Medtronic

Engineering the extraordinary

Reimbursement guide

Extravascular ICD therapy

Facility & physician coding, coverage, and payment

January 2024

Facility & physician reimbursement guide

ICD therapy

This guide has been developed to help you understand Medicare coverage, coding, and payment for implantable cardioverter defibrillators (ICD).

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Overview

ICD therapy applies to EV ICD

The implantable automatic defibrillator is an electronic device designed to detect and treat life-threatening tachyarrhythmias. The device consists of a pulse generator and electrodes for sensing and defibrillating. When the device senses an arrhythmia, it sends an electrical signal through the leads to terminate the arrhythmia and restore normal heart rhythm.

Section 20.4 of the Medicare National Coverage Determinations (NCD) manual establishes conditions of coverage for ICDs.[1] First issued in 1986, the NCD provided limited coverage of ICDs and the policy has been expanded over the years since then. CMS last reconsidered this NCD in 2018. The most recent changes to the policy removed the registry requirement and added the shared decision making requirement for primary prevention indications.

Coverage for ICD therapy

Medicare coverage

The Medicare coverage policy for ICD implants occurring on or after February 15, 2018, is printed verbatim; however, it is reformatted for easier readability.[1]

The following information represents the CMS nationally covered indications for the use of implantable cardioverter defibrillators (ICDs) based on the national coverage determination (NCD) for ICDs (20.4).1 Effective February 15, 2018. CMS covers ICDs for the following patient indications:

Medicare coverage policy

20.4 Implantable automatic defibrillators, Medicare National Coverage Determinations Manual (Chapter 1, Part I (Sections 10-80.12) Coverage Determinations)[1]

A. General

An ICD is an electronic device designed to diagnose and treat life-threatening ventricular tachyarrhythmias.

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.6 Medicare Advantage plan administrators may have policies and additional requirements such as prior testing and prior authorization. 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 implant procedure or device interrogation may result in unpaid claims, leaving both the hospital and the physician without compensation.

Coverage with non-Medicare payers

Non-Medicare payers typically determine coverage for procedures based on medical policy and prior authorization requirements. It is recommended that you review the payer's coverage policy to verify that you have met all the criteria for coverage for your specific patient. Not all published policies apply to all patients covered by a specific payer. We recommend you contact the payer to obtain a prior authorization or prior approval. Determining coverage after implant may result in unpaid claims, leaving both the hospital and the physician without compensation.

Coverage for ICD therapy

Indications and limitations of coverage

B. Nationally covered indications

Effective for services performed on or after February 15, 2018, CMS has determined that the evidence is sufficient to conclude that the use of ICDs, (also referred to as defibrillators) is reasonable and necessary:

1. Patients with a personal history of sustained ventricular tachyarrhythmia (VT) or cardiac arrest due to ventricular fibrillation (VF). Patients must have demonstrated:
   - An episode of sustained VT, either spontaneous or induced by an electrophysiology (EP) study, not associated with an acute myocardial infarction (MI) and not due to a transient or reversible cause; or
   - An episode of cardiac arrest due to VF, not due to a transient or reversible cause.

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2. Patients with a prior MI and a measured left ventricular ejection fraction (LVEF) ≤ 0.30. Patients must not have:
   - New York Heart Association (NYHA) Classification IV heart failure; or
   - Had a coronary artery bypass graft (CABG) or percutaneous coronary intervention (PCI) with angioplasty and/or stenting, within the past three months; or
   - Had an MI within the past 40 days; or
   - Clinical symptoms and findings that would make them a candidate for coronary revascularization.

For these patients identified in 2, a formal shared decision-making encounter must occur between the patient and a physician (as defined in Section 1861(r)(1) of the Social Security Act (the Act)) or qualified non-physician practitioner (meaning a physician assistant, nurse practitioner, or clinical nurse specialist as defined in §1861(aa) (5) of the Act) using an evidence-based decision tool on ICDs prior to initial ICD implantation. The shared decision-making encounter may occur at a separate visit.

