

Importance of Hospital Charging Practices- WATCHMAN™ LAAC Device

This document provides information and education to hospital providers on the importance of appropriate charging as related to the WATCHMAN™ Left Atrial Appendage Closure (LAAC) Device. Since the WATCHMAN LAAC procedure will be relatively new technology for Medicare and private payers, it will be important for hospitals to charge appropriately for the WATCHMAN implant device as future Medicare payment rates are dependent on the current charging practices of hospitals. This procedure is currently restricted by Medicare to the inpatient hospital site of service.

1. What should hospitals know about establishing appropriate charges for the WATCHMAN LAAC Device?

On October 1, 2015, the ICD 10 reporting mechanism became effective for reporting hospital inpatient procedures. The ICD 10 procedure code for reporting WATCHMAN implants is 02L73DK (occlusion of left atrial appendage with intraluminal device, percutaneous approach). This procedure code maps to MS-DRGs 273 and 274 for hospital inpatient payment.

Hospitals should continue to capture all charges and resources reported with the WATCHMAN implant. This is important because CMS uses hospital charges and cost report data to determine payment rates under the Inpatient prospective payment system. For example, claims data from October 1, 2014 through September 30, 2015 were used to determine payment rates for discharges that took place from October 1, 2015 through September 30, 2016. Therefore, it is important to appropriately capture all charges associated with WATCHMAN implants for CMS to set payment rates that most accurately reflect procedure costs, including the cost of the devices utilized. Since the WATCHMAN LAAC procedure is relatively new, prior claims data for insertion of left atrial appendage device (ICD-9 procedure code 37.90) procedures typically reflect costs in a clinical trial setting. The cost parameters and resources reflected may vary based on clinical practice so it is important that your documentation and charges accurately reflect what is occurring in your hospital. (The Medicare claims reflect data that predate the year for which rates are being set usually by two years.)

2. How is this applicable to the WATCHMAN LAAC Device?

The WATCHMAN LAAC procedures present a critical opportunity for CMS to collect and track resources associated with the system implant. These procedures are reported with ICD10 procedure code 02L73DK for specifically tracking transcatheter closure of the LAA with an implant. CMS reviews the MS-DRG definitions annually to ensure that each group continues to include cases with clinically similar conditions that require a comparable level of inpatient resources.

Generally, when the data demonstrates that subsets of clinically similar cases within a MS-DRG consume significantly different amounts of resources, CMS may reassign them to a different MS-DRG with comparable resource use or

create a new MS-DRG category. This means that if the resources (i.e., costs, length of stay, etc.) for the WATCHMAN LAAC procedure fall outside their current DRG classification and the volume is significant enough where it impacts those DRGs, then CMS may reconsider placement into another comparable DRG or create a new category altogether. CMS created new MS-DRGs 273 and 274 effective on October 1, 2015 for WATCHMAN implants because of the reasons described above. Boston Scientific will continue to monitor and analyze this data over the next two years to ensure that these MS-DRGs payment categories are appropriate in best representing the hospital resources associated with these implants. This is the reason why it is important to account for all the resources utilized in performing the WATCHMAN LAAC implants.

3. Who should I contact if I have additional questions about the WATCHMAN™ LAA Closure System as it relates to coding, coverage, and reimbursement?

Contact our Customer Support line at 1-800-CARDIAC and ask for WATCHMAN [Reimbursement](#).

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Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.