

# Medtronic

Engineering the extraordinary

Reimbursement guide

# LINQ family of subcutaneous cardiac rhythm monitors

Hospital & physician coding, coverage, and payment

March 2024



Reveal  
LINQ™ IICM

LINQ II™  
ICM

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# Hospital & physician reimbursement guide

## LINQ family of subcutaneous cardiac rhythm monitors



This guide has been developed to help you understand Medicare coverage, coding, and payment for LINQ family of insertable cardiac monitors (ICMs), which includes Reveal LINQ™ ICM and LINQ II™ ICM.

### Please contact Reimbursement Customer Support for further information:

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# Overview

## LINQ family of subcutaneous cardiac rhythm monitors

The LINQ family of insertable cardiac monitors (ICMs) are subcutaneous cardiac rhythm monitors (SCRM), also known as implantable loop records (ILRs). The reimbursement information contained in this document refers to the policies for all SCRM/ILRs.

### FDA-cleared indications

**The Reveal LINQ ICM is an insertable automatically-activated and patient-activated monitoring system that records subcutaneous ECG and is indicated in the following cases:**

- ✔ Patients with clinical syndromes or situations at increased risk of cardiac arrhythmias.
- ✔ Patients who experience transient symptoms such as dizziness, palpitations, syncope, and chest pain that may suggest a cardiac arrhythmia.

This device has not been tested specifically for pediatric use.

**The LINQ II ICM is an insertable automatically-activated and patient-activated monitoring system that records subcutaneous ECG and is indicated in adult patients, and in pediatric patients who are at least 2 years old, in the following cases:**

- ✔ Patients with clinical syndromes or situations at increased risk of cardiac arrhythmias.
- ✔ Patients who experience transient symptoms such as dizziness, palpitations, syncope, and chest pain that may suggest a cardiac arrhythmia.

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# 2024 updates

## Removal of G2066 for remote monitoring

The Centers for Medicare & Medicaid Services (CMS) have announced changes to remote monitoring codes beginning January 1, 2024. The changes include deletion of HCPCS G2066, currently used to report technical services associated with remote monitoring of both subcutaneous cardiac rhythm monitors (i.e., **Reveal LINQ™** & **LINQ II™** insertable cardiac monitors) and implantable cardiovascular physiologic monitors (as used with **OptiVol™** & **TriageHF™**). In place of G2066, CMS has added technical service (-TC) and professional service (-26) modifiers to both CPT® codes 93297 and 93298 for this service.<sup>3</sup>

**Code G2066 for remote monitoring will be deleted January 1, 2024**

**Modifiers (-TC) and (-26) will be applicable to 93297 and 93298**

Services rendered	Prior to January 1, 2024	After January 1, 2024
<b>SCRM remote interrogation - global</b>	G2066 + 93298	93298
National unadjusted rate*	Contractor priced + \$26	\$100
<b>SCRM remote interrogation - professional</b>	93298	93298 - <b>26</b>
National unadjusted rate*	\$26	\$24
<b>SCRM remote interrogation - technical</b>	G2066	93298 - <b>TC</b>
National unadjusted rate*	Contractor priced	\$76

\*Unadjusted rates do not include sequestration or any other local payment adjustments.

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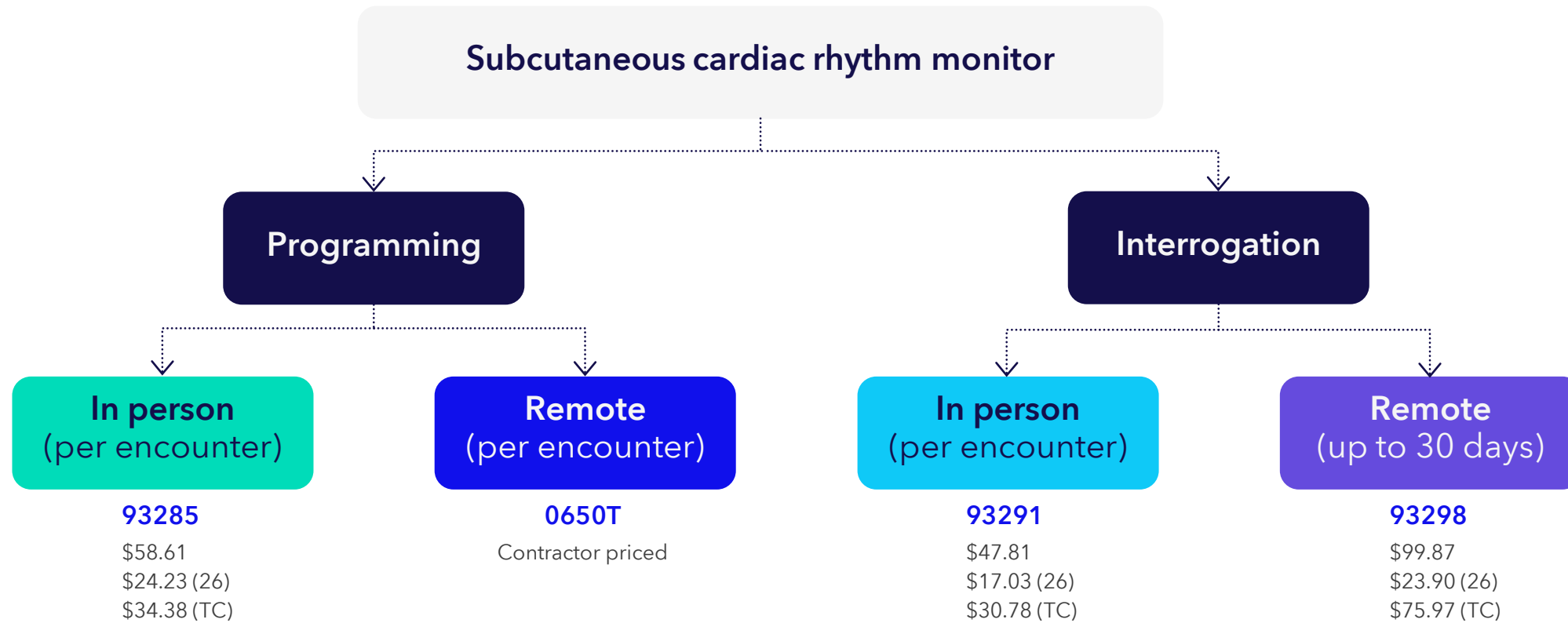
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# 2024 updates

## Removal of G2066 for remote monitoring



Information regarding the removal of HCPCS code G2066, and updated coding for remote monitoring is available in a stand-alone document on our reimbursement website [www.Medtronic.com/CRHFreimbursement](http://www.Medtronic.com/CRHFreimbursement) or by clicking [here](#).

