REIMBURSEMENT AND HEALTH POLICY IMPLANT AND MONITORING FREQUENTLY ASKED QUESTIONS

Core Devices:
Pacemakers (PM)
Implantable Cardioverter-defibrillators (ICD)
Cardiac Resynchronization Therapy (CRT)

Medtronic

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INTRODUCTION

An implantable pacemaker (PM) helps control abnormal heart rhythms, such as a slow heart rate. An implantable cardioverter-defibrillator (ICD) is implanted to treat tachyarrhythmias. A cardiac resynchronization therapy (CRT) device synchronizes the rhythm of the right and left ventricles.

This guide is intended to answer frequently asked questions regarding coding, coverage, and payment for PMs, ICDs, and CRT devices, and related procedures/services. This document is to be used as a guideline only.

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IMPLANT/EXPLANT

CORE DEVICES

Q1: What is the CPT®[1] code to use for a system (generator and applicable lead[s]) transvenous implant of an implantable pacemaker (PM) or defibrillator (ICD)?

The codes are listed in the table below.

Insertion of Pacemaker or Implantable Defibrillator System

CPT®[1] Code	Description
33206	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial
33207	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular
33208	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular
33249	Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber

Q2: What is the CPT®[1] code to use for the insertion of an implantable PM or ICD generator when the patient has existing lead(s) when no new leads are placed?

The codes are listed in the tables below.

Insertion of Pacemaker (Generator Only)

CPT®[1] Code	Description
33212	Insertion of pacemaker pulse generator only; with existing single lead
33213	Insertion of pacemaker pulse generator only; with existing dual leads
33221	Insertion of pacemaker pulse generator only; with existing multiple leads

Insertion of Implantable Defibrillator (Generator Only)

CPT®[1] Code	Description
33240	Insertion of defibrillator pulse generator only; with existing single lead
33230	Insertion of defibrillator pulse generator only; with existing dual leads
33231	Insertion of defibrillator pulse generator only; with existing multiple leads

Q3: How are implantable PM or ICD generator replacements coded?

Implantable PM and ICD generator replacements are coded using the PM or ICD remove and replace codes. The codes are used when the same type (PM or ICD) generator is removed and replaced with the same type generator; the number of chambers in the removed device has no impact on the code choice. The code is selected based on the number of active leads attached to the new generator, including an existing or newly placed left ventricular (LV) lead.

Generator Remove and Replace Codes for Pacemakers

CPT®[1] Code	Description
33227	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system
33228	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system
33229	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system

Generator Remove and Replace Codes for Implantable Defibrillators

CPT®[1] Code	Description
33262	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; single lead system
33263	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system
33264	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system

Q4: When are the codes used that describe removal of a generator only, and placement of a generator only, for both implantable PMs and ICDs?

There are instances when the patient's condition, such as when a generator is changed from one type to another type, or when an ICD system is downgraded to a PM system.

Example: The physician removes the ICD generator and inserts a new dual chamber PM generator. The defibrillator lead is deactivated and the right atrial (RA) and right ventricular (RV) pacing leads are connected to the newly implanted PM generator.

The table below lists the CPT®[1] codes that are appropriate to use when removing an ICD generator and inserting a dual chamber PM generator (no new leads are placed).

Example: Removal of ICD Generator and Insertion of PM Generator

CPT®[1] Code	Description
33241	Removal of implantable defibrillator pulse generator only
33213	Insertion of pacemaker pulse generator only; with existing dual leads

Q5: What are the CPT® codes to use when removing an implantable PM or ICD generator and then inserting a new generator and a right ventricular (RV) or right atrial (RA) lead? The physician did not remove any leads.

Example: An ICD generator is removed; a replacement dual chamber ICD generator is inserted and the physician connects a new RV defibrillator lead to the replacement generator.

The table below lists the CPT®[1] codes for removing an ICD generator, inserting a new RV defibrillator lead and a replacement dual chamber (ICD) generator.