Coverage for ICD therapy

3 Patients who have severe, ischemic, dilated cardiomyopathy but no personal history of sustained VT or cardiac arrest due to VF, and have NYHA Class II or III heart failure, LVEF ≤ 35%. Additionally, patients must not have:

- Had a CABG, or PCI with angioplasty and/or stenting within the past three months; or
- Had an MI within the past 40 days; or
- Clinical symptoms and findings that would make them a candidate for coronary revascularization.

For these patients identified in 3, a formal shared decision-making encounter must occur between the patient and a physician (as defined in Section 1861(r)(1) of the Act) or qualified non-physician practitioner (meaning a physician assistant, nurse practitioner, or clinical nurse specialist as defined in §1861(aa)(5) of the Act) using an evidence-based decision tool on ICDs prior to initial ICD implantation. The shared decision-making encounter may occur at a separate visit.

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4 Patients who have severe, nonischemic, dilated cardiomyopathy but no personal history of cardiac arrest or sustained VT, NYHA Class II or III heart failure, LVEF≤ 35%, been on optimal medical therapy for at least three months. Additionally, patients must not have:

- Had a CABG or PCI with angioplasty and/or stenting within the past three months; or
- Had an MI within the past 40 days; or
- Clinical symptoms and findings that would make them a candidate for coronary revascularization.

For these patients identified in 4, a formal shared decision-making encounter must occur between the patient and a physician (as defined in Section 1861(r)(1) of the Act) or qualified non-physician practitioner (meaning a physician assistant, nurse practitioner, or clinical nurse specialist as defined in §1861(aa)(5) of the Act) using an evidence-based decision tool on ICDs prior to initial ICD implantation. The shared decision-making encounter may occur at a separate visit.

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5 Patients with documented, familial, or genetic disorders with a high risk of life-threatening tachyarrhythmias (sustained VT or VF, to include, but not limited to, long QT syndrome or hypertrophic cardiomyopathy.)

For these patients identified in 5, a formal shared decision-making encounter must occur between the patient and a physician (as defined in Section 1861(r)(1) of the Act) or qualified non-physician practitioner (meaning a physician assistant, nurse practitioner, or clinical nurse specialist as defined in §1861(aa)(5) of the Act) using an evidence-based decision tool on ICDs prior to initial ICD implantation. The shared decision-making encounter may occur at a separate visit.

Coverage for ICD therapy

6 Patients with an existing ICD may receive an ICD replacement if it is required due to the end of battery life, elective replacement indicator (ERI), or device/lead malfunction..

For each of the six covered indications above, the following additional criteria must also be met:

1. Patients must be clinically stable (e.g., not in shock, from any etiology);

2. LVEF must be measured by echocardiography, radionuclide (nuclear medicine) imaging, cardiac magnetic resonance imaging (MRI), or catheter angiography;

3. Patients must not have:
   - Significant, irreversible brain damage; or
   - Any disease, other than cardiac disease (e.g., cancer, renal failure, liver failure) associated with a likelihood of survival less than one year; or
   - Supraventricular tachycardia such as atrial fibrillation with a poorly controlled ventricular rate.

Coverage for ICD therapy

Exceptions to waiting periods for patients that have had a CABG or PCI with angioplasty and/or stenting within the past three months, or had an MI within the past 40 days:

Cardiac pacemakers

Patients who meet all CMS coverage requirements for cardiac pacemakers, and who meet the criteria in this national coverage determination for an ICD, may receive the combined devices in one procedure, at the time the pacemaker is clinically indicated.

Replacement of ICDs

Patients with an existing ICD may receive an ICD replacement if it is required due to the end of battery life, ERI, or device/lead malfunction.

C. Nationally non-covered indications

N/A

D. Other

For patients that are candidates for heart transplantation on the United Network for Organ Sharing (UNOS) transplant list awaiting a donor heart, coverage of ICDs, as with cardiac resynchronization therapy, as a bridge-to- transplant to prolong survival until a donor becomes available, is determined by the local Medicare Administrative Contractors (MACs).

All other indications for ICDs not currently covered in accordance with this decision may be covered under Category B Investigational Device Exemption (IDE) trials (42 CFR 405.201).

Please see the following page for a Medicare ICD coverage overview chart.

