Percutaneous Ventricular Assist Device

Guideline Number: MPG 240.08
Approval Date: March 10, 2021

➲ Terms and Conditions

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Policy Summary

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Overview

Percutaneous insertion of an endovascular cardiac assist device will be covered itself under limited conditions. Until the literature clearly demonstrates the efficacy of the treatment approach, coverage may be made only in the following three life-threatening situations and only when external counterpulsation (intraaortic balloon pump, IABP) is not expected to be sufficient:

- Cardiogenic shock; or
- Severe decompensated heart failure with threatening multi-organ failure; or
- Complications/disturbances of the circulatory system intra-operatively or postoperatively

This service will only be covered when the FDA approval guidelines are adhered to strictly.

Guidelines

Part A Providers – Use ICD Procedure code 5A0221D or 5A02216
Part B Providers – Use CPT 33990, 33991, 33995 or 33997

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 guideline 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 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
33990	Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; left heart arterial access only
33991	Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; left heart, both arterial and venous access, with transseptal puncture

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CPT Code	Description
33992	Removal of percutaneous left heart ventricular assist device, arterial or arterial and venous cannula(s), at separate and distinct session from insertion
33993	Repositioning of percutaneous right or left heart ventricular assist device with imaging guidance at separate and distinct session from insertion
33995	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; right heart, venous access only (Effective 01/01/2021)
33997	Removal of percutaneous right heart ventricular assist device, venous cannula, at separate and distinct session from insertion (Effective 01/01/2021)

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Diagnosis Code	Description
I50.21	Acute systolic (congestive) heart failure
I50.23	Acute on chronic systolic (congestive) heart failure
I50.41	Acute combined systolic (congestive) and diastolic (congestive) heart failure
I50.43	Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure
I97.0	Postcardiotomy syndrome
I97.110	Postprocedural cardiac insufficiency following cardiac surgery
I97.111	Postprocedural cardiac insufficiency following other surgery
I97.130	Postprocedural heart failure following cardiac surgery
I97.131	Postprocedural heart failure following other surgery
I97.710	Intraoperative cardiac arrest during cardiac surgery
I97.711	Intraoperative cardiac arrest during other surgery
I97.790	Other intraoperative cardiac functional disturbances during cardiac surgery
I97.791	Other intraoperative cardiac functional disturbances during other surgery
I97.88	Other intraoperative complications of the circulatory system, not elsewhere classified
I97.89	Other postprocedural complications and disorders of the circulatory system, not elsewhere classified
R57.0	Cardiogenic shock

ICD Procedure Code	Description
5A0221D	Assistance with Cardiac Output using Impeller pump, Continuous
5A02216	Assistance with Cardiac Output using Other Pump, Continuous

References

CMS Local Coverage Determinations (LCDs) and Articles

LCD	Article	Contractor	Medicare Part A	Medicare Part B
N/A	A52966 Billing and Coding: Percutaneous Endovascular Cardiac Assist Procedures and Devices	Noridian	AS, CA, GU, HI, MP, NV	AS, CA, GU, HI, MP, NV
N/A	A52967 Billing and Coding: Percutaneous Endovascular Cardiac Assist Procedures and Devices	Noridian	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY

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LCD	Article	Contractor	Medicare Part A	Medicare Part B
N/A	A53986 Billing and Coding: Percutaneous Ventricular Assist Device	Palmetto		AL, GA, NC, SC, TN, VA, WV
N/A	A53988 Billing and Coding: Percutaneous Ventricular Assist Device	Palmetto	AL, GA, NC, SC, TN, VA, WV	

Other(s)

CGS Medicare News and Publications: Coding for Impella® Heart Device, Dated July 18, 2014

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
04/01/2021	**Template Update** • Reformatted policy; transferred content to new template
03/10/2021	**Policy Summary** *Overview* • Revised list of life-threating situations for/in which percutaneous insertion of an endovascular cardiac assist device will be covered [when external counterpulsation (intraaortic balloon pump, IABP) is not expected to be sufficient]; added "complications/disturbances of the circulatory system intra-operatively or postoperatively" *Guidelines* • Updated coding instruction to indicate: ○ For Part A Providers: Use ICD-10-PCS code 5A0221D or 5A02216 ~~○~~ For Part B Providers: Use CPT code 33990, 33991, 33995, or 33997 **Applicable Codes** *CPT Codes* • Added 33995 and 33997 • Revised description 33990, 33991, 33992, and 33993 *Diagnosis Codes* • Added ICD-10-PCS code 5A02216 **Supporting Information** • Updated *References* section to reflect the most current information • Archived previous policy version MPG240.07

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

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

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage

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requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. 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 the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines 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 Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines 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.

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*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.

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