Medtronic

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Please look to device-specific pages for answers to your questions.

Implant and monitoring reimbursement

Frequently asked questions

Pacemakers, implantable cardioverter defibrillators, and cardiac resynchronization therapy

March 2022

Frequently asked questions

This guide has been developed to help answer frequently asked reimbursement questions related to pacemakers, implantable cardioverter defibrillators, and cardiac resynchronization therapy.

Please contact Reimbursement Customer Support for further information:

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Overview

Frequently asked questions

This document is provided to help answer frequently asked coding and coverage questions for the following therapies:

- Pacemakers
- Implantable cardioverter defibrillators
- Leadless pacemakers
- Device monitoring (including remote monitoring)

Click on the topics above to be brought to the device-specific reimbursement webpages.

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Pacemaker & ICD procedures

Implant/Explant

01 What is the CPT®[1] code for the implantation of a transvenous implantable pacemaker (PM) or defibrillator (ICD) system (generator and applicable lead[s])?

The code options are listed in the table below.

CPT®[1] code	Description
Insertion of pacemaker	
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

CPT®[1] code	Description
Implantable defibrillator system	
33249	Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s); single or dual chamber

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Pacemaker & ICD procedures

Implant/Explant

02 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 combination 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.

CPT®[1] code	Description
Generator remove and replace codes for pacemakers	
33227	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system
33228	Removal of permanent 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

CPT®[1] code	Description
Generator remove and replace codes for implantable defibrillators	
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

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Pacemaker & ICD procedures

Implant/Explant

03 What is the CPT®[1] code for the insertion of a transvenous implantable PM or ICD generator when the patient has existing lead(s) and no new leads are placed?

Example: The patient had existing generator removed due to infection. On a separate date of service, the patient comes in for generator placement using existing leads. (Note: for generator change-outs, see Q2 above.)

The tables below contain CPT®[1] code options that apply to initial insertion of transvenous implantable PM or ICD generator only and connecting to existing leads.

CPT®[1] code	Description
Insertion of pacemaker (generator only)	
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

CPT®[1] code	Description
Insertion of implantable defibrillator (generator only)	
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

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Pacemaker & ICD procedures

Implant/Explant

04 What are the codes used when downgrading an ICD to a PM when only the generators are changed?

In this scenario there would be a combination of two codes reported. One for the removal of the ICD generator and another for the placement of the new PM generator.

Below is an example of the codes reported for this scenario.

CPT®[1] code	Description
Removal of ICD generator and insertion of new dual PM generator	
33241	Removal of implantable defibrillator pulse generator only
33213	Insertion of pacemaker pulse generator only; with existing dual leads

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Pacemaker & ICD procedures

Implant/Explant

05 What are the CPT®[1] 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 implants and 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 lead and a replacement dual chamber (ICD) generator.

CPT®[1] code	Description
Example: Removal and replacement of ICD generator and insertion of RV lead	
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

06 Is there a CPT®[1] code to use when a lead is capped and not removed?

There is no code for capping a lead. It is considered part of the procedure and not reported separately.

07 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®[1] 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]

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Pacemaker & ICD procedures

Implant/Explant

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

In this scenario, both the removal and insertion are reported separately. The table below lists the CPT®[1] codes for removing an RA or RV lead and the inserting a new RA or RV lead into an existing PM or ICD.

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 placement code	
33216	Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator

09 What CPT®[1] 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®[1] code 33224: Insertion of a 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]

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Pacemaker & ICD procedures

Implant/Explant

10 What CPT®[1] code is reported 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®[1] 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 reported in addition to the code for the primary procedure.

11 Our implanting physician wants to know if Medicare will reimburse for removing and replacing a pacemaker or defibrillator generator before it reaches ERI.

There are two different terms that are used quite frequently:

- ERI: Elective Replacement Indicator
- EOS: End of Service

Medicare does not have any policies that specify requirements for replacement procedures. The payer will determine coverage based on physician-documented medical necessity.[2]

12 What CPT®[1] code should be reported when a RA or RV lead is repositioned?

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

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

The CPT®[1] codes 33222 and 33223 can only be used when a new pocket is created. They should not be used when enlarging the skin pocket only.

