INTRODUCTION
An insertable loop recorder (ILR) is a subcutaneously placed device that continuously records the electrocardiographic rhythm triggered automatically by rapid and slow heart rates or by the patient during a symptomatic episode. Procedures or services related to these devices are reported using the procedure codes for subcutaneous cardiac rhythm monitors. This guide is intended to answer frequently asked questions regarding coverage, coding, and payment for services related to the Reveal LINQ™ device.

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Please contact Cardiac Rhythm & Heart Failure Reimbursement Services for further information:
Website: www.Medtronic.com/crhfreimbursement
Phone: 866-877-4102 (M-F, 8:00 a.m. to 5:00 p.m. CT)
Email: rs.healthcareeconomics@medtronic.com
CODING AND PAYMENT

1. What are the correct CPT® codes to use for the insertion and removal of the Reveal LINQ?
A: Starting in 2019, new codes and descriptors replace the previous codes and language to reflect evolving nomenclature for cardiac monitoring devices (also referred to as implantable loop recorders or ILRs). The table below lists the CPT codes for insertion and removal of the Reveal LINQ.

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>33285</td>
<td>Insertion, subcutaneous cardiac rhythm monitor, including programming</td>
</tr>
<tr>
<td>33286</td>
<td>Removal, subcutaneous cardiac rhythm monitor</td>
</tr>
</tbody>
</table>

2. What CPT code should be reported when the Reveal LINQ requires repositioning?
A: There is no specific CPT code that describes repositioning a Reveal LINQ. The provider may consider billing CPT 33999 (Unlisted procedure, cardiac surgery) and then must submit a description of the procedure that was performed. The payer will determine coverage.

3. How is the Reveal LINQ payment for outpatient hospital and physician services affected when more than one procedure is performed during the same episode of care/date of service?
A: Hospital Outpatient Payment: Medicare reimburses device-intensive procedures performed in the hospital outpatient setting using Comprehensive Ambulatory Payment Classifications (C-APCs). Under C-APCs, if two procedures designated by Medicare as included in C-APCs are performed concurrently, the procedure with the highest-weighted C-APC will be paid to the hospital. C-APCs package all supplies and services during that episode into one single payment.

Example: If an AF ablation and Reveal LINQ implant are both performed, only one C-APC will be paid to the hospital. In this case, the AF ablation procedure will be paid, as it is the higher-weighted procedure. The cost of inserting the Reveal LINQ is then included in this single payment.

Physician Payment: Medicare physician payment is determined using the multiple procedure reduction rule. For concurrent procedures, the physician will be paid the full amount for the highest-weighted procedure and will be paid at 50% of the fee schedule amount for all additional procedures. For an AF ablation and a Reveal LINQ insertion, for example, the AF ablation will be paid at 100% and the Reveal LINQ insertion will be paid at 50%.

GLOBAL SURGICAL PERIOD

4. What is the global surgical period associated with the Reveal LINQ insertion and removal codes?
A: The insertion and removal codes have a global period of 000 days (minor surgical procedures). Previous codes had 090-day global periods (major surgical procedures). Removal of the global period means that physician coding and payments will no longer be impacted depending on order of procedure when a LINQ insertion occurs around the time of another service (e.g., ablation).
CREDENTIALING

5. Can non-physician practitioners (NPPs), such as nurse practitioners (NPs) and physician assistants (PAs), perform Reveal LINQ insertion & removal procedures?

A: Prior to 2019, Medicare did not cover ILR or subcutaneous cardiac rhythm monitor insertion or removal procedures when performed by an NPP due to their classification as major surgical procedures. On or after January 1, 2019, CMS may cover an insertion/removal when performed by an NPP if the following criteria are all fulfilled:

- The procedure is within the scope of practice of the license for the state in which the NPP practices.\(^4\)
- Payer rules must be followed. Payers may allow insertions by NPPs, and the NPP needs to research each payer to obtain policy requirements, supervision rules, and the approval process.
- The NPP must meet the credentialing and supervision requirements at the location where the implant will occur.
- Also consider whether malpractice insurance covers the NPP for performing insertion/removal procedures.

PLACE OF SERVICE

6. What places of service can receive payment for a Reveal LINQ insertion or removal?

A: Reveal LINQ insertions and removals may receive payment in the following settings\(^2,3,5,6\):

- Ambulatory surgical center (ASC)
- Hospital inpatient
- Hospital outpatient
- Physician office (beginning January 1, 2019)

7. What place of service (POS) codes are used to identify the implant site on the physician and ASC claim form?

A: Applicable POS service codes and their associated Medicare fee schedules are listed in the table below.

