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Information for Medicare Providers
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CENTERS for MEDICARE & MEDICAID SERVICES

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Ventricular Assist Devices (VADs) for Destination Therapy

This provider education article discusses the expansion in Medicare coverage for VADs for destination therapy for certain services performed on and after

October 1, 2003. The article also discusses VAD claims processing and provides VAD information resources.

Background

For services performed on and after October 1, 2003, coverage has been expanded for VADs when used as destination therapy under the following conditions:

- The VAD has received approval from the Food and Drug Administration (FDA) for that purpose;
- The VAD is used according to FDA-approved labeling instructions;
- The patient meets specified criteria; and
- The procedure is performed in specified facilities.

NOTE: All other indications for the use of VADs remain the same.

VAD Claims Processing Information

Services Provided to Medicare+Choice (M+C) Patients

- Until Medicare capitation rates to M+C organizations are adjusted to account for expanded VAD coverage, providers will be paid on a fee-for-service basis for VAD services that fall under the new indication for destination therapy.
- Medicare will not have systems changes in place to pay claims for risk M+C patients until January 5, 2004.
- Medicare contractors will hold claims for risk M+C patients that fall under the new indications for VADs submitted with modifier KZ or condition code 78 from October 1, 2003 until December 31, 2003.
- Medicare contractors shall release these claims for payment with any applicable interest on or after January 5, 2004.

• M+C patients are liable for applicable coinsurance, but are not liable for Part A or Part B deductibles.

Services Provided to Fee-for-Service Patients

• ICD-9-CM procedure code 37.62 was incorrectly included in Diagnosis Related Group (DRG) 525 when it was created in 2003. Code 37.62 is clinically and financially dissimilar to the other procedures in DRG 525. Therefore, the following changes regarding the mapping of codes assigned to DRG 525 have been completed:

- ICD-9-CM procedure code 37.62 (implant of other heart assist system has been removed and assigned to DRGs 104 (cardiac valve) and DRG 105 (other major cardiothoracic procedures with and without cardiac catheterization).
- Procedure codes that still map to DRG 525 are 37.63 (replacement and repair of heart assist system), 37.65 (implant of an external, pulsatile heart assist system), and 37.66 (implant of an implantable, pulsatile heart assist system).
- Payment for cases remaining in DRG 525 have been increased from approximately $75,000 to $90,000.
- Payment for cases with procedure code 37.62 have been decreased from approximately $75,000 to $35,000.
- CMS will have a new Grouper software program in place to correctly group these services on November 1, 2003; therefore, claims submitted between October 1, 2003 and October 31, 2003 will be grouped and paid under the software programs in place on October 1, 2003.
- Claims with DRGs 104, 105, and 525 will be adjusted on or after November 1, 2003 in order to correctly pay these services.

VAD Information Resources

http://www.cms.hhs.gov/transmittals/comm_date_dsc.asp

Change Request Number 2958 dated October 17, 2003

http://www.cms.hhs.gov/manuals/cmsindex.asp

Pub. 100-03 - Medicare National Coverage Determination Manual, Section 20.9