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Pacemaker & ICD procedures

Implant/Explant

14 What CPT®[1] codes may be applicable for epicardial lead placement and removal?

The table below lists the CPT®[1] codes for inserting or removing epicardial leads. These codes are classified by Medicare as "inpatient only" procedures, and therefore cannot be reported on a hospital outpatient claim.[3]

CPT®[1] code	Description
Insertion or removal of epicardial lead(s)	
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

15 What codes should be used for procedures related to an infected pocket, such as debridement?

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

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Pacemaker & ICD procedures

Implant/Explant

16 What is the appropriate coding when a patient has a dual chamber PM or ICD and now has a need for 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 removal and replacement 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.

CPT®[1] code	Description
Example: Upgrade of dual chamber ICD to CRT-D	
33264	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system
+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)

17 PM implant services include a code for an upgrade of a single chamber to a dual chamber pacemaker. Is there a similar code for an ICD upgrade?

There is not a CPT®[1] code that describes the upgrade of a single ICD to a dual ICD as there is for pacemakers.

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Pacemaker & ICD procedures

Implant/Explant

18 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-APC, 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.[4]

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 catheters ablation of the AV node is included in this single payment.

Physician: Medicare physician payment is determined using the multiple procedure payment reduction rule. When multiple procedures are performed on the same date of service, the highest weighted procedure is reimbursed at 100% and the other procedure would be reimbursed at 50%.

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

At the time of the placement of the temporary PM lead report code: CPT®[1] 33210 for a single lead, and 33211 for dual leads. When the temporary PM is removed when the permanent PM is placed there is no code for the temporary removal and only the placement of the permanent PM is reported. Check with individual payers for specific coverage criteria.

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Pacemaker & ICD procedures

Modifiers

20 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 there is 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
Modifiers for PM and ICDs	
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

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Pacemaker & ICD procedures

TYRX™ - absorbable antibacterial envelope

TYRX™

is an absorbable antibacterial envelope designed for use with cardiac implantable electronic devices (CIEDs), including implantable cardioverter defibrillators (ICDs) and pacemakers.

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

3E0102A – Introduction of anti-infective envelope into subcutaneous tissue, open approach. This envelope placement procedure code is reported in addition to the device implant procedure. There is no additional reimbursement for this procedure.[5]

22 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 CPT®[1] 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.

23 What is the HCPCS code for the TYRX™ absorbable antibacterial envelope?

There is no applicable HCPCS code for this product.

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Leadless pacemaker procedures

Micra™

is a transcatheter pacing system and the world's smallest pacemaker, delivered percutaneously via a minimally invasive approach without the use of leads.

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

Yes, Medicare established a National Coverage Determination (NCD 20.8.4) on January 18, 2017 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. The policy can be found here and the claim processing instructions can be found here.

Under the NCD, Medicare covers leadless pacemakers through coverage with evidence development (CED), which means CMS will provide coverage for leadless pacemakers when procedures are performed as part of an ongoing, CMS-approved study and used according to the FDA-labeled indications for the device.

There are special billing requirements when CED studies are involved. For additional claim reporting requirements and billing information, including the CED study, please see our Micra Reimbursement Guide.

ICD-10 PCS code[5]	Description
Hospital ICD-10 procedure inpatient codes for leadless pacemakers	
02HK3NZ	Insertion of intracardiac pacemaker into right ventricle, percutaneous approach
02PA3NZ	Removal of intracardiac pacemaker from heart, percutaneous approach

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Leadless pacemaker procedures

CPT®[1] code	Description
Physician and hospital outpatient CPT®[1] codes for leadless pacemakers	
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

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Leadless pacemaker procedures

25 What are the HCPCS codes associated with Micra™ leadless pacemaker system?

HCPCS code C1786 is for the leadless pacemaker device/generator, and C1894 is for the introducer sheath.[7]

26 Does C1786 apply for all versions of Micra™ TPS?

Yes. C1786 is described as “Pacemaker, single chamber, rate-responsive (implantable)” and is applicable to all versions of Micra™ TPS.[7]

Device monitoring

Pacemaker & implantable defibrillator devices

27 What CPT®[1] codes are used to report monitoring of pacemaker 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).

CPT®[1] code	Description
Monitoring for pacemakers – transvenous and leadless 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

Device monitoring

Pacemaker & implantable defibrillator devices

CPT®[1] code	Description
Monitoring for implantable defibrillators – 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
93295	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

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Device monitoring

Pacemaker & implantable defibrillator devices

28 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.[8]

29 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 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 when it occurs on the same day. These modifiers are defined as: Modifier 76: Repeat procedure or service by the same physician or other qualified health care professional. Modifier 77: Repeat procedure or service by another physician or other qualified health care professional.