Example: Removal and Replacement of ICD Generator and Insertion of RV Lead

CPT®[1] Code	Description
33241	Removal of implantable defibrillator pulse generator only
33249	Insertion or replacement of permanent implantable defibrillator system with transvenous lead(s), single or dual chamber

Q6: What are the CPT®[1] codes for the removal of a right atrial (RA) or right ventricular (RV) lead and the insertion of a new RA or RV lead into the existing implantable PM or ICD?

The table below lists the CPT® codes for removing an RA or RV lead and then inserting a new RA or RV lead into an existing PM or ICD.

Removal and Replacement of an RA or RV Lead

CPT®[1] Code	Description
Pacemaker Removal RA or RV Lead Code Options	
33234	Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular
33235	Removal of transvenous pacemaker electrode(s); dual lead system
ICD Removal RA or RV Lead Code	
33244	Removal of single or dual chamber implantable defibrillator electrode(s); by transvenous extraction
RA or RV Lead Replacement Code	
33216	Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator

Q7: What is the CPT®[1] code to use when a lead is capped and not removed?

There is no existing code for capping a lead. It is packaged into the procedure.

Q8: What CPT®[1] code is added for the insertion of a left ventricular (LV) lead when implanting a biventricular PM or ICD system or upgrading a dual chamber PM or ICD system to a biventricular PM or ICD system?

The correct code is the add-on CPT® code +33225: Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator. This add-on code should be listed separately in addition to the code for the primary procedure.[1]

Q9: What CPT® code should be considered when the physician inserts the pacing electrode into the cardiac venous system for left ventricular pacing (LV lead) and then attaches this lead to an existing ICD or PM generator?

Example: The patient was scheduled for a biventricular ICD (CRT-D) implant about four months ago, and due to complications, the physician was unable to place the LV lead. The patient now returns to have the LV lead placed.

Use CPT® code 33224: Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or implantable defibrillator pulse generator (includes revision of pocket, removal, insertion, and/or replacement of existing generator).[1]

Q10: The physician attempts to place a left ventricular (LV) lead during an implant for a biventricular PM or ICD, and is unsuccessful. Should the physician or hospital bill for the attempted LV lead placement? How should this be coded?

Yes, the service may be billed, provided there is documentation in the record that supports the efforts to implant the LV lead and the decision to discontinue the procedure.

For an outpatient procedure;

- The hospital would bill using modifier 74 (discontinued procedure after administration of anesthesia).
- The physician would bill using modifier 53 (discontinued service).

Q11: The implanting physician wants to know if Medicare will reimburse for removing and replacing a pacemaker or defibrillator generator because it "is at ERI."

There are two different terms that are used quite frequently:
ERI: Elective Replacement Indicator
EOS: End of Service

Medicare will reimburse the procedure based on physician-documented medical necessity.[2]

Q12: What CPT®[1] codes may be applicable when inserting or removing PM or ICD leads when the procedure is not performed transvenously?

The table below lists the CPT® codes for inserting or removing PM or ICD leads when the procedure is not performed transvenously. These codes are defined by Medicare (CMS) as "inpatient only" procedures, and therefore cannot be reported on a hospital outpatient claim.[3]

Insertion or Removal of PM or ICD Leads When Procedure Is NOT Performed Transvenously[3]

CPT®[1] Code	Description
33202	Insertion of epicardial electrode(s); open incision (e.g., thoracotomy, median sternotomy, subxiphoid approach
33203	Insertion of epicardial electrode(s); endoscopic approach (e.g., thoracoscopy, pericardioscopy)
33236	Removal of permanent epicardial pacemaker and electrodes by thoracotomy; single lead system, atrial or ventricular
33237	Removal of permanent epicardial pacemaker and electrodes by thoracotomy; dual lead system
33238	Removal of permanent transvenous electrode(s) by thoracotomy
33243	Removal of single or dual chamber implantable defibrillator electrode(s); by thoracotomy

Q13: What CPT® code should be reported when a lead is repositioned?