\*Unadjusted rates do not include sequestration or any other local payment adjustments.

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# 2024 updates

## Summary of rate changes



Medicare physician payment rates across all services are decreasing due largely to Centers for Medicare & Medicaid Services (CMS) calculations mandated by legislation.

### SCRM insertions in the **hospital and ASC settings**:

Physician payment rates will decrease by 4.1%-4.5% compared to 2023, driven by overall CMS physician fee schedule decreases. Facility payments (which include device cost reimbursement) are paid separately. See below for more information on facility payment rates.

Procedure	National unadjusted* facility payments in outpatient hospital (APC) <sup>1</sup>				National unadjusted* facility payments in ASC (CPT®) <sup>2</sup>			
	2023	2024	\$ change	% change	2023	2024	\$ change	% change
SCRM insertion (APC 5222, CPT® 33285)	\$8,163	\$8,103	(\$60)	-0.7%	\$7,048	\$6,904	(\$144)	-2.0%
SCRM removal (APC 5071, CPT® 33286)	\$649	\$671	\$22	+3.3%	\$338	\$365	\$27	+8.0%

\*Unadjusted rates do not include sequestration or any other local payment adjustments.

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## Summary of rate changes

### SCRM insertions performed in the office setting:

Physician payment rates (which includes device cost reimbursement) will decrease by 7.9% compared to 2023, in line with resulting from changes in clinical labor inputs used to calculate the relative value units for physician services. Procedures with high supply and equipment costs (such as SCRM in-office insertions) are more impacted by the CMS payment changes.

CPT® code	Description	National unadjusted* physician payments in office (non-facility) <sup>3</sup>				National unadjusted* physician payments in hospital (facility) or ASC <sup>3</sup>			
		2023	2024	\$ change	% change	2023	2024	\$ change	% change
33285	Insertion subcutaneous cardiac rhythm monitor	\$4,421	\$4,071	(\$350)	-7.9%	\$88	\$84	(\$4)	-4.5%
33286	Removal subcutaneous cardiac rhythm monitor	\$134	\$127	(\$7)	-5.2%	\$86	\$82	(\$4)	-4.7%

\*Unadjusted rates do not include sequestration or any other local payment adjustments.

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# Pediatric indication for LINQ II™ ICM

Now available



Beginning in September 2022, LINQ II™ ICM was the first subcutaneous cardiac rhythm monitor available for use in patients **as young as 2 years old**.

## Impact on coding:

The CPT® codes that apply to LINQ II™ device use are as follows:

Service	CPT® code	Description
SCRM procedures	33285	Insertion, subcutaneous cardiac rhythm monitor, including programming
	33286	Removal, subcutaneous cardiac rhythm monitor
SCRM in-person interrogation	93291	Interrogation device evaluation (in person) with analysis, review, and report by a physician or other qualified healthcare professional, including connection, recording, and disconnection per patient encounter; subcutaneous cardiac rhythm monitor system, including heart rhythm-derived data analysis
SCRM in-person programming	93285	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review, and report by a physician or other qualified healthcare professional; subcutaneous cardiac rhythm monitor system
SCRM remote interrogation	93298	Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s), and report(s) by a physician or other qualified healthcare professional
SCRM remote programming	0650T	Programming device evaluation (remote) of subcutaneous cardiac rhythm monitor system, with iterative adjustment of the implantable device to test the function of the device and select optimal permanently programmed values with analysis, review and report by a physician or other qualified healthcare professional

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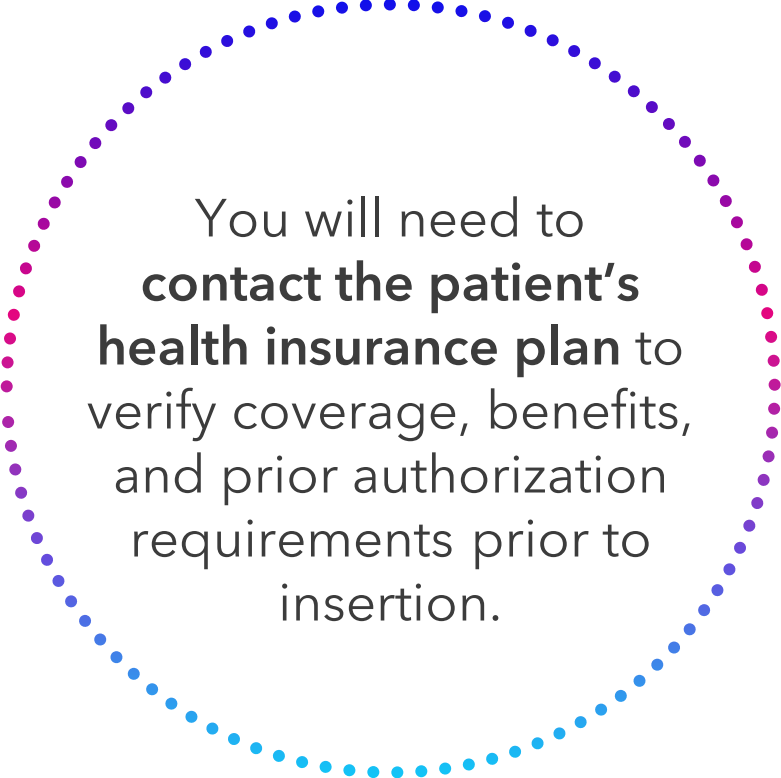
# Pediatric indication for LINQ II™ ICM

Now available

## Impact on coverage:

FDA approval or clearance does not equate to coverage. Coverage is determined by the patient's individual health insurance plan. Many payers have medical policies for subcutaneous cardiac rhythm monitors. There are a few things to consider when determining coverage for a subcutaneous cardiac rhythm monitor:

- ▶ **Diagnosis:** Some payers will have specific diagnoses for which a subcutaneous cardiac rhythm monitor is deemed a covered benefit.
- ▶ **Coverage criteria:** Some private payers will have specific criteria that must be met to confirm coverage for services prior to those services being rendered.
- ▶ **Prior authorization or pre-determination requirements:** Some payers may require prior authorization or pre-determination be completed prior to services being rendered.



