

Ventricular Assist Devices (for Nebraska Only)

Policy Number: CS122NE.Q
Effective Date: November 1, 2023

[Instructions for Use](#)

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Related Policy
<ul style="list-style-type: none"> Clinical Trials
Related Clinical Guideline
<ul style="list-style-type: none"> Mechanical Circulatory Support Devices

Application

This Medical Policy only applies to the State of Nebraska.

Coverage Rationale

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

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

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
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

CPT Code	Description
33997	Removal of percutaneous right heart ventricular assist device, venous cannula, at separate and distinct session from insertion

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Policy History/Revision Information

Date	Summary of Changes
11/01/2023	<ul style="list-style-type: none"> Routine review; no change to coverage guidelines Archived previous policy version CS122NE.P

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.