Total Artificial Heart and Ventricular Assist Devices (for Louisiana Only)

Policy Number: CS122LA1.B~~A~~
Effective Date: ~~May 1, 2021~~**TBD**

➲ Instructions for Use

~~Content mandated by Louisiana Department of Health~~

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Application

This Medical Policy only applies to the state of Louisiana. ~~The coverage rationale contained in this policy represents Louisiana Medicaid coverage policy and is set forth below in accordance with State requirements.~~

Coverage Rationale

Total Artificial Heart

State Specific Criteria

Services not covered by Louisiana Medicaid include but are not limited to:

- Man-made hearts or xenografts

Ventricular Assist Devices (VADs), also known as Mechanical Circulatory Support Devices (MCSD)

Non-State Specific Criteria

Optum has established an infrastructure to support the review, development, and implementation of comprehensive clinical guidelines. The evidence-based clinical guidelines are available in Mechanical Circulatory Support Devices (MCSD).

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. Benefit coverage for health services is determined by federal, state, or contractual requirements 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
33927	Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy
33928	Removal and replacement of total replacement heart system (artificial heart)
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**
33995	**Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; right heart, venous access only**
33997	**Removal of percutaneous right heart ventricular assist device, venous cannula, at separate and distinct session from insertion**

References

Optum Mechanical Circulatory Support Devices. Clinical Guideline. Effective May 9, 2022. https://www.uhcprovider.com/content/dam/provider/docs/public/policies/clinical-guidelines/mechanical-circulatory-support-device.pdf. Accessed August 29. 2022.

UnitedHealthcare 2020 Care Provider Manual, Physician, Health Care Professional, Facility and Ancillary Care, Louisiana, Chapter 3, Care Provider Office Procedures and Member Benefits, Non-Covered Services. Care Provider Manual for Healthy Louisiana - UnitedHealthcare Community Plan of Louisiana (uhcprovider.com). Accessed April 13, 2021.

Policy History/Revision Information

Date	Summary of Changes
TBD	**Title Change** • Previously titled *Total Artificial Heart (for Louisiana Only)* **Application** • Removed language indicating the coverage rationale contained in this policy represents Louisiana Medicaid coverage policy and is set forth below in accordance with State requirements **Coverage Rationale** ***Ventricular Assist Devices (VADs), also known as Mechanical Circulatory Support Devices (MCSD)*** **Non-State Specific Criteria** • Added language to indicate Optum has established an infrastructure to support the review, development, and implementation of comprehensive clinical guidelines; the evidence-based clinical guidelines are available in *Mechanical Circulatory Support Devices (MCSD)* **Applicable Codes** • Added CPT codes 33975, 33976, 33979, 33981, 33982, 33983, 33995, and 33997 **Supporting Information** • Updated *References* section to reflect the most current information • Archived previous policy version CS122LA.A

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies 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.