You will need to **contact the patient's health insurance plan** to verify coverage, benefits, and prior authorization requirements prior to insertion.

Coverage criteria and prior authorization or pre-determination requirements will vary by payer and patient-specific insurance plan.

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# Pediatric indication for LINQ II™ ICM

Now available

## Impact on **payment**:

Reimbursement rates for private payers are variable, and specific to proprietary negotiations between individual hospitals/providers and health insurance companies. To determine the specific reimbursement rate for services, contact your internal revenue cycle and/or contracting teams.

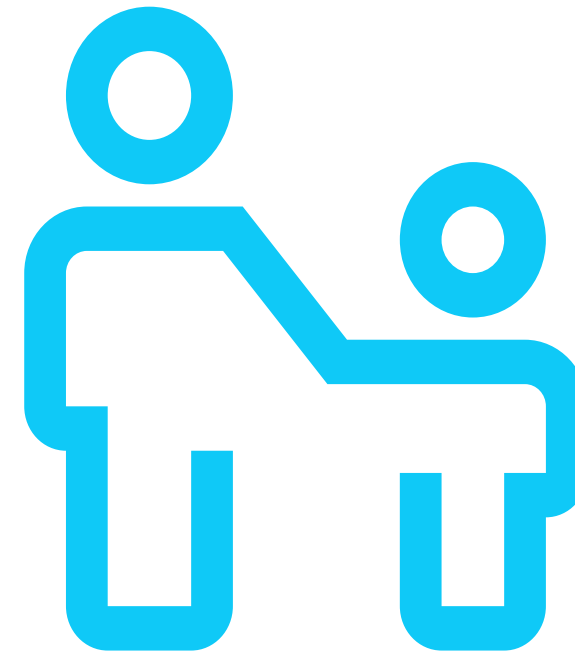
### Additional inquiries can be sent to our Reimbursement Customer Support team:



Email: [rs.healthcareeconomics@medtronic.com](mailto:rs.healthcareeconomics@medtronic.com)



Phone: 866.877.4102



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# Prior authorization

## Summary

Seeking prior authorization (sometimes referred to as pre-authorization, pre-certification, or prior approval) from the patient's payer for the insertion of a subcutaneous cardiac rhythm monitor (SCRM)/implantable loop recorder (ILR) device for all payers other than traditional Medicare is encouraged. Traditional Medicare does not require, nor does it provide, prior authorization.

This section is not intended as a guide through prior authorization, but rather depicts a simplified version of the prior authorization process for your convenience. The requirements vary by payer. Check with the payer regarding their specific processes. All interactions with private payers should be performed by specially trained personnel. A prior authorization does not guarantee coverage.

## Definition

Prior authorization is approval from a health plan that may be required prior to a service or prescription in order for that service or prescription to be potentially covered by the plan.

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# Prior authorization

## Steps

### 01

#### Collect information

- ▶ Collect all patient, physician, and payer information.
  - Patient's name
  - Insurance ID card/payer information
  - Physician/facility information (NPI and Tax ID numbers)
- ▶ Obtain patient consent to release patient information to their insurance company (if required).
- ▶ Identify diagnosis and corresponding facility and/or physician billing codes.
- ▶ Include documentation supporting the need for the intended procedure or service and any prior testing with results.

### 02

#### Contact the payer

- ▶ Confirm eligibility and benefits.
- ▶ Inquire about coverage for the intended procedure or service.
- ▶ Determine payer policy requirements for prior authorization. If prior authorization is not required, inquire if a predetermination can be filed.

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### Send the requested information

Gather all requested materials and mail, fax, provide verbally, or submit online through the payer website to the department responsible for the prior authorization decision.

**Note:** Verbal authorization may be given based on the information above. Written authorization is preferred. Whether authorization is verbal or written, obtain an authorization number. For written authorization, provide any required prior authorization form(s) for the payer and/or a letter of medical necessity along with supporting documentation and prior testing results.

# 04

### Follow up

Call the payer to verify receipt of the prior authorization request and continue to follow up routinely with the payer until a coverage decision has been made and communicated back to you.

# 05

### Re-verify eligibility

When the prior authorization has been granted, obtain the prior authorization number and expiration date for your files and request an official approval correspondence. Re-verify the patient's eligibility to confirm that the patient is still covered by this payer and that the patient's plan has not changed.

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# Prior authorization

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### If necessary, appeal

If the prior authorization is denied, the physician and patient must decide if they want to appeal the decision. For an appeal, be prepared to:

- ▶ Review the denial and any information provided by the payer. If no information is provided, request information from the payer regarding their appeal process.
- ▶ Send an appeal letter and any required materials as directed by the payer.
- ▶ Verify the payer received appeal materials.
- ▶ File the appeal within the time limit set by the payer as listed in the denial letter.
- ▶ Patients can also submit a personal appeal to their payer or contact their employer for assistance.

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Having trouble  
with **prior**  
authorizations?

Check out our  
new resources!

