Territories	
MAC Name (Abbreviation)	**States/Territories**
CGS Administrators, LLC (CGS)	KY, OH
First Coast Service Options, Inc. (First Coast)	FL, PR, VI
National Government Services, Inc. (NGS)	CT, IL, ME, MA, MN, NH, NY, RI, VT, WI
Noridian Healthcare Solutions, LLC (Noridian)	AS, AK, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY
Novitas Solutions, Inc. (Novitas)	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX, VA**
Palmetto GBA (Palmetto)	AL, GA, NC, SC, TN, VA**, WV
Wisconsin Physicians Service Insurance Corporation (WPS)*	IA, IN, KS, MI, MO, NE
Notes	
*Wisconsin Physicians Service Insurance Corporation: Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers. **For the state of Virginia: Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction.	

Clinical Evidence

Faulder et al. (2024) conducted a systematic review and meta-analysis to evaluate the agreement of fractional flow reserve estimated by computed tomography (FFR-CT) with invasively measured FFR. The diagnostic accuracy of FFR-

CT, defined as the ability of FFR-CT to classify lesions as hemodynamically significant (invasive FFR ≤ 0.8) or insignificant (invasive FFR >0.8) was also evaluated. Forty-three studies encompassing 5,236 patients and 7,291 vessels were analyzed. Only 36 of the 43 studies presented demographic details of the assessed population. Available data suggest that studies included older adult males with a high prevalence of the most commonly reported cardiovascular risk factors (smoking, diabetes, hypertension, hypercholesterolemia, and high body mass index). The authors reported a moderate positive linear relationship between FFR-CT and invasively measured FFR was observed (Spearman r = 0.67). Agreement between the two modalities increased as invasively measured FFR values approached 1. Overall diagnostic performance of FFR-CT was characterized by an accuracy of 82.2%, sensitivity of 80.9%, and specificity of 83.1%. Marked differences in the diagnostic accuracy of FFR-CT were observed for different FFR-CT values. Accuracy of 90% was demonstrated for FFR-CT values >0.90 and <0.49; however, accuracy decreased to 67% for patients with FFR-CT values of 0.70 to 0.80. An additional secondary endpoint from this study was the agreement between off-site and on-site FFR-CT estimates. Statistical comparison revealed that predictions made by on-site providers were modestly more accurate than off-site providers in the studies included (84.1% vs. 79.3%). The authors concluded that the agreement between FFR-CT and invasive FFR is moderate, although agreement is highest in vessels with FFR-CT >0.9. Additionally, both on-site and off-site computational platforms demonstrate comparable performance. According to the authors, this data suggests FFR-CT may be a useful adjunct to CT coronary angiography as a gatekeeper for invasive coronary angiogram. This study is subject to several limitations. Heterogeneity among included studies may affect generalizability, including differences in patient populations, vessel sites analyzed, stenosis thresholds, and CT scanner technology. Potential publication and sponsorship bias may also exist, as many studies were industry-supported. Additionally, diagnostic accuracy declined for FFR-CT values between 0.70 to 0.80, introducing uncertainty in decision-making for these cases.

In a prospective, multicenter observational study, Madsen et al. (2024) assessed the prognostic value of coronary CT angiography (CTA)-derived fractional flow reserve (FFR) test results on 3-year clinical outcomes in patients with coronary stenosis and among a subgroup of patients with high levels of coronary artery calcium (CAC). Patients with new-onset stable angina pectoris who were consecutively enrolled in the Assessing Diagnostic Value of Noninvasive CT-FFR in Coronary Care, known as ADVANCE registry, between December 2015 and October 2017 at three Danish sites were included in this study. Eligibility required the presence of at least one coronary stenosis of 30% or greater and the absence of persistent atrial fibrillation or previous revascularization procedures. A high CAC was defined as an Agatston score of at least 400. A lesion-specific coronary CTA-derived FFR value of 2 cm with distal-to-stenosis value at or below 0.80 represented an abnormal test result. The primary end point was a composite of all-cause death and nonfatal spontaneous myocardial infarction. This study included 900 patients: 523 with normal results (mean age 64 years; 61% male) and 377 with abnormal results from coronary CTA-derived FFR (mean age 65 years; 70% male). The authors reported that the primary endpoint occurred in only 2.1% of patients with normal CTA-derived FFR values (11/523), compared with 6.6% of those with abnormal findings (25/377), corresponding to a relative risk of 3.1 (95% CI, 1.6–6.3; p < 0.001). Among participants with high CAC scores, the primary endpoint occurred in 2.2% of those with normal CTA-derived FFR values (4/182) compared with 9.0% of those with abnormal values (19/212), corresponding to a relative risk of 4.1 (95% CI, 1.4–11.8; P = 0.001). The authors concluded that in patients with stable angina, a normal coronary CTA–derived FFR result identified individuals with a low 3-year risk of all-cause death or nonfatal spontaneous myocardial infarction, both in the overall cohort and in those with high CAC scores. This study has several limitations. This was a substudy of the nonrandomized ADVANCE cohort, in which clinical management decisions were at the discretion of the local treating physicians and were subject to potential selection bias. Additionally, generalizability may be limited as all data was collected from Danish centers using specific CT systems. The study was also missing information on medication adherence and treatment duration, variables that significantly influence cardiovascular risk.

