An implantable cardiovascular monitoring (ICM) code for OptiVol™ technology is available for heart failure management.

An ICM device collects longitudinal physiologic cardiovascular data elements from one or more internal sensors, such as right ventricular pressure, left atrial pressure, or an index of lung water and/or external sensors, such as blood pressure or body weight, to help with ongoing management of conditions like heart failure.

The CPT® codes reflect ICM interrogations, not programming. Interrogation includes analysis, review(s), and report(s) by a physician or other qualified healthcare professional. The medical necessity for services provided must be documented in the medical record.

The Implantable Cardiovascular Monitor (ICM) device interrogation service can be performed both in person and remotely. The following codes are associated with different service delivery methods:

- **In Person**
  - 93290
  - $42.89 (Global)
  - $20.13 (26)
  - $21.90 (TC)

- **Remote**
  - 93297
  - Professional Analysis
    - Up to 30 Days
    - $26.49 Contractor Priced
  - 93299
    - Remote Data Acquisition and Technical Support
      - Up to 30 Days


Section 1862(a)(1)(A) of the Social Security Act allows coverage and payment for only those services that are considered to be medically reasonable and necessary. The medical necessity for services provided must be documented in the medical record.

Disclaimer
Medtronic provides this information for your convenience only. It does not constitute legal advice or a recommendation regarding clinical practice. Information provided is gathered from third-party sources and is subject to change without notice due to frequently changing laws, rules and regulations. The provider has the responsibility to determine medical necessity and to submit appropriate codes and charges for care provided. Medtronic makes no guarantee that the use of this information will prevent differences of opinion or disputes with Medicare or other payers as to the correct form of billing or the amount that will be paid to providers of service. Please contact your Medicare contractor, other payers, reimbursement specialists and/or legal counsel for interpretation of coding, coverage and payment policies. This document provides assistance for FDA approved or cleared indications. Where reimbursement is sought for use of a product that may be inconsistent with, or not expressly specified in, the FDA cleared or approved labeling (e.g., instructions for use, operator's manual or package insert), consult with your billing advisors or payers on handling such billing issues. Some payers may have policies that make it inappropriate to submit claims for such items or related service.

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2019 Medicare program payments above DO NOT REFLECT a reduction of 2% due to sequester effective for services provided on or after 4-1-2013. This 2% reduction is required by the Budget Control Act (BCA) of 2011, as amended by the American Taxpayers Relief Act of 2012. The 2019 Medicare physician national payment rates reported on the CMS website at https://www.cms.gov/apps/physician-fee-schedule/overview.aspx.
Additional Coding Information:
It is important to refer to the CPT code descriptions in order to ensure that a billed code meets the specific requirements defined for each individual code. You should contact your local Medicare contractor/payer for interpretation of applicable policies. Furthermore, please check the National Correct Coding Initiative (NCCI) edits.

The monitoring period described by these codes includes in person and a 30- or 90-day monitoring period. Remote monitoring codes have separate CPT codes for the professional and technical components. For in person codes, the Global CPT codes comprise the Professional and Technical Components. If both components of care are rendered in an office setting (POS 11), it is not necessary to append a modifier to the code. However, the remote monitoring codes require two different CPT codes to be billed together. One code represents the Professional service and another code represents the Technical service (e.g., CPT 93294 and 93296, 93295 and 93296, 93297 and 93299, and 93298 and 93299) when billing a global service.

The Professional Component reflects physician time and intensity in furnishing the service, including activities before and after direct patient contact. When only the professional component is performed, modifier –26 should be added to the appropriate CPT code to identify the service. The –26 modifier would not be appended if the code represents only the technical component of the CPT code description (e.g., CPT 93294, 93295, 93297, and 93298). The Technical Component refers to the resources used in furnishing the service, such as office rent, wages of personnel, and other office practice expenses. Modifier –TC should be added to the appropriate CPT code when only the technical component is performed. Modifier –TC would not be appended if the CPT code description represents only the technical support and service (e.g., CPT 93296 and 93299).

Physician Supervision Requirements:
Medicare established specific diagnostic test supervision requirements applicable to the technical component of the electronic analysis of implanted cardiac devices. These supervision requirements are in addition to any other Medicare coverage requirements. The Medicare supervision requirements for individual CPT codes are available on the Physician Fee Schedule Lookup function on the Medicare website or under “PFS Relative Value Files” for 2019.

Medicare requires:
- General supervision of the technical component for all remote interrogation services and transtelephonic pacemaker monitoring (codes 93296, 93299, and 93293)
- Direct supervision of the technical component for all in person cardiac device interrogations

Medicare has also indicated that the specific supervision requirements for device monitoring of implanted cardiac devices are inapplicable where the physician is eligible to bill a global CPT code. A CPT code with a professional component modifier (–26) or a specific code that represents the professional component (93294, 93295, 93297, and 93298) for their analysis.

General supervision means the procedure is furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the procedure. Under general supervision, the training of the non-physician personnel who actually performs the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

Direct supervision means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

The Heart Rhythm Society (HRS) released a document which represents their consensus statement on the role of manufacturers’ representatives in the care of patients with heart rhythm disorders. This policy statement also contains HRS’ perspective on appropriate delivery of and billing for the technical component of services associated with cardiac devices. We encourage providers to seek confirmation or clarification from the payer about the policy statement.

For questions or more information, please contact Medtronic at 1-866-877-4102. Cardiac Rhythm Heart Failure (CRHF) reimbursement, customer information is available at www.medtronic.com/crhfreimbursement.