Consider reporting 33215: Repositioning of previously implanted transvenous PM or ICD, (right atrial or right ventricular) electrode.[1]

Q14: The descriptions for CPT®[1] codes 33222 (PM) and 33223 (ICD) were revised from "skin pocket revision" to "skin pocket relocation." What is the appropriate use of these codes?

The following example and table below lists the appropriate CPT® codes for this patient scenario.

Example: A patient with an infection required that the existing dual chamber ICD generator be removed. This procedure was performed over three months ago, the infection was properly treated, and this past week the physician performed a skin pocket relocation and implanted the replacement generator.

Example: CPT®[1] Coding for ICD Generator Only Insertion and Skin Pocket Relocation

CPT®[1] Code	Description
33230	Insertion of pacing cardioverter-defibrillator pulse generator only; with existing dual leads
33223	Relocation of skin pocket for implantable defibrillator

Q15: What codes should be used for wound care, such as debridement, related to an infected pocket?

CPT® recommends using codes in the Integumentary System (skin) section of the CPT®[1] code book.

Q16: For hospital inpatient procedure coding under ICD-10, is it necessary that the leads and generator are coded separately?

Yes. ICD-10 procedure codes (PCS) utilize specific rules to build codes, including the components of a device. For more detail, see our ICD-10 PCS coding documents.[4]

Q17: What is the appropriate coding for a situation where a patient has a dual chamber PM or ICD and now has a need for a biventricular device to provide cardiac resynchronization therapy (CRT)?

Example: The patient has a dual chamber ICD and, due to worsening heart failure, now requires a CRT-D device (biventricular defibrillator). The existing ICD leads are retained.

The coding rules require using device remove and replace codes when a generator is removed and replaced with the same type of generator, AND there are no new right atrial or ventricular (RA or RV) leads placed. The placement of the left ventricular (LV) lead to accomplish the left ventricular pacing utilizes an add-on code and is coded separately. The resulting system will have three leads.

Example: Upgrade of Dual Chamber ICD to CRT-D

CPT®[1] Code	Description
+33225	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator (e.g., for upgrade to dual chamber system) (List separately in addition to code for primary procedure)
33264	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system

Q18: How is the Medicare payment for outpatient hospital and physician services affected when more than one procedure is performed during the same episode of care?

The payment for the outpatient hospital and physician is outlined below.

Outpatient Hospital: The Medicare payment system currently reimburses device-intensive procedures performed in the hospital outpatient setting using Comprehensive Ambulatory Payment Classifications (C-APCs). Under C-APCs, if two or more procedures, designated by Medicare (CMS) as a C-APC, 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.[5]

Example: If an intracardiac catheter ablation of the atrioventricular (AV) node function and a dual chamber ICD system implant are both performed: Only one C-APC will be paid to the hospital. In this case, the dual chamber ICD system implant will be paid, as it is the higher-weighted procedure. The cost of the intracardiac catheter ablation of the AV node is included in this single payment.

Physician: Medicare physician payment is determined using the multiple procedure rule. For concurrent procedures, the physician will be paid the full Physician Fee Schedule (PFS) amount for the highest-weighted procedure, and 50% of the PFS amount for additional procedures.[6]

MODIFIERS

Q19: Most of the PM and ICD procedure codes (e.g., lead insertions, lead removals, system implants, device replacements) have a 90-day global surgical period. What modifiers might be applicable when the same physician performs a subsequent, additional procedure during the 90-day global surgical period?

The following table lists modifiers which may be used to describe subsequent, additional procedures.

Modifier	Description
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period.
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period.
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period.

IMPLANT/EXPLANT

Q20: PM implant services include a code for an upgrade of a single chamber to a dual chamber pacemaker. What does this code include, and is there a similar code for an ICD upgrade?

An upgrade of a single chamber to a dual chamber PM is coded with CPT®[1] 33214 and includes removal of a previously implanted single chamber generator, insertion of a dual chamber generator, and placement of a right atrial (RA) or ventricular (RV) lead. There is no similar code for ICD upgrades.