<table>
<thead>
<tr>
<th>SETTING</th>
<th>POS CODE</th>
<th>MEDICARE FEE SCHEDULE (TECHNICAL COMPONENT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office</td>
<td>11</td>
<td>Medicare Physician Fee Schedule (PFS)</td>
</tr>
<tr>
<td>Off-campus — Outpatient Hospital</td>
<td>19</td>
<td>Excepted: Outpatient Prospective Payment System (OPPS) Non-excepted: 40% of OPSS</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>21</td>
<td>Inpatient Prospective Payment System (IPPS)</td>
</tr>
<tr>
<td>On-campus — Outpatient Hospital</td>
<td>22</td>
<td>Outpatient Prospective Payment System</td>
</tr>
<tr>
<td>Ambulatory Surgical Center</td>
<td>24</td>
<td>ASC Fee Schedule</td>
</tr>
</tbody>
</table>
Ambulatory Surgical Center (ASC)

8. Do payers allow Reveal LINQ to be inserted or removed in an ASC?
A: Yes. Medicare maintains a list of approved ASC services by CPT code that is reviewed on an annual basis. Most commercial payers also allow Reveal LINQ insertion and removal procedures in an ASC.5

9. How is an ASC defined? What makes a facility an ASC?
A: An ASC is a distinct entity that operates exclusively to provide surgical services to patients not requiring hospitalization and has an agreement with CMS to participate in the Medicare program as an ASC.5

10. How does Medicare physician payment vary when the Reveal LINQ insertion is performed at a hospital or ASC?
A: The physician receives the same payment for their professional service regardless of the location where the insertion or removal procedure is performed.3

11. How do ASC payments for Reveal LINQ procedures compare to hospital outpatient payments?
A: Medicare ASC payments follow rules like those for hospital outpatient payments and include a geographic adjustment. ASC payments are generally less than the Medicare hospital outpatient rates. Rate files are available from the Medicare contractor where the ASC is located.5

Hospital

12. In the hospital setting, can the implant be performed somewhere other than an operating room or EP lab?
A: Each hospital must make an individual decision regarding where to insert or remove a Reveal LINQ device, considering patient safety and requirements/processes for tracking revenue and expense. Hospitals have definitive processes to determine these aspects of a procedure:
- Approval by the hospital’s medical administration and finance department
- State credentialing rules
- Compliance with accreditation received by the hospital

Physician Office

13. When an insertion takes place in a office, how is the office reimbursed for the cost of the device?
A: The device cost is included in the global Medicare PFS amount paid to the office for the insertion procedure.

14. Is there a separate code I need to report for the device when the insertion is performed in the office?
A: There is no additional or separate code reported for the device itself when the insertion procedure is performed in the office. HCPCS c-codes are only used by the hospital outpatient department.
15. What CPT codes are used to describe monitoring for the Reveal LINQ?
A: CPT codes that describe monitoring for a subcutaneous cardiac rhythm monitor are listed in the table below.¹

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
| 93285    | Programming and Interrogation Evaluation Services  
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 |
| 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 |

Remote Interrogation Evaluation Services

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>93298</td>
<td>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</td>
</tr>
<tr>
<td>93299</td>
<td>Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system or subcutaneous cardiac rhythm monitor system, remote data acquisition(s), receipt of transmissions and technician review, technical support, and distribution of results</td>
</tr>
</tbody>
</table>

16. What is the minimum number of days that the Reveal LINQ patient needs to be in the remote monitoring program for the services (professional component, technical component) to be billable?
A: The patient must be monitored for a minimum of 10 of a 30-day monitoring period to meet services.¹

17. Reveal LINQ has a summary report for a 30-day remote episode. May the summary report be used as a billing document?
A: The summary report is not sufficient as a billing document; however, it may be used as documentation to support that the patient met the required minimum of 10 days of monitoring during the 30-day period.

18. How frequently can the 30-day remote monitoring codes be billed?
A: The professional (93298) and technical (93299) components of the service may not be billed more than every 31 days. Local Medicare Administrative Contractors (MACs) and commercial payers may have more specific rules about dates of service and billing. Contact the payer for further instructions.¹

19. What are the differences between interrogation and programming evaluation?
A: CPT language¹ specifies that both interrogation and programming services require evaluation of all device parameters. In addition, during programming evaluation, iterative adjustments provide information that allows for the selection of the most appropriate final program parameters to provide for consistent delivery of the appropriate therapy and to verify the efficiency and function of the device. The final program parameters may or may not change after evaluation.

For a subcutaneous cardiac rhythm monitor, often but not always, the tachycardia and bradycardia detection criteria will be adjusted during programming evaluation.
20. Why are the remote interrogation services for subcutaneous cardiac rhythm monitors reported once per 30 days while in-person programming services are reported per patient encounter?
A: Conceptually, programming should only be performed and billed when medically necessary. In a stable patient, this could be as little as once per year. Of course, if the situation demands and the patient is clinically indicated, they could receive programming services more often. In contrast, interrogation services are meant for the clinically stable patient who requires more routine monitoring to demonstrate adequate, continued, and safe device function. The payer will always determine coverage based on documented medical necessity.