An ECRI Health Technology Assessment entitled FFRct Software (HeartFlow, Inc.) for Evaluating Coronary Artery Disease (CAD) states that the evidence shows FFRct is useful for guiding treatment in patients with CAD and those suspected of having CAD. The assessment notes FFRct provides actionable information in up to 66% of patients and may allow safe invasive coronary angiography (ICA) deferral in up to 61% of patients with suspected CAD (ECRI, 2023).

Tao et al. (2023) conducted a systematic review and meta-analysis to evaluate the utility of fractional flow reserve computed tomography (FFRct) in patients with stable coronary artery disease (CAD). Ten studies, including four prospective and six retrospective cohort, were included in the review. Studies were excluded if they assessed patients with acute coronary syndrome or if they did not provide the frequency of events in each cohort for the end points of interest. A total of 11,275 patients were eligible for meta-analysis. The mean age was 65 years; 64.8% of patients were male, and the average duration of follow-up was 17 months (ranging between 3 and 56 months). The authors reported no difference in risk of all-cause mortality (ACM) between patients with obstructive and those with nonobstructive CAD on FFRct. However, obstructive lesions were associated with an increased risk of major adverse cardiovascular events (MACE), acute myocardial infarction (AMI), and the need for coronary revascularization. The authors concluded that FFRct is a useful tool for risk stratification in patients with stable CAD, helping to identify those at higher risk for adverse

cardiovascular outcomes. This review is limited by differences in study design, follow-up duration, and patient characteristics introducing heterogeneity into the overall conclusions.

In a 2021 open label, multi-center randomized controlled trial (FORECAST), Curzen et al. evaluated the total cardiac costs and improved clinical outcomes in patients receiving fractional flow reserve derived from computed tomography coronary angiography (FFRct) compared to the standard of care set forth by National Institute for Health and Care Guidance (NICE) Recent-onset chest pain of suspected cardiac origin: assessment and diagnosis Clinical guideline [CG95]. This is the first randomized trial to assess FFRct as a tool for assessment of chest pain. A total of 1,400 patients with stable chest pain were randomized as follows: 700 to initial testing utilizing computed tomography coronary angiography (CTCA) with selective FFRct (Experimental Group) and 700 to standard clinical pathways (e.g., CTCA without FFRct, Stress test, Invasive angiogram) based on NICE guidance (Standard Group). Patients consisted of 48% women, average age of 59 years with diabetes, hypertension, history of smoking, hyperlipidemia, and family history of ischemic heart disease among the clinical characteristics. During the 9 month follow up, invasive coronary angiography use was 22% lower in the experimental group. However, there was no significant difference in the number of hospitalizations, visits to outpatient clinics, and emergency departments. Changes in medication use from enrollment to 9 months were similar in the 2 groups for aspirin, statins, antiplatelets, ACE inhibitors, beta blockers, and angiotensin receptor blockers. Additionally, the rate of coronary revascularization (e.g., percutaneous coronary intervention (PCI) and coronary artery bypass graft), major adverse cardiac events (MACE), angina status, and quality of life (QOL) did not vary greatly between the two groups. The authors concluded that a strategy of CTCA with selective FFRct in patients with stable chest pain did not differ significantly from standard clinical pathways in clinical outcomes or QOL improvements; however, it did decrease the use of invasive coronary angiography. This finding is consistent with previous observational studies. This review is limited by conflicts of interest among authors and potential bias. Further independent research is needed to identify the optimal use of FFRct in routine clinical practice.