Q21: The Pacemaker National Coverage Determination (NCD)[7] was revised and became effective in August 2013. Where do I find the rules for submitting a claim for a pacemaker implant based on the 2013 NCD?

The local Medicare contractors have published local coverage articles that identify the requirements for billing for pacemaker implants. Check with your local contractor for specific billing instructions.

Q22: How do I bill for an MRI scan on a patient who has an MR-conditional PM?

The KX modifier is appended to the MRI procedure code to indicate that the device is MR-conditional. In addition, the ICD-10 diagnosis code Z95.0 (presence of a cardiac pacemaker) must be included on the claim to indicate that the patient has a pacemaker.[8]

Q23: What is the proper way to code for placement of a temporary PM, with probable placement of a permanent pacemaker a few days later?

Code first for the placement of the temporary PM lead: CPT®[1] 33210 for single lead, or 33211 for dual leads. Check with the specific payer to confirm rules for use of the temporary pacemaker codes when a new pacemaker is inserted within a few days.

LEADLESS PACEMAKERS

Q24: Is there a coverage policy addressing the Micra™ Transcatheter Pacing System (TPS)?

Yes. Medicare has implemented a National Coverage Determination (NCD 20.8.4) that addresses coverage for leadless pacemakers. This NCD was implemented August 29, 2017 for local MAC system edits and January 2, 2018 for shared system edits. This policy can be found at cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm10117.pdf.

Physician and Hospital Outpatient CPT®[1] Codes for Leadless Pacemakers

CPT®[1] Code	Description
33274	Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (e.g., fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming) when performed
33275	Transcatheter removal of permanent leadless pacemaker, right ventricular, including imaging guidance (e.g., fluoroscopy, venous ultrasound, ventriculography, femoral venography) when performed
93279	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 health care professional; single lead pacemaker system or leadless pacemaker system in one cardiac chamber
93286	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead pacemaker system, or leadless pacemaker system
93288	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system, or leadless pacemaker system
93294	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, or leadless pacemaker system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional
93296	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, leadless pacemaker system, or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review technical support and distribution of results

Hospital ICD-10 Procedure Inpatient Codes for Leadless Pacemakers[4]

ICD-10-PCS Code	Description
02HK3NZ	Insertion of Intracardiac Pacemaker into Right Ventricle, Percutaneous Approach
02PA3NZ	Removal of Intracardiac Pacemaker from Heart, Percutaneous Approach

Q25: Is there an HCPCS (C-Code) for Micra™ TPS?

Yes. C1786 — Pacemaker, Single Chamber, Rate-responsive (Implantable) is applicable to Micra™ TPS.[9]

IMPLANTABLE CARDIOVERTER-DEFIBRILLATORS

Q26: Are there different CPT® codes for the insertion of an ICD if the leads are implanted subcutaneously?

Yes. CPT® code 33270: Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed.[1]

Q27: Due to patient instability, the physician did not perform defibrillator for threshold (DFT) testing at the time of the implant. However, the next day, the patient was brought back to the cath lab for threshold testing. How should this be coded?

The DFT procedure should be reported with CPT®[1] code 93642: Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters).[1]

TYRX™ ABSORBABLE ANTIBACTERIAL ENVELOPES

Q28: What is the inpatient hospital procedure code when an implantable device is placed in a TYRX™ envelope?

There are two ICD-10 inpatient hospital procedure codes; one for an open approach and one for a percutaneous approach:

- 3E0102A — Introduction of Anti-Infective Envelope into Subcutaneous Tissue, Open Approach
- 3E0132A — Introduction of Anti-Infective Envelope in Subcutaneous Tissue, Percutaneous Approach

This envelope placement procedure code is reported in addition to the device implant procedure code. There is no additional reimbursement for this procedure.[4]

Q29: A PM or ICD system was implanted with a TYRX™ envelope. What is the CPT®[1] code for placing the generator into the TYRX™ envelope?

There is no applicable CPT® code for the placement of an implantable device into a TYRX™ envelope. The physician should report only the applicable implant code for the PM or ICD system, 33206-33208, 33249.