## [General prior authorization guide](#)

- › General process of prior authorization
- › Documentation and information to collect
- › Payer differences
- › Contacting the payer
- › Submitting the request
- › Peer-to-peer
- › Initial submission vs. appeal



## [Reveal LINQ™ and LINQ II™ prior authorization resources](#)

- › Sample prior authorization letter
- › Sample pre-service appeal letter
- › Summary of guidelines and key evidence



[www.Medtronic.com/CRHFreimbursement](http://www.Medtronic.com/CRHFreimbursement)

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# Coverage

## Medicare & Medicare Advantage



### Traditional Medicare coverage

For traditional Medicare patients, Medicare has not issued a national coverage determination nor have any contractors issued any local coverage determinations specific to subcutaneous cardiac rhythm monitors (SCRMs)/implantable loop recorders (ILRs). In the absence of a formal coverage policy, the Social Security Act allows for coverage for Reveal LINQ and LINQ II FDA-labeled indications when the local contractors determine it is medically reasonable and necessary.<sup>4</sup> Traditional Medicare does not require, nor does it provide, prior authorization, and no prior testing requirements are specified. It is the provider's responsibility to document "reasonable and necessary."<sup>5</sup>



### Medicare Advantage coverage

Medicare Advantage plans are required to cover at least what is covered by Traditional Medicare. Therefore, Medicare coverage policies apply to both traditional Medicare and Medicare Advantage plans.<sup>6</sup> Medicare Advantage plan administrators may only have additional policies or requirements, such as prior testing, if an applicable NCD or LCD does not exist. Prior authorization is only authorized for confirmation of diagnosis or other medical criteria. Medtronic recommends that you review the specific payer coverage policies applicable to your patient to verify all the criteria for coverage are met and/or to request a prior authorization. Asking about coverage or requesting authorization after an insertion procedure may result in unpaid claims, leaving both the hospital and the physician without compensation.

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# Coverage

## Non-Medicare payers and documentation



### Non-Medicare payer coverage

Non-Medicare payers typically determine coverage for procedures based on any applicable medical policies and prior authorization when indicated. Not all published policies apply to all patients covered by a particular payer. Medtronic recommends that you review the specific payer coverage policies applicable to your patient to verify all the criteria for coverage are met and to request a prior authorization. Asking about coverage or requesting authorization after an insertion procedure may result in unpaid claims, leaving both the hospital and the physician without compensation.



### Best practices for documentation

Documentation in the patient's medical record must support the medical necessity of all procedures being performed. Some factors to consider including in that documentation might be:

- ▶ Any prior incidents, signs, or symptoms that might suggest a history of possible arrhythmia.
- ▶ Any prior cardiac monitoring, including any in-hospital cardiac telemetry/monitoring, and/or other prior diagnostic testing.
- ▶ Any significant risk factors or comorbidities that may affect clinical management.
- ▶ Other alternative diagnostic and/or therapeutic modalities that were considered for this patient but not selected for use.
- ▶ Intended use and/or impact of the data acquired from the SCRM/ILR on the clinical management of this patient.

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# Coding



The coding information below does not replace seeking coding advice from the payer and/or your own coding staff. The ultimate responsibility for correct coding lies with the provider of services. All diagnosis and procedure codes must be supported by clear documentation within the medical record.<sup>7</sup>

- ▶ CPT<sup>®</sup> codes
- ▶ HCPCS (C-code)
- ▶ ICD-10-PCS (procedure codes)
- ▶ ICD-10-CM (diagnosis codes)
- ▶ Miscellaneous coding information

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# Coding

## Subcutaneous cardiac rhythm monitor CPT® codes

### CPT® codes

The following CPT® codes describe procedures associated with subcutaneous cardiac rhythm monitors (SCRMs)/implantable loop recorders (ILRs). Documentation will dictate the appropriate coding. These codes may be used by physicians for all services and may be used by facilities when services are rendered in the outpatient hospital or ambulatory surgery center setting. It is the physician's discretion as to what codes to report based on what procedures were performed and documented.

CPT® code <sup>8</sup>	Description
<b>Subcutaneous cardiac rhythm monitor procedures (includes loop recorders)</b>	
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming
33286	Removal, subcutaneous cardiac rhythm monitor
<b>Subcutaneous cardiac rhythm monitor interrogation - in person</b>	
93291	Interrogation device evaluation (in person) with analysis, review, and report by a physician or other qualified healthcare professional, includes connection, recording, and disconnection per patient encounter; subcutaneous cardiac rhythm monitor system, including heart rhythm-derived data analysis
<b>Subcutaneous cardiac rhythm monitor programming - in person</b>	
93285	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review, and report by a physician or other qualified healthcare professional; subcutaneous cardiac rhythm monitor system

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## Subcutaneous cardiac rhythm monitor CPT® codes

CPT® code <sup>8</sup>	Description
<b>Subcutaneous cardiac rhythm monitor interrogation - remote</b>	
93298	Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s), and report(s) by a physician or other qualified healthcare professional
<b>Subcutaneous cardiac rhythm monitor programming - remote</b>	
0650T	Programming device evaluation (remote) of subcutaneous cardiac rhythm monitor system, with iterative adjustment of the implantable device to test the function of the device and select optimal permanently programmed values with analysis, review and report by a physician or other qualified healthcare professional

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# Coding

## Subcutaneous cardiac rhythm monitor HCPCS codes

### HCPCS codes (C-codes)

Medicare provides device C-codes for hospital use in billing Medicare for medical devices in the outpatient setting.<sup>9</sup> The following HCPCS device c-code relates to the insertion of the subcutaneous cardiac rhythm monitors. For a complete list of Medtronic cardiac products and their associated C-Codes, access our searchable C-code finder is found [here](#).