Nørgaard et al. (2021) conducted a systematic review and meta-analysis to assess clinical outcomes of CT-derived calculation of FFR (FFRct) in patients with stable coronary artery disease (CAD). Five studies, including three multi-center prospective and two single-center observational, were included in the review. A total of 5,460 patients were eligible for meta-analysis. Lack of a 12-month follow up or patients overlapping between databases were reasons for patient exclusion. The authors reported all-cause mortality (ACM), or myocardial infarction (MI) occurred in 60 patients: 13 with a negative FFRct result and 47 with a positive FFRct result. Major adverse cardiovascular events (MACE), MI, spontaneous MI, or unplanned revascularization [percutaneous coronary intervention (PCI) and coronary artery bypass grafting (CABG)] also occurred more frequently in patients with a positive FFRct result versus patients with a negative FFRct result. Each FFRct unit reduction was associated with a greater risk of ACM or MI. The authors concluded that in patients with stable CAD, a negative FFRct result is associated with a low prevalence of adverse events at 12 months, with a considerably lower risk of death or MI when compared to those with a positive FFRct result. The FFRct numerical value was inversely related to clinical outcomes, suggesting the safety of deferring additional testing in patients with a negative FFRCT result. This review is limited by conflicts of interest among authors and potential bias, and a small number of observational and registry studies analyzed. Furthermore, definitions of clinical outcomes and the length of follow up varied among the studies. Additional independent research with larger scale, randomized controlled trials are needed to validate these findings.

In this retrospective, cross-sectional study, Budde R et al. (2021) evaluated the first cohort of heart transplant patients (HTx) that received FFRct analysis of coronary computed tomography angiography (CCTA) performed for routine annual screening of cardiac allograft vasculopathy (CAV). Seventy-three patients, an average of 11 years post heart transplantation, were included in the study. The cohort consisted of 37% women, average age of 56 years with diabetes, hypertension, and history of smoking among the clinical characteristics. No chest pain was recorded at the time of the study. The authors reported 18 patients had focal stenosis with a positive FFRct result and 55 patients had a positive FFRct result without focal stenosis. At 1-year follow-up, 13 patients had additional testing with invasive coronary angiography (ICA) performed. Additional testing, revascularization, and major adverse cardiac events (MACE) occurred more frequently in those that previously received a positive FFRct result with focal stenosis and in patients at a longer time post-transplant. The authors concluded that FFRct was successfully performed on CCTA scans of HTx patients and 25% had a focal coronary stenosis with a positive FFRct result. However, even in the absence of focal stenosis, FFRct values were often abnormal in HTx patients. This study is limited by the cross-sectional nature of its design and the potential that patients who were longer post-transplant may represent less severe and/or slower progression of CAV, conflicts of interest among authors and potential bias, and limited follow-up time. Further independent studies with longer follow-up times are needed to validate if FFRct provides the same prognostic value in heart transplant patients as invasive FFR.

Douglas et al. (2016, included in the ECRI health technology assessment and Nørgaard systematic review above) conducted a prospective, multi-center, consecutive cohort study (PLATFORM) to determine the one-year clinical and

quality of life (QOL) outcomes using fractional flow reserve (FFRct) instead of invasive coronary angiography (ICA) in patients with stable, new onset chest pain with suspected coronary artery disease (CAD). Five hundred and eighty-four participants were assigned as follows: 204 to receive noninvasive testing, of which 100 received standard noninvasive testing and 104 received FFRct, and 380 received ICA. The cohort consisted of 40% women, average age of 61 years with diabetes, hypertension, history of smoking and dyslipidemia among the clinical characteristics. The one-year follow up was completed in 581 participants via a clinical visit in 97.4% and chart review in the remainder. During the one- year follow up, two major adverse cardiovascular events (MACE) occurred within 90 days in the group receiving FFRct. In the group that received usual care, two MACE events and two vascular complications occurred during the follow up period. QOL improved from baseline to 12 months of follow-up in the planned invasive group and the improvements were similar in the participants in the FFRCT and usual care groups. Vascular complications were infrequent in both groups. Changes in medication use from enrollment to one year were similar in the two arms for aspirin, statins, and P2Y12 inhibitors. The authors concluded that when used as an alternative diagnostic strategy to guide patient care with planned invasive catheterization, CTA with selective FFRct was associated with a significantly lower rate of angiography showing no obstructive CAD, low rates of clinical outcomes and similar QOL improvements. When used in those with planned noninvasive testing, clinical events were rare and there were similar improvements in QOL outcomes. This study is limited by conflicts of interest among authors and potential bias, and a lack of randomization. Additional independent randomized studies are needed to validate these findings.