Q30: What is the HCPCS code for the TYRX™ Absorbable Antibacterial Envelope?

There is no applicable HCPCS code for this product.

CORE DEVICES

Q31: What CPT®[1] codes are used to report monitoring of pacemakers and implantable defibrillator devices?

The rhythm-related monitoring codes for PMs, ICDs, and CRT devices are included in the tables below. See the heart failure section for monitoring codes applicable to physiologic data elements (non-rhythm related).

Monitoring for Pacemakers

CPT®[1] Code	Description
Transvenous Leads PMs	
93279	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 health care professional; single lead pacemaker system or leadless pacemaker system in one cardiac chamber
93280	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 health care professional; dual lead pacemaker system
93281	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 health care professional; multiple lead pacemaker system
93288	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system or leadless pacemaker system
93294	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system or leadless pacemaker system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional
93296	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system leadless pacemaker system, or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results

Monitoring for Implantable Defibrillators

CPT®[1] Code	Description
Transvenous Leads ICDs	
93282	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 health care professional; single lead transvenous implantable defibrillator system
93283	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 health care professional; dual lead transvenous implantable defibrillator system
93284	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 health care professional; multiple lead transvenous implantable defibrillator system
93289	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead transvenous implantable defibrillator system, including analysis of heart rhythm derived data elements
92395	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional
93296	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system leadless pacemaker system, or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results
Subcutaneous Leads	
93260	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 health care professional; implantable subcutaneous lead defibrillator system
93261	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable subcutaneous lead defibrillator system

Q32: For Medicare patients, what is the coinsurance responsibility for implantable PM or ICD device monitoring?

The Medicare beneficiary is responsible for a 20% coinsurance payment for hospital outpatient (this may include services performed in the emergency department) and physician office device monitoring, for both the technical and professional services. For inpatient hospital monitoring, the beneficiary is responsible for the coinsurance on the professional component only.[10]

Q33: If a patient receives a PM or ICD that stores atrial fibrillation (AF) patient data, and is transmitting this data remotely to the physician office or hospital outpatient department for review, may separate codes be billed specifically for the AF monitoring?

No, PM or ICD remote monitoring codes (93294 for PM or 93295 for ICD, and 93296) are billed to identify receipt of transmissions, review, and interpreting this rhythm data from a PM or ICD.

Q34: When should the periprocedural CPT®[1] codes 93286 for a PM or 93287 for an ICD be billed? How should they be billed?

Periprocedural services should be reported when PM or ICD system device settings are evaluated to determine if adjustments to these settings are needed for a patient prior to and/or after a surgery, procedure, or test. Both the pre-testing and post-testing, if performed, may be submitted for payment. The professional component for services performed in the hospital is billed with a -26 modifier. The applicable additional modifier -76 or -77 would also be billed for the second evaluation. These modifiers are defined as:
Modifier 76: Repeat procedure or service by same physician or other qualified health care professional
Modifier 77: Repeat procedure by another physician or other qualified health care professional.

The technical component for these services is packaged. See table below for CPT® code 93286 and 93287 descriptions.

Periprocedural CPT®[1] Codes

CPT®[1] Code	Description
93286	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead pacemaker system
93287	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead implantable defibrillator system

Q35: Is there a National Coverage Determination (NCD) for pacemaker device evaluations?

Yes, the PM device evaluation NCD (20.8.1 and 20.8.1.1) applies for these services. The PM device evaluation NCD speaks to routine monitoring, and thus increased monitoring due to symptoms and issues may be acceptable to bill as long as there is documented medical necessity. The local MAC will determine coverage.[11,12]

Q36: There are some practices that continue to use transtelephonic (TTM) codes for monitoring PMs. The NCD for pacemaker evaluations suggest the frequency of these TTM evaluations. May the TTM code be billed every time these TTM services are performed?

No. TTM monitoring is billed using an episode of care code, which includes all TTM monitoring in a 90-day period.