Medicare ICD coverage overview chart

Primary or secondary prevention	Indication	Left ventricle ejection fraction*	NYHA class	Shared decision making required	Exclusions or other criteria
Secondary	History of sustained ventricular tachyarrhythmia (VT)† or cardiac arrest due to ventricular fibrillation (VF).	n/a	n/a	No	▸ An episode of sustained VT, either spontaneous or induced by an electrophysiology (EP) study, not associated with an acute myocardial infarction (MI) and not due to a transient or reversible cause; or ▸ An episode of cardiac arrest due to VF, not due to a transient or reversible cause
Primary	Documented prior MI**	≤ 30%	Any except IV	Yes	▸ Had a CABG or PCI with angioplasty and/or stenting with the past three months‡; or ▸ Had an MI within the past 40 days‡; or ▸ Clinical symptoms and findings that would make them a candidate for coronary revascularization.
Primary	Ischemic, dilated cardiomyopathy but no personal history of sustained VT or cardiac arrest due to VF	≤ 35%	II or III	Yes	
Primary	Nonischemic, dilated cardiomyopathy but no personal history of cardiac arrest or sustained VT† and has been on optimal medical therapy for at least three months	≤ 35%	II or III	Yes	
Primary	Documented, familial, or genetic disorders with a high risk of life- threatening tachyarrhythmias (sustained VT or VF, to include, but not limited to, long QT syndrome or hypertrophic cardiomyopathy)	n/a	n/a	Yes	
N/A	ICD replacement	n/a	n/a	No	▸ Due to the end of battery life, elective replacement indicator (ERI), or device/lead malfunction

*Ejection fractions must be measured by angiography, radionuclide scanning, or echocardiography.
**MIs must be documented and defined according to the consensus document of the Joint European Society of Cardiology/American College of Cardiology Committee for the Redefinition of Myocardial Infarction.
‡ Exceptions to waiting periods for patients that have had a CABG or PCI with angioplasty and/or stenting within the past three months, or had an MI within the past 40 days:
Cardiac pacemakers: Patients who meet all CMS coverage requirements for cardiac pacemakers, and who meet the criteria in this national coverage determination for an ICD, may receive the combined devices in one procedure, at the time the pacemaker is clinically indicated.
Replacement of ICDs: Patients with an existing ICD may receive an ICD replacement if it is required due to the end of battery life, ERI, or device/lead malfunction.

Shared decision making (SDM)

For primary prevention patients, the CMS NCD specifies that a formal shared decision-making encounter must occur between the patient and a physician or qualified non-physician practitioner (physician assistant, nurse practitioner, or clinical nurse specialist) using an evidence-based decision tool on ICDs prior to initial ICD implantation.4 This encounter can happen during a separate visit.

The NCD references a sample shared decision-making tool that can be found at: https://patientdecisionaid.org/icd/.
In addition, guidelines published in 2017 by AHA/ACC/HRS provide recommendations for the elements of shared decision-making.[5]

A commonly accepted definition for shared decision making includes four components:

1. At least two participants – the clinician and the patient – are involved
2. Both parties share information
3. Both parties take steps to build a consensus about the preferred treatment
4. An agreement is reached on the treatment to implement

Prior authorization information – EV ICD

Overview

This document is intended to provide information that may be pertinent to physicians and patients in cases for extravascular ICDs, requiring prior authorization with private insurers, when used in accordance with FDA-approved labeling. The document is not intended as a guide through prior authorization; instead, it is a resource to depict a simplified version of the prior authorization process and provide an overview of evidence available about leadless pacemakers. Check with the payer regarding their specific prior authorization requirements and processes. This document highlights general steps in the prior authorization process, which may be required by private payers, and provides an overview of Medicare coverage for ICDs, which applies to Medicare Advantage plans administered by private payers.

Overview of the prior authorization process

The information below depicts the basic process for obtaining prior authorization from a payer for a medical procedure. In general, requirements include providing patent- and case-specific information along with any supporting evidence for the clinical course of action, as well as verifying benefits and eligibility.

Collect patient & procedure information

Collect information needed to perform patient eligibility verification

- Patient name & insurance card
- Procedure & diagnosis detail
- Facility details

Verify benefits

- Verify patient benefits and eligibility
- What are conditions for this patient?
- What are prior authorization requirements for patient and service?

