St. Jude Medical offers a reimbursement customer support line to provide coding and reimbursement information. The reimbursement support line is available from 8 a.m. to 5 p.m. Central Time, Monday through Friday at 855-569-6430 or email VADReimbursement@sjm.com. Customer reimbursement assistance is provided subject to the disclaimers set forth in this guide.

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This guide provides physician and hospital coding and reimbursement information for the CentriMag™ acute circulatory support system, which is used to hemodynamically stabilize patients in need of cardiopulmonary support.

Indications for the CentriMag™ acute circulatory support system are as follows:

- Cleared for clinical use up to six hours for extracorporeal circulatory support
- Approved for use as a right ventricular assist device (RVAD) for periods of support up to 30 days for patients in cardiogenic shock due to acute right ventricular failure.¹

¹ Humanitarian Use Device. The CentriMag™ RVAS is authorized by Federal law to provide temporary circulatory support for up to 30 days for patients in cardiogenic shock due to acute right ventricular failure. The effectiveness of this device for this use has not been demonstrated. Distribution of this device is restricted to use by or on the order of a physician.
Medicare Reimbursement

Medicare reimburses acute care facilities under a Medical-severity adjusted diagnosis-related group (MS-DRG) system. This means each hospitalization is paid a single bundled amount.

Medicare has determined that the CentriMag™ MCS system procedure would fall under other non-implantable VADs which are assigned to MS-DRG 215 (Other Heart Assist System Implant). The CentriMag™ blood pump is an extracorporeal circulatory support device that provides hemodynamic stabilization in patients in need of cardiopulmonary support.

Medicare Payment for Hospital Transfers

According to the CMS manuals, the transferring hospital receives a per diem, prorated from the expected MS-DRG. The per diem is derived from the MS-DRG’s average length of stay when the transferring facility submits a claim to Medicare with the discharge status code of 02, “discharged/transferred to another short term general hospital for inpatient care.” The geometric mean length of stay in FY2016 for MS-DRG 215 is 12.0 days.1

The second hospital can expect full MS-DRG payment, even if the MS-DRG assignment turns out to be different from the transferring hospital. Hospital-specific factors-such as an ownership relationship between the transferring and receiving hospital-could affect payment.

Find CMS Hospital Manual language on transfers in Chapter 3 Section 40.2.4 of the CMS Claims Processing Manual.

Physician Codes for CentriMag™ MCS System - Extracorporeal Approach Effective Dates: January 1, 2017 – December 31, 20172

Under the Medicare Resource Based Relative Value System (RBRVS), physicians are allowed to bill for services using Current Procedural Terminology (CPT™) codes defined by the American Medical Association (AMA). Each CPT code is assigned a set of relative value units (RVUs) that reflect the average time and practice costs (with geographic adjustment) involved in performing a given procedure. Medicare payment amounts are based on a procedure’s RVUs multiplied by a dollar conversion factor and then adjusted by regional factors.

The CPT codes below describe possible surgeon services in the hospital inpatient setting where the CentriMag™ MCS system procedure occurs. These services are restricted to the inpatient hospital site of service.

### CentriMag™ MCS System Implant

<table>
<thead>
<tr>
<th>CPT™ Code</th>
<th>Description</th>
<th>Work RVUs</th>
<th>National Avg. Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>33975</td>
<td>Insertion of ventricular assist device; extracorporeal, single ventricle</td>
<td>25.00</td>
<td>$1,369</td>
</tr>
<tr>
<td>33976</td>
<td>Insertion of ventricular assist device; extracorporeal, biventricular</td>
<td>30.75</td>
<td>$1,668</td>
</tr>
</tbody>
</table>

### CentriMag™ MCS System Removal

<table>
<thead>
<tr>
<th>CPT™ Code</th>
<th>Description</th>
<th>Work RVUs</th>
<th>National Avg. Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>33977</td>
<td>Removal of ventricular assist device; extracorporeal, single ventricle</td>
<td>20.86</td>
<td>$1,178</td>
</tr>
<tr>
<td>33978</td>
<td>Removal of ventricular assist device; extracorporeal, biventricular</td>
<td>25.00</td>
<td>$1,395</td>
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</tbody>
</table>

### CentriMag™ MCS System Replacement

<table>
<thead>
<tr>
<th>CPT™ Code</th>
<th>Description</th>
<th>Work RVUs</th>
<th>National Avg. Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>33981</td>
<td>Replacement of extracorporeal ventricular assist device, single or biventricular, pump(s), single or each pump</td>
<td>16.11</td>
<td>$867</td>
</tr>
</tbody>
</table>
Global Surgical Periods

Medicare has developed global surgical periods associated with certain CPT™ codes. During the global period, routine care related to surgery, such as a follow-up office visit, is considered part of the surgical procedure and should not be billed separately to Medicare. Depending on the specific code, global periods for procedures can last up to 90 days.

CPT codes associated with both the insertion of a VAD and explants of a VAD do not have global billing periods, meaning that any follow-up or post-op work done by the physician can be billed and paid separately using the appropriate procedure code, beginning the day after implantation, or the day after explantation for recovery.

Evaluation and Management (E/M) codes should be used for pre-op and/or post-op care and are separately payable under most circumstances. Please contact your local carrier for exact billing and coding requirements regarding global surgical periods.

In the case of a return to the operating room for a procedure during the implant admission, that surgical procedure would not eliminate the opportunity to bill for the VAD implantation follow-up care during the post-operative period.

Even if the initial implant procedure was performed in conjunction with a surgical procedure that carries a 90-day global billing period, if the follow-up care is related to the VAD implantation and not the other procedure performed, the resulting post-operative care is billable using a -24 modifier with appropriate documentation. Please contact your local carrier for exact billing and coding requirements regarding global surgical periods.

For additional information on global periods, please see Medicare Claims Processing Manual Chapter 12, Section 40.

Outpatient Coding and Reimbursement

CMS restricts VAD procedures and extracorporeal VAD procedures to the inpatient site of service so the outpatient codes and payment for these procedures are not applicable. Since the CentriMag™ blood pump is a short-term medical solution until longer-term options become more clinically appropriate, there are no long-term accessories and drive-line stabilization supplies required after the procedure.

If clinically appropriate patients pursue a VAD implant via the HeartMate II™ LVAS system, please refer to the Billing and Reimbursement Guide for the HeartMate II™ LVAS.