Q37: All of the defibrillator and pacemaker implant codes have a 90-day global surgical period. Will the physician practice be allowed to bill for monitoring during this global surgical period?

Yes. Medicare classifies device monitoring services as diagnostic tests, and diagnostic tests are not included in the global surgical period.[13]

Q38: Is there a way to separately bill for a CareLink™ alert during a 90-day remote monitoring period?

No. When remote monitoring services are performed, there will be only one payment for the 90-day episode, regardless of the number of times that the data is transmitted and reviewed.

Q39: What is the minimum number of days that a patient with an implantable PM or ICD needs be enrolled in a remote monitoring period during the 90-day period in order for the service to be billable?

The patient must be in the 90-day remote monitoring program period for at least 30 days or the CPT® codes 93294-93296 are not billable.

Q40: If the automatic (remote) transmission from a PM or ICD is received and the physician or non-physician practitioner (NPP), such as a nurse practitioner (NP) or physician assistant (PA), does not review this information for a few days, what date of service (DOS) should be submitted on the claim?

CMS has published guidance on the appropriate date of service to be used on professional claims when reporting cardiac monitoring. The guidance states that the date of service reported for cardiac monitoring is based on the code description and time listed. In situations where the code describes the professional service, CMS states, "The date of service is the date the physician completes that activity." In situations where the code describes the technical service, CMS states, "The date of service is the date the monitoring concludes based on the description of the service." CMS recommends for further information to view the Medicare National Coverage Determination Manual, Chapter 1, Section 20.8.1.1.[14,15]

Q41: If the patient receives an in-person interrogation of their implanted PM or ICD (CPT®[1] codes 93288 [PM] or 93289 [ICD]) and this service is provided during a 90-day remote monitoring period for the implantable device, how does that affect billing?

When an in-person and remote interrogation of the same device during the same 90-day monitoring period is performed, the in-person interrogation should not be billed. Only the remote service is billable (CPT® codes 93294 [PM] or 93295 [ICD], and 93296).

Q42: If the patient receives an in-person programming evaluation of their implanted pacemaker or defibrillator (CPT®[1] codes 93279-93281 [PM] or 93282-93284 [ICD] depending on the number of active leads, and this service is during a 90-day remote monitoring period for the implanted pacemaker or defibrillator, how does that affect billing?

When an in-person programming evaluation is performed during the remote 90-day episode, the programming evaluation does not impact the 90-day monitoring period and may be separately billed.

HEART FAILURE

Q43: What CPT®[1] code should be reported for a heart failure (HF) patient when the physician reviews the heart failure parameters from the patient's defibrillator?

If the implanted defibrillator stores at least one physiologic data element (non-rhythm related), such as intrathoracic impedance (OptiVol™ monitoring) to assist with HF monitoring, and the patient is in person, then CPT® code 93290 is appropriate. If the patient is transmitting remotely, then the implantable cardiovascular monitor (ICM) CPT® codes may be reported. See table below.

Implantable Cardiovascular Monitor (ICM) CPT®[1] Codes

CPT®[1] Code	Description
93290	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors
93297	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional
G2066	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, implantable loop recorder system, or subcutaneous cardiac rhythm monitor system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results

Q44: What is the appropriate coding if the rhythm PM or ICD remote monitoring is running concurrently with the HF management remote monitoring (ICM), and the same practice or physician or hospital outpatient clinic is reporting the remote monitoring for both rhythm and physiological (OptiVol™) ICM monitoring?

The codes that apply when both components (professional and technical) are being done together would be 93295 and 93296. Effective January 1, 2020, Medicare created new national correct coding initiative (NCCI) edits that prevented code 93297 from being billed on the same date of service as 93295 and/or 93296. These edits are scheduled to be deleted on July 1, 2020 so that claims with a date of service on or after July 1, 2020 can bill 93297 on the same date of service as 93295 and/or 93296.[16] Medicare implements these edits on a national level.

The NCCI edit files are updated on a quarterly basis, so it is recommended to check with the NCCI files for any updates that may apply.