Prior authorization

- If patient meets coverage criteria, collect supporting documentation
- Submit required information to gain appropriate payer approval for procedure

Document & verify

- Obtain the prior authorization number and expiration date for your files. Request official approval correspondence
- Reverify eligibility immediately before procedure

Prior authorization procedures can vary by payer plan and within a payer based on an individual patient's coverage policy. Providers should contact the health plan for specific steps and requirements regarding advance notification and approval processes specific to your patient. Prior authorization does not guarantee coverage.

Medicare covers EV ICDs under traditional and Medicare Advantage plans

Medicare has a National Coverage Determination (NCD) designating coverage for ICDs. This NCD applies to ICD systems, including EV ICDs and can be found in Section 20.4 of the Medicare NCD Manual.[1] The NCD for ICDs (20.4) defining this coverage applies to both traditional Medicare and Medicare Advantage Plans.[2]

Prior authorization for EV ICD insertion procedures is not required for traditional Medicare, however, may be required from some insurers that manage Medicare Advantage plans to determine the applicability of covered benefits for a specific patient case.

Summary of coverage/prior authorization for EV ICD insertion and replacement by payer type

<table>
<tr><th></th><th>Medicare</th><th>Medicare advantage</th><th>Private/commercial insurer</th></tr>
<tr><td>Coverage: EV ICD insertion or replacement</td><td colspan="2">Yes, covered.</td><td>Depend; check with plan for specific policy</td></tr>
<tr><td>Prior authorization requirements</td><td>None</td><td colspan="2">Depends; check with plan for specific requirements.</td></tr>
</table>

Coding for ICD therapy

These coding suggestions do 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 reported must be supported by clear documentation within the medical record.

Physician procedure codes

The following CPT®[3] codes describe procedures associated with ICD therapy implants. Depending on the type of ICD implanted, one or more of the following codes may be appropriate. This is not an all-inclusive list. These codes are used by physicians to report their services. Additionally, hospitals use CPT® codes to report services rendered in the outpatient hospital setting.

Hospital coding – C codes

Medicare provides device C-codes for hospital use in billing Medicare for medical devices in the outpatient setting.[14] The following HCPCS device c-codes relate to the insertion of extravascular implantable cardioverter defibrillators (EV ICDs). For a complete list of Medtronic cardiac products and their associated C-Codes, access our searchable, downloadable (Excel, CSV) C-Code Finder is found here

HCPCS code	HCPCS code description
C1722	Cardioverter-defibrillator, single chamber (implantable)
C1896	Lead, cardioverter-defibrillator, other than endocardial single or dual coil (implantable)
C1894	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, non-laser

Hospital outpatient & physician coding

The following CPT codes describe commonly performed defibrillator procedures. This is not an all-inclusive list. These codes are used by hospitals for reporting outpatient services, and by physicians to report in- and outpatient services.

CPT® code	CPT® code description
0571T	Insertion or replacement of implantable cardioverter-defibrillator system with substernal electrode(s), including all imaging guidance and electrophysiological evaluation (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters), when performed
0572T	Insertion of substernal implantable defibrillator electrode
0573T	Removal of substernal implantable defibrillator electrode
0574T	Repositioning of previously implanted substernal implantable defibrillator-pacing electrode
0577T	Electrophysiologic evaluation of implantable cardioverter-defibrillator system with substernal electrode (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)
0580T	Removal of substernal implantable defibrillator pulse generator only
0614T	Removal and replacement of substernal implantable defibrillator pulse generator

Remote and in-person device monitoring coding

The following CPT codes describe device evaluation procedures for the Aurora EV-ICD™ system.
This is not an all-inclusive list.

CPT® code	CPT® code description
0575T	Programming device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, 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 health care professional
0576T	Interrogation device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter
0578T	Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional
0579T	Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results

Hospital inpatient procedure codes

The following ICD-10- PCS codes describe commonly performed defibrillator procedures. **This is not an all-inclusive list**. These codes are only used by hospitals for reporting inpatient services.