21. If the automatic transmission is received and the physician or NPP does not review this information for a few days, what date of service should be submitted on the claim?
A: There is no current guidance from Medicare (CMS) regarding what date of service should be used when billing remote services. However, some local Medicare contractors have provided guidance. The local MAC should be contacted for their specific contractor policy. It is important to develop a consistent method of billing to ensure that each episode of care has a period of 30 days before it is billed.

22. For Medicare patients, what is the coinsurance responsibility for Reveal LINQ monitoring?
A: The Medicare beneficiary is responsible for a 20% coinsurance payment for hospital outpatient and physician office device monitoring, for both the technical and professional services. A patient deductible may also apply in addition to the coinsurance amount if the patient’s deductible has not been met for the year.

23. Is there a way to bill additionally for each CareLink™ alert during a remote monitoring period?
A: No, remote monitoring codes are time-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.

24. How is billing affected if the patient receives an in-person interrogation evaluation during a 30-day remote monitoring period?
A: In-person interrogation services are not separately reportable during the same period when remote monitoring is being performed. Only the remote monitoring service is billable (CPT code 93298 for the professional service and 93299 for the technical service).

25. How is billing affected if the patient receives an in-person programming evaluation during a 30-day remote monitoring period?
A: When an in-person programming evaluation is performed during the remote 30-day episode, the programming evaluation may be separately billed. The payer will determine coverage based on documented medical necessity.

26. What components of a subcutaneous cardiac rhythm monitor must be evaluated during interrogation evaluation services?
A: The required components are the same for both remote and in-person interrogation:
- All programmed parameters
- Heart rate and rhythm during recorded episodes from both patient-initiated and device algorithm-detected events, when present
SUPERVISION REQUIREMENTS

27. What type of supervision does Medicare require when performing monitoring services for Reveal LINQ?
A: The Medicare PFS defines the type of supervision required for a diagnostic test, which is listed in the table below.³

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-person programming</td>
<td>Direct supervision by a physician (the physician must be in the suite/office when the test is being performed)</td>
</tr>
<tr>
<td>or interrogation</td>
<td></td>
</tr>
<tr>
<td>Remote monitoring</td>
<td>General supervision, which means there must be physician oversight of the monitoring program</td>
</tr>
</tbody>
</table>

28. Can an NPP serve as a supervisor for in-person Reveal LINQ monitoring?
A: No. Medicare diagnostic testing rules state that the supervisor must be a physician. If an NPP performs the service, the NPP may bill the service with his/her own billing number, provided state licensure allows it. The NPP may NOT supervise a technician, nurse, or other office staff for in-person monitoring services.³

29. Should the submitted claim include the billing number of the physician who was the supervisor in the office when the monitoring service was performed?
A: No. Under Medicare diagnostic testing rules, the physician who reads the report bills for the service. The practice should keep a schedule to document the physician supervisor for the date of service when the in-person monitoring was performed. Note the difference between these and alternative incident to billing rules that govern how to report evaluation and management (E/M) services.⁸

PROFESSIONAL AND TECHNICAL COMPONENTS

30. What is the definition of the technical and professional component for device monitoring?
A: See the definitions for each component in the table below.

<table>
<thead>
<tr>
<th>SERVICE COMPONENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical Component (TC)</td>
<td>- All non-physician work, and includes administrative personnel and capital (equipment and facility) costs, and related malpractice expenses.</td>
</tr>
<tr>
<td></td>
<td>- For remote services, the TC includes remote data acquisition(s), receipt of transmissions and technician review, technical support, and distribution of results.</td>
</tr>
<tr>
<td>Professional Component (PC or “26”)</td>
<td>Physician's work interpreting a diagnostic test or performing a procedure and includes indirect practice and malpractice expenses related to that work.</td>
</tr>
</tbody>
</table>

31. How does a practice bill when an industry representative provides the technical component of an in-person service?
A: The practice bills only the professional component (93285 or 93291) by appending modifier “-26” on the professional claim form.⁹
32. How does a hospital clinic or a provider-based office bill for device monitoring?
A: The table below outlines how a hospital (inpatient, outpatient, or clinic) or a provider-based department may bill for monitoring.¹