Clinical Practice Guidelines

American College of Cardiology (ACC)/American Heart Association (AHA)

The ACC and AHA developed a joint clinical practice guideline for the evaluation and diagnosis of chest pain that recommends:

FFR-CT for diagnosis of vessel-specific ischemia and to guide decision-making regarding the use of coronary revascularization for the following patients:

- Intermediate-risk with acute chest pain and previously unknown CAD with coronary stenosis of 40-90% in proximal or middle coronary artery on CCTA.
- Intermediate-risk with stable chest pain and previously unknown CAD with coronary stenosis of 40-90% in proximal or middle coronary artery on CCTA.
- Intermediate-risk with acute chest pain and known CAD with coronary stenosis of 40-90% in proximal or middle coronary artery on CCTA.
- Known nonobstructive CAD with stable chest pain and stenosis from 40-90% on CCTA.

In the clinical pathways, FFR-CT or stress test is recommended. The guidelines state an advantage of FFR-CT is that additional testing for the patient is not required. However, FFR-CT should not be ordered in cases where CCTA imaging is suboptimal or if extensive plaque is present and a high-quality CCTA is unlikely to be achieved. FFR-CT should also not be considered when a delay in the results could impact patient care (Gulati M et al., 2021).

Class IIA – Moderate strength recommendation. Benefits are felt to outweigh risk.

Level of evidence B-NR – Moderate quality evidence from one or more well-designed, non-randomized study and/or meta-analysis of such studies.

For patients with unknown CAD who are symptomatic with chest pain likely to be angina, refer to the following AHA 2021 guideline: Pretest Probabilities of Obstructive CAD in Symptomatic Patients, figure 11, page e407.
(Accessed Jan. 14, 2026)

National Institute for Health and Care Excellence (NICE)

In a 2017 guideline on HeartFlow FFRct for estimating fractional flow reserve from coronary CT angiography, NICE recommends the following:

- HeartFlow FFRct is safe and has a high level of diagnostic accuracy.
- HeartFlow FFRct should be given consideration for patients with stable, recent-onset chest pain who are offered CCTA in accordance with the NICE guideline on chest pain. The use of HeartFlow FFRct may avoid the need for invasive coronary angiography and revascularization. For correct use, HeartFlow FFRct requires access to 64-slice (or above) CCTA facilities.

This guideline was updated in 2021 with no change to the current level of support.

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

For information on coronary vascular physiologic simulation software devices, refer to the following website (use product code PJA): https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed Jan. 14, 2026)

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Policy History/Revision Information

Date	Summary of Changes
03/01/2026	**Centers for Medicare and Medicaid Services (CMS) Related Documents** • Updated list of documents available in the *Medicare Coverage Database* to reflect the most current information **Supporting Information** • Updated *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information • Archived previous policy version MMP372.11

Instructions for Use

The Medicare Advantage Policy documents are generally used to support UnitedHealthcare coverage decisions. It is expected providers retain or have access to appropriate documentation when requested to support coverage. This document may be used as a guide to help determine applicable:

- Medical necessity coverage guidelines; including documentation requirements, and/or
- Medicare coding or billing requirements.

Medicare Advantage Policies are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates. This Policy is provided for informational purposes and does not constitute medical advice. It is intended to serve only as a general reference 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. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

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 member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes this policy. For more information on a specific member's benefit coverage, call the customer service number on the back of the member ID card or refer to the Administrative Guide.

Medicare Advantage Policies are developed as needed, are regularly reviewed, and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policies at any time by publishing a new version on this website. Medicare source materials used to develop these policies may include, but are not limited to, CMS statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. The information presented in this Policy is believed to be accurate and current as of the date of publication. Where there is a conflict between this document and Medicare source materials, the Medicare source materials apply. Medicare Advantage Policies are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing certain items or services referenced in this Medical Policy 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, in these circumstances, UnitedHealthcare applies internal coverage criteria as referenced in this Medical Policy. The internal coverage criteria in this Medical Policy 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.

You are responsible for submission of accurate claims. Medicare Advantage Policies are intended to ensure that coverage decisions are made accurately. UnitedHealthcare Medicare Advantage Policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate’s requirements need to be followed.