HCPCS code <sup>9</sup>	Description
C1764	Event recorder, cardiac(implantable)

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## ICD-10-PCS codes

### ICD-10-PCS procedure codes subcutaneous cardiac rhythm monitors

Hospitals assign ICD-10-PCS codes for procedures performed during an inpatient admission. The following ICD-10-PCS codes describe commonly performed subcutaneous cardiac rhythm monitor procedures.<sup>10</sup>

ICD-10-PCS code <sup>10</sup>	Description
<b>Insertion of monitoring device</b>	
0JH632Z	Insertion of monitoring device into chest subcutaneous tissue and fascia, percutaneous approach
<b>Removal of monitoring device</b>	
0JPT32Z	Removal of monitoring device from trunk subcutaneous tissue and fascia, percutaneous approach
0JPT02Z	Removal of monitoring device from trunk subcutaneous tissue and fascia, open approach

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# Coding

## ICD-10-CM codes

### ICD-10-CM diagnosis codes that may support subcutaneous cardiac rhythm monitors

Hospitals and other providers assign ICD-10-CM codes to indicate a patient's diagnosis or clinical status. The following is a list of examples of possible ICD-10-CM diagnosis codes that may relate to indications associated with subcutaneous cardiac rhythm monitor procedures. This is not an all-inclusive list and the diagnosis codes reported should be based on documentation appropriate to individual patient presentation.<sup>11</sup>

ICD-10-CM code <sup>11</sup>	Description
<b>Cryptogenic stroke and transient ischemic attack</b>	
I63.0-I63.9	Acute ischemic stroke
G45.0-G45.3, G45.8-G45.9	Transient cerebral ischemic attacks and related syndromes
I69.30-I69.998	Sequelae of cerebral infarction (late effect of ischemic stroke) and other cerebrovascular disease
Z86.73	Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits
<b>Suspected arrhythmia: syncope/pre-syncope</b>	
R00.2	Palpitations
R42	Dizziness and giddiness (light-headedness)
R55	Syncope and collapse (pre-syncope)
R94.31	Abnormal electrocardiogram (ECG) (EKG)

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## ICD-10-CM codes

ICD-10-CM code <sup>11</sup>	Description
<b>Suspected arrhythmia: atrial fibrillation</b>	
R00.2	Palpitations
R06.02	Shortness of breath
R07.89	Other chest pain (includes chest pressure, discomfort, and tightness)
R07.9	Chest pain, unspecified
R42	Dizziness and giddiness (light-headedness)
R53.83	Other fatigue (includes lack of energy, tiredness)
R55	Syncope and collapse (includes fainting, pre-syncope, and near-collapse)
R94.31	Abnormal electrocardiogram (ECG) (EKG)
<b>Monitoring of known atrial fibrillation</b>	
I48.0	Paroxysmal atrial fibrillation
I48.11	Longstanding persistent atrial fibrillation
I48.19	Other persistent atrial fibrillation
I48.20	Chronic atrial flutter, unspecified
I48.21	Permanent atrial fibrillation
I48.91	Unspecified atrial fibrillation
Z79.01	Long-term (current) use of anticoagulants

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## ICD-10-CM codes

ICD-10-CM code <sup>11</sup>	Description
<b>Monitoring of other known arrhythmias</b>	
I47.0	Reentry ventricular arrhythmia
I47.1	Supraventricular tachycardia
I47.20	Ventricular tachycardia, unspecified
I47.21	Torsades de pointes
I47.29	Other ventricular tachycardia
I47.9	Paroxysmal tachycardia, unspecified
I48.3	Typical atrial flutter
I48.4	Atypical atrial flutter
I48.92	Unspecified atrial flutter
I49.01	Ventricular fibrillation
I49.02	Ventricular fibrillation
I49.1	Atrial premature depolarization (premature atrial beats and contractions)
I49.2	Junctional premature depolarization
I49.3	Ventricular premature depolarization (premature ventricular contractions)

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# Coding

## Miscellaneous coding information

## Supervision requirements



Effective January 1, 2021, CMS permits non-physician practitioners [such as nurse practitioners (NPs) and physician assistants (PAs)] to supervise diagnostic tests (including cardiac implantable electronic device (CIED) management) only in states where it is allowed by state law and scope of practice.<sup>12</sup>

In all other states, only a physician can supervise diagnostic tests.

Previously, CMS permitted non-physician practitioners to order diagnostic tests (including CIED management), but the regulations did not address whether these practitioners could supervise others who furnished diagnostic tests.

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# Payment

## Physician

The following information reflects the Medicare national allowable amount published by CMS and **does not** include Medicare payment reductions resulting from sequestration adjustments to the amount payable to the provider, as mandated by the Budget Control Act of 2011. The Medtronic Customer Economics and Reimbursement teams can provide current site-specific information upon request.

- ▶ Physician (CPT®) payment
- ▶ Outpatient (APC) payment
- ▶ Ambulatory Surgical Center (ASC) payment
- ▶ Inpatient (MS-DRG) payment

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# Payment

## Physician

### Physician coding and payment<sup>3</sup>

Effective January 1, 2024-December 31, 2024

Physicians use CPT<sup>®</sup> codes to represent procedures and services performed in all places of service. Under Medicare’s methodology for physician payment ,each CPT<sup>®</sup> code is assigned a value, known as a relative value units (RVUs). RVU’s are part of how Medicare determines a payment amount.

Procedure	CPT <sup>®</sup> code	Mod.	Description	2024 Medicare national non-facility		2024 Medicare national facility	
				Total RVU’s <sup>3</sup>	Unadjusted* payment rate <sup>3</sup>	Total RVU’s <sup>3</sup>	Unadjusted* payment rate <sup>3</sup>
Subcutaneous cardiac rhythm monitor procedures (includes loop recorders)	33285		Insertion, subcutaneous cardiac rhythm monitor, including programming	124.35	\$4,071	2.57	\$84
	33286		Removal, subcutaneous cardiac rhythm monitor	3.87	\$127	2.52	\$82

\*Unadjusted rates do not include sequestration or any other local payment adjustments.

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# Payment Physician

Procedure	CPT® code	Mod.	Description	2024 Medicare national non-facility		2024 Medicare national facility	
				Total RVU's <sup>3</sup>	Unadjusted* payment rate <sup>3</sup>	Total RVU's <sup>3</sup>	Unadjusted* payment rate <sup>3</sup>
Subcutaneous cardiac rhythm monitor interrogation - in person	93291		Interrogation device evaluation (in person) with analysis, review, and report by a physician or other qualified healthcare professional, includes connection, recording, and disconnection per patient encounter; subcutaneous cardiac rhythm monitor system, including heart rhythm-derived data analysis	1.46	\$48	N/A	N/A
	93291	26		0.52	\$17	0.52	\$17
	93291	TC		0.94	\$31	N/A	N/A

\*Unadjusted rates do not include sequestration or any other local payment adjustments.