ICD-10-PCS	Description
Implant cardioverter-defibrillator generator	
0JH608Z	Insertion of defibrillator generator into chest subcutaneous tissue and fascia, open approach
0JH808Z	Insertion of defibrillator generator into abdomen subcutaneous tissue and fascia, open approach
Insert EV ICD lead	
0WHC3GZ	Insertion of defibrillator lead into mediastinum, percutaneous approach
Revise or relocate pocket	
0JWT0PZ	Revision of cardiac rhythm-related device in trunk subcutaneous tissue and fascia, open approach
Remove generator	
0JPT0PZ	Removal of cardiac rhythm-related device from trunk subcutaneous tissue and fascia, open approach

Hospital outpatient procedure codes

Medicare no longer uses procedure-to-device and device-to-procedure edits for device-intensive hospital outpatient services. For a procedure that requires a device to be implanted and is also assigned to a device-intensive ambulatory payment classification (APC), the claim must include a "device code."

The table below provides implantable cardioverter defibrillator device-intensive APCs[4]:

Device-intensive APC number and APC description	CPT® code	CPT® code brief description
5232 Level 2 ICD and similar procedures	0571T	Insertion or replacement of implantable cardioverter-defibrillator system with substernal electrode(s)
5222 Level 2 Pacemaker and similar procedure	0572T	Insertion of substernal implantable defibrillator electrode
5221 Level 1 Pacemaker and similar procedures	0573T	Removal of substernal implantable defibrillator electrode
	0574T	Repositioning of previously implanted substernal implantable defibrillator-pacing electrode

ICD-10-CM diagnosis codes

The following is a list of examples of possible ICD-10-CM diagnosis codes that can relate to indications associated with ICD procedures. Payers will determine coverage based on their medical policies, criteria, and documented medical necessity. This is not an all-inclusive list and the diagnosis codes reported should be based on documentation of what the individual patient presents with.[5]

ICD-10-CM diagnosis code	ICD-10-CM diagnosis code description
I47.20	Ventricular tachycardia, unspecified
I47.21	Torsades de pointes
I47.29	Other ventricular tachycardia
I49.01	Ventricular fibrillation
I49.02	Ventricular flutter
I46.2	Cardiac arrest due to underlying cardiac condition
I46.9	Cardiac arrest, cause unspecified
I49.9	Cardiac arrhythmia, unspecified
T82.120A	Displacement of cardiac electrode, initial encounter
T82.121A	Displacement of cardiac pulse generator (battery), initial encounter
T82.190A	Other mechanical complication of cardiac electrode, initial encounter
T82.191A	Other mechanical complication of cardiac pulse generator (battery), initial encounter
Z86.74	Personal history of sudden cardiac arrest (SCA) (successfully resuscitated)

ICD-10-CM diagnosis codes

ICD-10-CM diagnosis code	ICD-10-CM diagnosis code description
Ischemic cardiomyopathy	
I25.5	Ischemic cardiomyopathy
I25.6	Silent myocardial ischemia
I25.9	Chronic ischemic heart disease, unspecified
Nonischemic cardiomyopathy	
I42.1	Obstructive hypertrophic cardiomyopathy
I42.2	Other hypertrophic cardiomyopathy
I42.0	Dilated cardiomyopathy
I42.5	Other restrictive cardiomyopathy
I42.8	Other cardiomyopathies
I42.9	Cardiomyopathy, unspecified
Long QT syndrome	
I45.81	Long QT syndrome
QRS duration, wide and narrow	
R94.31	Abnormal electrocardiogram [ECG] [EKG]

Prior myocardial infraction

With ICD-10-CM diagnosis coding: An acute myocardial infarction (AMI) is identified as “acute” for four weeks from the time of the incident.

Documentation best practices

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.[6] The tip sheet includes common codes, clinical documentation tips, and clinical scenarios. Some of these tips are:

- Document why the patient encounter took place
- When known, document whether the patient is compliant with their medications
- Document lab test results, both normal and abnormal
- Document any criteria required from policy

Please review the CMS tip sheet for complete information at:
https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD10ClinicalConceptsCardiology1.pdf

Heart failure codes requirement

There are three indications in Medicare's NCD that include heart failure as part of the criteria. The reporting of the heart failure codes is required on ICD implant claims even if the heart failure is being appropriately treated and the patient is not in "acute" heart failure. Additional information on this requirement can be found in MLN SE20006 that can be found at https://www.cms.gov/files/document/se20006.pdf

Heart failure can be a CC (complication or comorbidity) or MCC (major complication or comorbidity)

Under the MS-DRG system, heart failure can be considered both a chronic and acute condition. Documentation about the specific type of heart failure is critical to determine if the condition is considered a CC or an MCC.