Q45: The remote technical component (TC) for the Medtronic OptiVol™ monitoring feature (CPT® code G2066) is contractor-priced. How does that affect payment?

Contractor-priced means that the reimbursement for the service is determined by the local MAC for office-based services. These rates vary greatly throughout the country depending on the MAC. For Medicare hospital outpatient (OP) services, there is an identified APC payment for CPT® code G2066.[5,6]

Q46: Why are there no relative value units (RVUs) for the technical component CPT® G2066?

Medicare (CMS) does not assign RVUs for services that are contractor-priced.[6]

ALL DEVICES: SUPERVISION

Q47: What type of supervision does Medicare (CMS) require when performing device monitoring services?

Device monitoring services are diagnostic tests. The Medicare PFS defines the type of supervision required for a diagnostic test, which is listed in the table below.[6]

Supervision Definitions[6]

Service	Description
In-person programming or interrogation	**Direct supervision** by a physician (the physician must be in the suite/office when the test is being performed)
Remote monitoring	**General supervision**, which means there must be physician oversight of the monitoring program

Q48: May an NPP serve as a supervisor for in-person monitoring services?

No. Medicare (CMS) 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.[13]

Q49: Should the submitted claim include the billing number of the physician who was the supervisor in the office when the monitoring service was performed?

No, under Medicare (CMS) diagnostic testing rules, the physician who reads the report may bill 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. This is different than the incident-to rules that govern how to report evaluation and management services.[11]

ALL DEVICES: PROFESSIONAL AND TECHNICAL COMPONENTS

Q50: If the industry representative provides the technical component of an in-person service, how does the practice bill for the service?

It is recommended that the practice bill only the professional component by using modifier -26 on the professional claim form.[17]

Q51: How does a hospital clinic or a provider-based office bill for device monitoring?

The table below outlines how a hospital (inpatient, outpatient, emergency department, or clinic), or a provider-based clinic may bill for monitoring.

Billing for Device Monitoring (Hospital or Provider-based Clinic)

Service	Modifier	Description
In-person programming or interrogation	-26	▪ 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
	N/A	The hospital or provider-based practice bills the CPT® code for the professional component on a professional claim with the appropriate POS
Remote monitoring	N/A	The hospital or provider-based practice bills the CPT® code for the professional component on a professional claim with the appropriate POS
	N/A	The hospital bills the CPT® code for the technical component (TC) of the outpatient service

Q52: Who bills the professional component if the technical component is provided by a commercial company such as an independent diagnostic testing facility (IDTF)?

If the technical component of the claim for remote monitoring is provided by an IDTF, the physician or NPP bills the professional component of the service only, with place of service "office" (POS 11).[18]

OTHER REMOTE MONITORING

Q53: How does a hospital bill for CareLink Express™ services?

It is not appropriate to ever report the technical component when in person or remote interrogation is supported by a Medtronic representative or a Medtronic device monitoring specialist.[13] If the hospital staff reviews the CareLink Express™ interrogation and they meet all of the criteria to report the technical component of in person interrogation, the hospital may consider reporting the appropriate in person interrogation code. They would not use modifiers, as the hospital is inherently only billing the technical component. The professional component would be reported by the physician if/when the physician reads and interprets the report. Please refer to the CareLink™ Mobile Reimbursement Overview document for additional information. It can be found here: https://www.medtronic.com/content/dam/medtronic-com/us-en/hcp/reimbursement/documents/crhf-reimbursement-overview-carelink-express.pdf

Q54: Hospitals want to bill the MyCareLink™ monitor as durable medical equipment. Is that possible?

The MyCareLink™ monitor does not meet the definition for durable medical equipment and may not be billed as such. Furthermore, there is specific instruction from Medicare (CMS) that states that the implant procedure includes a monitoring device (packaged to the implant). Therefore, the MyCareLink™ monitor is not billable to Medicare as a separate line item.[19]

Q55: What dates of service should be used for remote monitoring services?

