90.2 - Heart Transplants

(Rev.10, 10-17-03)

A3-3613, HO-416

Cardiac transplantation is covered under Medicare when performed in a facility which is approved by Medicare as meeting institutional coverage criteria. On April 6, 1987, CMS Ruling 87-1, "Criteria for Medicare Coverage of Heart Transplants" was published in the "Federal Register." For Medicare coverage purposes, heart transplants are medically reasonable and necessary when performed in facilities that meet these criteria. If a hospital wishes to bill Medicare for heart transplants, it must submit an application and documentation, showing its ongoing compliance with each criterion.

The facility mails the application to the address below in a manner which provides it with documentation that it was received, e.g., return receipt requested.

Director
Division of Integrated Delivery Systems
Centers for Medicare & Medicaid Services
Mailstop C4-25-02
7500 Security Blvd.
Baltimore, MD 21244-1850

If an FI has any questions concerning the effective or approval dates of its hospitals, it should contact its RO.

For a complete list of transplant centers, please visit http://www.cms.hhs.gov/providers/transplant/hartlist.asp.

A - Effective Dates

The effective date of coverage for heart transplants performed at facilities applying after July 6, 1987, is the date the facility receives approval as a heart transplant facility. Coverage is effective for discharges October 17, 1986 for facilities that would have qualified and that applied by July 6, 1987.

CMS informs each hospital of its effective date in an approval letter.

B - Drugs

Medicare Part B covers immunosuppressive drugs following a covered transplant in an approved facility.

C - Noncovered Transplants

Medicare will **not** cover transplants or re-transplants in facilities that have not been approved as meeting the facility criteria. If a beneficiary is admitted for and receives a heart transplant from a hospital that is not approved, physicians' services, and inpatient services associated with the transplantation procedure are not covered.

If a beneficiary received a heart transplant from a hospital while it was not an approved facility and later requires services as a result of the noncovered transplant, the services are covered when they are reasonable and necessary in all other respects.

D. Charges for Heart Acquisition Services

The excising hospital bills the transplant (implant) hospital for applicable services. It should not submit a bill to its FI. The transplant hospital must keep an itemized statement that identifies the services rendered, the charges, the person receiving the service (donor/recipient), and whether this person is a potential transplant donor or recipient. These charges are reflected in the transplant hospital's heart acquisition cost center and are used in determining its standard charge for acquiring a donor's heart. The standard charge is not a charge representing the acquisition cost of a specific heart; rather, it reflects the average cost associated with each type of heart acquisition. Also, it is an all inclusive charge for all services required in acquisition of a heart, i.e., tissue typing, post-operative evaluation, etc.

E. - Bill Review Procedures

The FI takes the following actions to process heart transplant bills. It may accomplish them manually or modify its MCE and Grouper interface programs to handle the processing.

1 - Change MCE Interface

The MCE creates a *Limited Coverage edit* for procedure code *37.51* (heart transplant). Where this procedure code is identified by MCE, the FI checks the provider number to determine if the provider is an approved transplant center, and checks the effective approval date. If payment is appropriate (i.e., the center is approved and the service is on or after the approval date) it overrides the *limited coverage* edit.

2 - Handling Heart Transplant Billings From Nonapproved Hospitals

Where a heart transplant and covered services are provided by a nonapproved hospital, the bill data processed through Grouper and Pricer must exclude transplant procedure codes and related charges.

90.2.1 - Artificial Hearts and Related Devices

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Medicare does not cover the use of artificial hearts, either as a permanent replacement for a human heart or as a temporary life-support system until a human heart becomes available for transplant (often referred to a "bridge to transplant").

Medicare does cover a Ventricular Assist Device (VAD). *A ventricular assist device (VAD) is used to assist a damaged or weakened heart in pumping blood. VADs are used as a bridge to a heart transplant, for support of blood circulation postcardiotomy or destination therapy. Please refer to the NCD Manual, section 20.9 for coverage criteria.*

The MCE creates a Limited Coverage edit for procedure code 37.66. This procedure code has limited coverage due to the stringent conditions that must be met by hospitals. Where this procedure code is identified by MCE, the FI shall determine if coverage criteria is met and override the MCE if appropriate.