Heart failure diagnosis codes must be explicitly documented by the physician; it cannot be assumed by the coder on the basis of the ejection fraction. Nondiagnostic and nonspecific terms such as "low ejection fraction" and "ventricular dysfunction" should also be avoided. Low ejection fraction is a characteristic of heart failure, and it is essential that physicians document the diagnosis clearly.

Payment for ICD therapy

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 payment[7]

Effective Jan. 1, 2024–Dec. 31, 2024

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

Physician payment

The Category III CPT codes reflect emerging technologies, and there are no assigned Relative Value Units (RVUs) for the calculation of physician payment. Payment is at the discretion of the applicable Medicare Administrative Contractor (MAC). Because there is no assigned Medicare payment for Category III codes, physicians submitting a claim for the EV-ICD implant are advised to reference an existing service or procedure that is comparable to the EV-ICD procedure in costs and resources.

CPT® code[7]	CPT® description	2024 Medicare national unadjusted rate	
		Total RVUs[11]	Unadjusted payment rate[11]
0571T	Insertion or replacement of implantable cardioverter-defibrillator system with substernal electrode(s)	n/a	Contractor priced*
0572T	Insertion of substernal implantable defibrillator electrode	n/a	Contractor priced*
0573T	Removal of substernal implantable defibrillator electrode	n/a	Contractor priced*
0574T	Repositioning of previously implanted substernal implantable defibrillator-pacing electrode	n/a	Contractor priced*
0577T	Electrophysiologic evaluation of implantable cardioverter-defibrillator system with substernal electrode (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)	n/a	Contractor priced*
0580T	Removal of substernal implantable defibrillator pulse generator only	n/a	Contractor priced*
0614T	Removal and replacement of substernal implantable defibrillator pulse generator	n/a	Contractor priced*

*Contractor priced: There is no Medicare national payment established and each Medicare contractor determines the reimbursement amount for their specific area on a case-by-case basis.

Hospital outpatient payment[8]

Effective Jan. 1, 2024–Dec. 31, 2024

Hospitals use CPT®,[13] 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® code is assigned to an ambulatory payment category. Each APC has a relative weight that is then converted to a flat payment amount.

CPT® code[7]	CPT® description	2024 APC[12]	Status indicator[12]	Relative weight[12]	2024 Medicare national unadjusted rate[12]
0571T	Insertion or replacement of implantable cardioverter-defibrillator system with substernal electrode(s)	5232	J1	359.0968	$31,379
0572T	Insertion of substernal implantable defibrillator electrode	5222	J1	92.7311	$8,103
0573T	Removal of substernal implantable defibrillator electrode	5221	Q2	42.8637	$3,746
0574T	Repositioning of previously implanted substernal implantable defibrillator-pacing electrode	5221	Q2	42.8637	$3,746

Hospital inpatient payment[9]

Effective Oct.1 2023-Sept. 30, 2024

Medicare reimbursement for inpatient hospital services is based on a classification system knows 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. If medical necessity criteria are met to support an inpatient admission for the defibrillator implant, the MS-DRG assignment may be:

MS-DRG[9]	MS-DRG description	FY2024 MS-DRG Medicare national unadjusted rate[9]
275	Cardiac defibrillator implant with cardiac catheterization and MCC	$49,262
276	Cardiac defibrillator implant with MCC	$43,481
277	Cardiac defibrillator implant without MCC	$33,484

Frequently asked questions

01

Do EV ICDs use the same codes as S ICDs?

No, they are different types of ICDs with separate lead placement locations and there are codes specific for both the EV ICDs and S ICD procedures. See page 16 for the list of codes that apply for EV-ICD procedures.

02

Does the Medicare NCD for ICDs apply for EV-ICDs?

Yes, the Medicare NCD is not specific to a specific type of ICDs and applies for all ICDs.

03

Do commercial payers cover the EV-ICD implant procedure?

That will depend on the specific payer and their policies. Check with the individual payer to verify coverage status.