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# Payment Physician

Procedure	CPT® code	Mod.	Description	2024 Medicare national non-facility		2024 Medicare national facility	
				Total RVU's <sup>3</sup>	Unadjusted* payment rate <sup>3</sup>	Total RVU's <sup>3</sup>	Unadjusted* payment rate <sup>3</sup>
Subcutaneous cardiac rhythm monitor programming - in person	93285		Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review, and report by a physician or other qualified healthcare professional; subcutaneous cardiac rhythm monitor system	1.79	\$59	N/A	N/A
	93285	26		0.74	\$24	0.74	\$24
	93285	TC		1.05	\$34	N/A	N/A

\*Unadjusted rates do not include sequestration or any other local payment adjustments.

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# Payment Physician

Procedure	CPT® code	Mod.	Description	2024 Medicare national non-facility		2024 Medicare national facility	
				Total RVU's <sup>3</sup>	Unadjusted* payment rate <sup>3</sup>	Total RVU's <sup>3</sup>	Unadjusted* payment rate <sup>3</sup>
Subcutaneous cardiac rhythm monitor interrogation - remote	93298		Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, including analysis of 1 of more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified healthcare professional	3.05	\$100	N/A	N/A
	93298	26		0.73	\$24	0.73	\$24
	93298	TC		2.32	\$76	N/A	N/A

\*Unadjusted rates do not include sequestration or any other local payment adjustments.

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# Payment

## Physician

Procedure	CPT® code	Mod.	Description	2024 Medicare national non-facility		2024 Medicare national facility	
				Total RVU's <sup>3</sup>	Unadjusted* payment rate <sup>3</sup>	Total RVU's <sup>3</sup>	Unadjusted* payment rate <sup>3</sup>

Subcutaneous cardiac rhythm monitor programming - remote	0650T		Programming device evaluation (remote) of subcutaneous cardiac rhythm monitor system, with iterative adjustment of the implantable device to test the function of the device and select optimal permanently programmed values with analysis, review and report by a physician or other qualified healthcare professional		**Contractor priced		
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26 - professional component.  
TC - technical component.

\*Unadjusted rates do not include sequestration or any other local payment adjustments.

\*\*Contractor-priced codes are not assigned a rate on a national level. Local contractors will determine the reimbursement amount on a case-by-case basis.

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# Payment

## Hospital outpatient coding & payment (APC)

### Hospital outpatient coding and payment<sup>1</sup>

Effective January 1, 2024-December 31, 2024

Hospitals use CPT<sup>®</sup> codes for outpatient services. The procedure codes below apply to services performed in the hospital outpatient setting.

Under Medicare’s Ambulatory Payment Classification (APC) methodology for hospital outpatient payment, each CPT<sup>®</sup> code is assigned to an ambulatory payment class. Each APC has a relative weight that is then converted to a flat payment amount.

CPT <sup>®</sup> code	Description	2024 APC <sup>1</sup>	APC title <sup>1</sup>	Status indicator <sup>1</sup>	Relative weight <sup>1</sup>	2024 Medicare national unadjusted* rate <sup>1</sup>
Subcutaneous cardiac rhythm monitor procedures (includes loop recorders)						
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	5222	Level 2 pacemaker and similar procedures	J1	92.73	\$8,103
33286	Removal, subcutaneous cardiac rhythm monitor	5071	Level 1 excision/biopsy/incision and drainage	Q2	7.68	\$671

\*Unadjusted rates do not include sequestration or any other local payment adjustments.

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# Payment

## Hospital outpatient coding & payment (APC)

CPT® code	Description	2024 APC <sup>1</sup>	APC title <sup>1</sup>	Status indicator <sup>1</sup>	Relative weight <sup>1</sup>	2024 Medicare national unadjusted* rate <sup>1</sup>
Subcutaneous cardiac rhythm monitor programming - in person						
93285	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review, and report by a physician or other qualified healthcare professional; subcutaneous cardiac rhythm monitor system	5741	Level 1 electronic analysis of devices	Q1	0.41	\$36
93291	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified healthcare professional, includes connection, recording and disconnection per patient encounter; subcutaneous cardiac rhythm monitor system, including heart rhythm derived data analysis	5731	Level 1 minor procedures	Q1	0.33	\$28

\*Unadjusted rates do not include sequestration or any other local payment adjustments.

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# Payment

## Hospital outpatient coding & payment (APC)

CPT® code	Description	2024 APC <sup>1</sup>	APC title <sup>1</sup>	Status indicator <sup>1</sup>	Relative weight <sup>1</sup>	2024 Medicare national unadjusted* rate <sup>1, 17</sup>
Subcutaneous cardiac rhythm monitor interrogation - remote						
93298	Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s), and report(s) by a physician or other qualified healthcare professional	5741	Level 1 electronic analysis of devices	Q1	0.41	\$36

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\*Unadjusted rates do not include sequestration or any other local payment adjustments.



# Payment

## Hospital outpatient coding & payment (APC)

CPT® code	Description	2024 APC <sup>1</sup>	APC title <sup>1</sup>	Status indicator <sup>1</sup>	Relative weight <sup>1</sup>	2024 Medicare national unadjusted* rate <sup>1</sup>
Subcutaneous cardiac rhythm monitor programming - remote						

0650T (Effective July 1, 2021)	Programming device evaluation (remote) of subcutaneous cardiac rhythm monitor system, with iterative adjustment of the implantable device to test the function of the device and select optimal permanently programmed values with analysis, review and report by a physician or other qualified healthcare professional	5741	Level 1 electronic analysis of devices	Q1	0.41	\$36
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\*Unadjusted rates do not include sequestration or any other local payment adjustments.