Remote monitoring is paid based on an episode of care. That episode is described as a period of 90 days for implantable PMs and ICDs, and a period of 30 days for for ICMs and implantable loop recorders (ILRs). The episode is not billed until after the 90 or 30 days is completed, and the date of service should reflect the episode, not an individual professional review of a transmission. Providers need to check with local MACs or private payers to establish what date of service is required.

Q56: Medicare (CMS) is promoting telehealth to help with patient access to care. Is remote monitoring using CareLink™ eligible to be billed to Medicare as a telehealth service?

No. Medicare (CMS) telehealth services are restricted to telehealth codes approved by Medicare (CMS), and the remote monitoring codes are not included in this listing as covered telehealth services. Telehealth also includes various rules regarding location and technical setup that need to be met even when service codes are included on the telehealth approved list.[19]

REFERENCES

[1] CPT codes and descriptions only are ©2019 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.

[2] 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.

[3] Addendum E. identifies the HCPCS Codes that would be Paid Only as Inpatient Procedures. This file is available for download under Related Links and then look for "Addenda": https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1717-FC.

[4] Medicare Hospital Outpatient CY 2016 final rule publication in the Friday, November 13, 2015 Federal Register is at: https://www.gpo.gov/fdsys/pkg/FR-2015-11-13/pdf/2015-27943.pdf.

[5] ICD-10 Procedure Coding System (ICD-10-PCS) files are available at: https://www.cms.gov/Medicare/Coding/ICD10/index.html.

[6] The National Medicare Physician Fee Schedule Relative Value file is at: https://www.cms.gov/Medicare/Medicare-Fee- for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html.

[7] The Medicare National Coverage Determination (NCD) for single and dual chamber pacemaker can be found at: https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=357&ncdver=2&SearchType=Advanced&CoverageSelection=National&NCSelection=NCD%7cMCD&kq=true&bc=IAAAACAAAAAAAA%3d%3d&. The MLN Matters® article announcing MAC discretion when processing claims is available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9078.pdf.

[8] Medicare MRI billing requirements for patients with an MR-conditional implanted pacemaker at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7441.pdf.

[9] Medtronic Cardiac Rhythm and Heart Failure comprehensive coding reference materials are available at: https://www.medtronic.com/us-en/healthcare-professionals/products/cardiac-rhythm/coding-coverage-reimbursement-resources.html.

[10] Publication 100-02 Medicare Benefit Policy Manual, Chapter 15, Section 80-Covered Medical and Other Health Services is available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.

[11] The Medicare NCD for Cardiac Pacemaker Evaluation Services 20.8.1 and 20.8.1.1 can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

[12] Publication 100-04 Medicare Claims Processing Manual, Chapter 12 Physician/NonPhysician Practitioners is available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf.

[13] HRS Coding Guide for Heart Rhythm℠ Society 2016.

[14] Centers for Medicare and Medicaid Services. MLN Matters Article SE17023 (Revised). Released February 1, 2019. Available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE17023.pdf. Accessed March 18, 2020.

[15] Centers for Medicare and Medicaid Services. Medicare National Coverage Determination Manual, Chapter 1: Coverage Determinations, Section 20.8.1.1: Transtelephonic Monitoring of Cardiac Pacemakers. Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_part1.pdf. Accessed March 18, 2020.

[16] CMS.gov. Quarterly PTP and MUE Version Update Changes. Available at https://www.cms.gov/files/zip/quarterly-additions-deletions-and-modifier-indicator-changes-ncci-ptp-edits-physicians-practitioners.zip-0

[17] Publication 100-04 Medicare Claims Processing Manual, Chapter 13, Section 20.1-Professional Component (PC). Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c13.pdf.

[18] Medicare Hospital Outpatient CY 2015 final rule publication page 66822 in the Monday, November 10, 2014. Available at: https://www.gpo.gov/fdsys/pkg/FR-2014-11-10/pdf/2014-26146.pdf.

[19] The list of Medicare-approved telehealth services is available at: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html.

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