04

Does Medicare grant prior authorization for services?

No, prior authorizations are not required by traditional Medicare for these procedures. Medicare Advantage plans may require it.

Frequently asked questions

05

What are the four NYHA (New York Heart Association) functional classifications?

The NYHA functional capacity is an estimation of a patient's limitation during physical activity as shown below[10].

- NYHA I: No limitation of physical activity. Ordinary physician activity does not cause undue fatigue, palpitation, dyspnea (shortness of breath).
- NYHA II: Slight limitation of physical activity. Comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea (shortness of breath).
- NYHA III: Marked limitation of physical activity. Comfortable at rest. Less than ordinary activity causes fatigue, palpitation, or dyspnea.
- NYHA IV: Unable to carry on any physical activity without discomfort. Symptoms of heart failure at rest. If any physical activity is undertaken, discomfort increases.

06

Is a heart failure diagnosis required on ICD procedures?

Yes, for primary prevention Medicare requires a heart failure diagnosis to be reported as a secondary diagnosis[11].

07

Are there any exceptions for the waiting period?

The Medicare NCD has specific exceptions for the waiting period after an intervention. They are when a patient qualifies for both a pacemaker and defibrillator or when a generator is being changed out[12].

Source: https://www.heart.org/en/health-topics/heart-failure/what-is-heart-failure/classes-of-heart-failure

For additional information, please contact

Reimbursement customer support

Visit our website:
Medtronic.com/crhfreimbursement

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1-866-877-4102

References

[1] CMS National Coverage Determination 20.4: IMPLANTABLE AUTOMATIC DEFIBRILLATORS. Available at: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=110&ncdver=5&bc=0. Accessed January 17, 2024.

[2] Bardy GH, Lee KL, Mark DB, et al. Amiodarone or an implantable cardioverter-defibrillator for congestive heart failure. [Published correction appears in N Engl J Med. May 19, 2005;352(20):2146.] N Engl J Med. January 20, 2005;352(3):225-237.

[3] CPT copyright 2023 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

[4] 2024 device-intensive procedure list can be found in Appendix P of the 2024 OPPS final rule. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, 2023, Addendum P.– Device-Intensive Procedures for CY 2024. Available at: https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1786-fc. Accessed January 17, 2024.

[5] 2024 ICD-10-CM https://www.cms.gov/medicare/icd-10/2024-icd-10-cm

[6] The CMS ICD-10-Clinical Concepts for Cardiology file can be found at: https://www.cms.gov/

[7] The Medicare Physician Fee Schedule (MPFS) 2024 National payment rates based on information published in the MPFS final rule CMS-1784-F that was released November 2, 2023. PFS Federal Regulation Notices. cms.gov https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1784-f Accessed December 13, 2023. PFS Relative Value Files. cms.gov https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files. 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.

[8] The OPPS 2024 National payment rates based on information published in the OPPS/ASC final rule CMS-1786-FC and corresponding Addendum B table which was released on November 2, 2023. Hospital Outpatient Regulations and Notices. cms.gov. https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1786-fc Accessed November 21, 2023. 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.

[9] The IPPS FY 2024 National payment rates based on information published in the IPPS final rule CMS-1771-F2 and corresponding tables and data files which was published on November 3, 2022. IPPS Final Rule Home Page. cms.gov https://www.cms.gov/medicare/medicare-fee-service-payment/acuteinpatientpps/ipps-regulations-and-notices/cms-1739-f Accessed August 5, 2023. 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.

[10] American Heart Association. (2017, May 8). Classes of heart failure. https://www.heart.org/en/health-topics/heart-failure/what-is-heart-failure/classes-of-heart-failure

[11] CMS. (2021, August 21). SE20006 NCD 20.4 Implantable Cardiac Defibrillators (ICDs). https://www.cms.gov/files/document/se20006.pdf

[12] CMS. (2018, February 15). NCD - Implantable automatic defibrillators (20.4). https://www.cms.gov/medicare-coverage database/view/ncd.aspx?ncdid=110&ncdver=4&bc=0

[13] American Medical Association. (2021). ICD-10-CM 2022 the complete official codebook with guidelines.

[14] 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 January 4, 2023.

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