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# Payment

## Ambulatory surgery center (ASC) coding & payment

### Ambulatory Surgical Center (ASC) coding and payment<sup>2</sup>

#### Effective January 1, 2024-December 31, 2024

ASCs use CPT<sup>®</sup> codes for their services. Medicare payment for procedures performed in an ambulatory surgery center is generally based on Medicare's ambulatory payment classification (APC) methodology for hospital outpatient payment. However, comprehensive APCs are used only for hospital outpatient services and are not applied to procedures performed in ASCs. Alternately, payment for some CPT<sup>®</sup> codes is based on the physician fee schedule payment, particularly for procedures commonly performed in the physician offices.

Each CPT<sup>®</sup> code designated as an approved procedure in an ASC is assigned a comparable relative weight as under the hospital outpatient APC system. This is then converted to a flat payment amount using a formula unique to ASCs. Multiple procedures can be paid for each claim. Certain ancillary services, such as imaging, may also be reimbursed when they are integral to an approved surgical procedure. Some of these ancillary services are not separately payable. There is not separate payment for these devices in the ASC setting; their payment is included in the payment for the procedure.

CPT <sup>®</sup> Code	Description	Subject to multiple procedure discounting <sup>2</sup>	2024 Medicare national unadjusted* payment rate <sup>2</sup>
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	Y	\$6,904
33286	Removal, subcutaneous cardiac rhythm monito	N	\$365

All other applicable CPT<sup>®</sup> codes for SCRM are not payable in the ASC setting and are not listed here.  
\*Unadjusted rates do not include sequestration or any other local payment adjustments.

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# Payment

## Hospital inpatient coding & payment

### Hospital inpatient coding and payment<sup>14</sup>

#### Effective October 1, 2023-September 30, 2024

Medicare reimbursement for inpatient hospital services is based on a classification system known as Medicare severity diagnosis related groups (MS-DRGs). MS-DRG assignment is determined by patient diagnoses and procedures. Only one MS-DRG is assigned per hospital admission, and one payment is made for all procedures and supplies related to that inpatient stay. MS-DRG assignment may be affected when one or more secondary diagnoses that are included in the major complication or comorbidity (MCC) or complication or comorbidity (CC) lists, which are maintained by CMS. Each MS-DRG has a relative weight that is then converted to a flat payment amount. Only one MS-DRG is assigned for each inpatient stay, regardless of the number of procedures performed. The MS-DRGs shown are those typically assigned to the following scenarios.

MS-DRG <sup>13</sup>	Description	2024 MS-DRG Medicare national unadjusted* payment rate <sup>14</sup>
SCRM insertion during an admission for cryptogenic stroke		
040	Peripheral/cranial nerve and other nervous system procedures with MCC	\$26,960
041	Peripheral/cranial nerve and other nervous system procedures with CC or peripheral neurostimulator	\$15,618
042	Peripheral/cranial nerve and other nervous system procedures without CC/MCC	\$12,181

All other applicable CPT® codes for SCRM are not payable in the ASC setting and are not listed here.  
\*Unadjusted rates do not include sequestration or any other local payment adjustments.

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# Payment

## Hospital inpatient coding & payment

MS-DRG <sup>13</sup>	Description	2024 MS-DRG Medicare national unadjusted* payment rate <sup>14</sup>
SCRM insertion during an admission for syncope		
260	Cardiac pacemaker revision except device replacement with MCC	\$23,212
261	Cardiac pacemaker revision except device replacement with CC	\$13,176
262	Cardiac pacemaker revision except device replacement without CC/MCC	\$11,520

CC - Complication or comorbidity

MCC - Major complication or comorbidity

All other applicable CPT® codes for SCRM are not payable in the ASC setting and are not listed here.

\*Unadjusted rates do not include sequestration or any other local payment adjustments.

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# Frequently asked questions

## Insertion & removal

01

**If a SCRM implant and another cardiac procedure, such as a catheter ablation, are performed together in the outpatient hospital setting, would that effect payment for the hospital??**

When a SCRM insertion and another procedure are done together on an outpatient basis, the hospital would be reimbursed for the highest weighted procedure. The other procedure would be bundled within that payment, and no additional payment will occur.

02

**Can a non-physician practitioner (NPP), such as nurse practitioners (NPs) and physician assistants (PAs), perform SCRM/ILR insertion and removal procedures?**

Medicare may reimburse an NPP performing this procedure as long as it is within the scope of their practice, it is allowed by state license requirements, and the facility allows NPPs to perform the procedure in their facility.<sup>15</sup>

03

**Is a HCPCS code for the device required for in-office implants?**

No, when performed in the office setting the device is included in the procedure code. No additional code is reported for the device.

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# Frequently asked questions

## Insertion & removal

04

### **When an insertion takes place in an office, how is the office reimbursed for the cost of the device?**

The device cost is included in the global Medicare PFS non-facility amount paid to the office for the insertion procedure.

05

### **What code should be reported when SCRM/ILR requires repositioning?**

There is no code that describes this procedure. The provider may use CPT® 17999 (unlisted procedure, skin, mucous membrane and subcutaneous tissue) for this procedure. When reporting an unlisted code, a description of the procedure performed must also be included on the claim. The payer will determine coverage based on documentation.<sup>16</sup>

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# Frequently asked questions

## Monitoring

06

### How many days does a patient have to be monitored to bill for remote monitoring?

A patient must be monitored for a minimum of 10 days of the full 30-day service period to meet the requirements to bill.<sup>16</sup>

07

### Can a provider bill additionally for each SCRM/ILR transmission reviewed during a remote monitoring period?

No, SCRM/ILR remote monitoring codes are day span-based and represent all work that occurs over a 30-day period. There is one payment made for the 30-day episode, regardless of the number of times that data is transmitted and/or reviewed.<sup>16</sup>

08

### Can a provider bill for an in-person interrogation during the remote monitoring period?

No, all interrogations (remote and in-person) are included in the remote monitoring period.<sup>16</sup>

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# Frequently asked questions

## Monitoring

09

### Can a provider bill for a programming during the remote monitoring period?

Yes, programming is separate service from interrogation and is billable during the remote monitoring period.<sup>16</sup> The payer will determine coverage based on documented medical necessity.