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>MODIFIER</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-person programming or interrogation</td>
<td>-26</td>
<td>The physician or non-physician practitioner (NPP) bills the professional component of the service. The professional claim (billing the professional component) includes the appropriate place of service (POS) code on the claim.</td>
</tr>
<tr>
<td>N/A</td>
<td></td>
<td>The hospital or provider-based department bills the technical component (TC) of the service.</td>
</tr>
<tr>
<td>Remote monitoring</td>
<td>N/A</td>
<td>The hospital or provider-based department bills the CPT code for the professional component on a professional claim with the appropriate POS.</td>
</tr>
<tr>
<td>N/A</td>
<td></td>
<td>The hospital bills the CPT code for the technical component (TC) of the outpatient service.</td>
</tr>
</tbody>
</table>

33. Who bills the professional component if the technical component is provided by a commercial company such as an Independent Diagnostic Testing Facility (IDTF)?
A: If the technical component of the claim is provided by an IDTF, the physician or NPP bills the professional component of the service only along with the appropriate place of service code.¹⁰

34. The remote technical component for the Reveal LINQ (CPT code 93299) is contractor-priced. How does that affect payment?
A: Codes that are contractor-priced do not have assigned relative value units (RVUs) in the Medicare PFS and therefore payment for these services is determined by the local MAC and varies throughout the country. There is, however, identified payment (assignment to an Ambulatory Payment Classification or [APC]) for 93299 in the hospital outpatient setting.³

35. Why are there no RVUs in the physician fee schedule for the technical component CPT 93299?
A: Medicare (CMS) does not assign RVUs for services that are contractor-priced.³
References

1. AMA 2019 CPT Professional Codebook.
7. Publication 100-01 Medicare General Information, Eligibility and Entitlement Manual, Chapter 1 can be found at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c01.pdf
Brief Statement

Indications

The Reveal LINQ™ LQN11 Insertable Cardiac Monitor and Patient Assistant

The Reveal LINQ Insertable Cardiac Monitor is an implantable patient-activated and automatically 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 specifically been tested for pediatric use.

Patient Assistant

The Patient Assistant is intended for unsupervised patient use away from a hospital or clinic. The Patient Assistant activates the data management feature in the Reveal LINQ Insertable Cardiac Monitor to initiate recording of cardiac event data in the implanted device memory.

Contraindications

There are no known contraindications for the implant of the Reveal LINQ Insertable Cardiac Monitor. However, the patient’s particular medical condition may dictate whether or not a subcutaneous, chronically implanted device can be tolerated.

Warnings/Precautions

Reveal LINQ LQN11 Insertable Cardiac Monitor

Patients with the Reveal LINQ Insertable Cardiac Monitor should avoid sources of diathermy, high sources of radiation, electrosurgical cautery, external de brillation, 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 precautions manual. MRI scans should be performed only in a specified MR environment under specified conditions as described in the Reveal LINQ MRI Technical Manual.

Patient Assistant

Operation of the Patient Assistant near sources of electromagnetic interference, such as cellular phones, computer monitors, etc., may adversely affect the performance of this device.

Potential Complications

Potential complications include, but are not limited to, device rejection phenomena (including local tissue reaction), device migration, infection, and erosion through the skin.

See the device manual for detailed information regarding the implant procedure, indications, contraindications, warnings, precautions, and potential complications/adverse events. For further information, please call Medtronic at 1-800-328-2518 or consult the Medtronic website at medtronic.com.

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The Medtronic MyCareLink™ patient monitor and the Medtronic CareLink™ network are indicated for use in the transfer of patient data from Medtronic implantable cardiac devices. These products are not a substitute for appropriate medical attention in the event of an emergency. Data availability and alert notifications are subject to internet connectivity and access, and service availability. The MyCareLink patient monitor must be on and in range of the device. Alert notifications are not intended to be used as the sole basis for making decisions about patient medical care.

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Medtronic MyCareLink™ Patient Monitor, Medtronic CareLink™ Network and CareLink™ Mobile Application.

Intended Use

The Medtronic MyCareLink patient monitor and CareLink network are indicated for use in the transfer of patient data from some Medtronic implantable cardiac devices based on physician instructions and as described in the product manual. The CareLink mobile application is intended to provide current CareLink network customers access to CareLink network data via a mobile device for their convenience. The CareLink mobile application is not replacing the full workstation, but can be used to review patient data when a physician does not have access to a workstation. These products are not a substitute for appropriate medical attention in the event of an emergency and should only be used as directed by a physician. CareLink network availability and mobile device accessibility may be unavailable at times due to maintenance or updates, or due to coverage being unavailable in your area. Mobile device access to the internet is required and subject to coverage availability. Standard text message rates apply.

Contraindications

There are no known contraindications.

Warnings and Precautions

The MyCareLink Patient Monitor must only be used for interrogating compatible Medtronic implantable devices.

See the device manual for detailed information regarding the instructions for use, indications, contraindications, warnings, precautions, and potential complications/adverse events. For further information, please call Medtronic at 1-800-929-4043 and/or consult the Medtronic website at medtronic.com.

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