10

### How does the removal of G2066 impact provider-based clinics reimbursed through the outpatient prospective payment system (OPPS) for 93297 and 93298?

Due to the deletion of G2066, CMS issued a correction notice on February 6, 2024 confirming that the status indicator of "M" will be changed to "Q1" for CPT<sup>®</sup> codes 93297 and 93298 making them separately payable under OPPS. This change will go into effect for services rendered on and after January 1, 2024.<sup>3, 17</sup>

CPT <sup>®</sup> code	APC	OPPS reimbursement rate <sup>1</sup>
93297	5741	\$36
93298	5741	\$36

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# Frequently asked questions

## Monitoring

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### Are the RVU's for CPT® codes 93297 and 93298 changing after January 1, 2024?

Yes. With this change, RVUs have been assigned to the technical services previously reported using G2066. The RVUs for 2024 are as follows:

CPT® code	Work RVU	Practice expense
<b>93297</b>	0.52	1.26
-TC	0	1.07
-26	0.52	0.19
<b>93298</b>	0.52	2.49
-TC	0	2.30
-26	0.52	0.19

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For information on the recent changes to remote monitoring coding, specifically the elimination of HCPCS code G2066, please refer to the Reimbursement Update for remote monitoring. It can be found [here](#).

## For additional information



Visit our website: [www.medtronic.com/crhfreimbursement](http://www.medtronic.com/crhfreimbursement)



Email us: [rs.healthcareeconomics@medtronic.com](mailto:rs.healthcareeconomics@medtronic.com)



Call our Reimbursement Customer Support: 1-866-877-4102

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Hospital specific rates will vary based on various hospital-specific factors not reflected in this document and CMS may make adjustments to any or all of the data inputs from time to time.
- <sup>2</sup> The Ambulatory Surgical Center (ASC) ASC 2024 National payment rates based on information published in the OPPS/ASC final rule CMS-1786-FC, Addendum AA table which was released on November 2, 2023. ASC Regulations and Notices. cms.gov <https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and/cms-1786-fc> Accessed November 16, 2023. ASC specific rates will vary based on various specific factors not reflected in this document and CMS may make adjustments to any or all of the data inputs from time to time.
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Local physician rates will vary based on location specific factors not reflected in this document. CMS may make adjustments to any or all of the data inputs from time to time
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- <sup>5</sup> Centers for Medicare & Medicaid Services. Medicare Program Integrity Manual. Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf>. Accessed November 16, 2023.
- <sup>6</sup> Centers for Medicare and Medicaid Services. Medicare Managed Care Coverage Manual – Chapter 4 section 10.7.1 and 10.7.3 <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c04.pdf>. Accessed on November 16, 2023.
- <sup>7</sup> CMS has posted a “Clinical Concepts in Cardiology” tip sheet on their website identifying several clinical documentation tips for Cardiology services and ICD-10-CM diagnosis codes. <https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10ClinicalConceptsCardiology1.pdf>. The resource includes common codes, clinical documentation tips, and clinical scenarios. Please review the CMS document on Clinical Concepts in Cardiology for complete information, keeping in mind this document is from 2015, and codes may have been revised or updated since its publication.
- <sup>8</sup> CPT codes and descriptions only are copyright ©2023 American Medical Association. All rights reserved. No fee schedules are included in CPT. The American Medical Association assumes no liability for data contained or not contained herein.
- <sup>9</sup> Device C-codes are HCPCS Level II codes and also maintained by the Centers for Medicare and Medicaid Services. Healthcare Common Procedure Coding System. <https://www.cms.gov/medicare/coding/hcpcsreleasecodesets/hcpcs-quarterly-update>. Accessed November 16, 2023.
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# Brief Statement for Medtronic LINQ Family Insertable Cardiac Monitor System (ICM) and Remote Monitoring

## Indications

The Reveal LINQ ICM is an insertable automatically-activated and patient-activated monitoring system that records subcutaneous ECG and is indicated in the following cases:

- patients with clinical syndromes or situations at increased risk of cardiac arrhythmias
- patients who experience transient symptoms such as dizziness, palpitation, syncope, and chest pain that may suggest a cardiac arrhythmia

This device has not been tested specifically for pediatric use.

The LINQ II ICM is an insertable automatically-activated and patient-activated monitoring system that records subcutaneous ECG and is indicated in adult patients, and in pediatric patients who are at least 2 years old, in the following cases:

- patients with clinical syndromes or situations at increased risk of cardiac arrhythmias
- patients who experience transient symptoms such as dizziness, palpitation, syncope, and chest pain that may suggest a cardiac arrhythmia

## Contraindications

There are no known contraindications for the insertion of the LINQ Family ICM's or their accessories. However, the patient's particular medical condition may dictate whether or not a subcutaneous, chronically inserted device can be tolerated.

## Warnings and Precautions

Patients with a LINQ Family ICM should avoid sources of diathermy, high sources of radiation, electrosurgical cautery, external defibrillation, lithotripsy, therapeutic ultrasound and radiofrequency ablation to avoid electrical reset of the device, and/or inappropriate sensing as described in the Medical procedure and EMI Warnings, Precautions and Guidance Manual. MRI scans should be performed only in a specified MR environment under specified conditions as described in the LINQ II or Reveal LINQ ICM MRI Technical Manual.

Wireless accessories available for use with a LINQ Family ICM may experience connectivity or performance issues. See product manuals for details and troubleshooting instructions.

## Potential Adverse Events

Potential adverse events from the LINQ Family ICM include, but are not limited to, device rejection phenomena (including local tissue reaction), device migration, infection, and erosion through the skin.

There are no known adverse events associated with the use of any LINQ Family ICM wireless accessories.

See the device manuals for detailed information regarding the implant procedure, indications/intended use, contraindications, warnings, precautions, and potential complications/adverse events. For further information, please call Medtronic at (800) 328-2518 (Technical Services), (800) 551-5544 (Patient Services), and/or consult Medtronic's website at [www.medtronic.com](http://www.medtronic.com).

**Caution:** Federal law (USA) restricts prescription devices to sale by or on the order of a physician.

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03/2024

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