When performed at a facility, the technical component for these services is bundled with the primary procedure. See table below for CPT®[1] code 93286 and 93287 descriptions.

CPT®[1] code	Description
Periprocedural CPT®[1] codes	
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

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Device monitoring

Pacemaker & implantable defibrillator devices

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

Yes, the PM device evaluation NCD (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.[9,10]

31 There are some practices that continue to use transtelephonic (TTM) codes for monitoring PMs. May the TTM code be billed every time these TTM services are performed?

No, per the NCD for pacemaker evaluations, TTM monitoring is billed using an episode of care code, which includes all TTM monitoring in a 90-day period.

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Device monitoring

90-day monitoring period

32 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. Diagnostic tests are not included in the global surgical period and can be reported during the global period.[11]

33 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, it will only be reported once for the 90-day monitoring period, regardless of the number of times that the data is transmitted and reviewed.

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

The patient must be in the 90-day remote monitoring program for at least 30 days or the CPT®[1] codes 93294-93296 are not billable.

Device monitoring

90-day monitoring period

35 If the 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 service." CMS recommends for further information to view the Medicare National Coverage Determination Manual, Chapter 1, Section 20.8.1.1.[12,13]

36 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 this affect billing?

When an in-person and remote interrogation of the same device during the same 90-day remote monitoring period is performed, the in-person interrogation should not be billed. Only the remote service is billable (CPT®[1] codes 93294 [PM] or 93295 [ICD], and 93296).

37 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.

Device monitoring

Heart failure

38 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®[1] code 93290 is appropriate. If the patient is transmitting remotely, then the implantable cardiovascular physiologic monitor (ICPM) CPT®[1] codes may be reported. See the table below.

CPT®[1] code	Description
Implantable cardiovascular physiologic monitor (ICPM) CPT codes	
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

Device monitoring

Heart failure

39 What is the appropriate coding if the rhythm PM or ICD remote monitoring is running concurrently with the HF management remote physiologic monitoring (ICPM), and the same practice or physician or hospital outpatient clinic is reporting the remote monitoring for both rhythm and physiological (OptiVol™) ICPM 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 were 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.[14] Medicare implements these edits on a national level.

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

40 The remote technical component (TC) for the Medicare OptiVol™ monitoring feature (CPT®[1] 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®[1] code G2066.[4,6]

41 Why are there no relative value units (RVUs) for the technical component CPT®[1] G2066?

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

Device monitoring

Supervision

42 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]

Service	Description
Supervision definitions	
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

43 May a non-physician provider (NPP) serve as a supervisor for in-person monitoring services?

Possibly. As of January 1, 2021, Medicare allows certain NPPs to supervise diagnostic tests (which includes CIED monitoring) ONLY in states where state law and scope of practice allows it.[19]

For all other states not impacted by this change, 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]

44 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.[9]

Device monitoring

Professional and technical components

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

It is recommended that the practice bill only the professional component by using modifier-26 on the professional claim form.[15]

46 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).[16]

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Device monitoring

Professional and technical components

47 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.

Service	Modifier	Description
Billing for device monitoring (hospital or provider-based clinic)		
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®[1] 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®[1] code for the professional component on a professional claim with the appropriate POS
	N/A	The hospital bills the CPT®[1] code for the technical component (TC) of the outpatient service

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Device monitoring

CareLink Express™

CareLink Express™ Mobile (CLEM) enables retrieval of Medtronic cardiac implantable electronic device (CIED) data to be reviewed remotely on the CareLink Express or CareLink™ websites by a Medtronic representative or device follow-up clinician (configurable by site).

48 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.[20] 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 by clicking here.

49 Medicare (CMS) is promoting telehealth to help with patient access to care. Is remote monitoring using CareLink™ eligible to be billed to Medicare as 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.[18]

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Device monitoring

Miscellaneous

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

No. 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 (packages to the implant). Therefore, the MyCareLink™ monitor is not billable to Medicare as a separate line item.[16,17]

51 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 ICPMs and implantable loop records (ILR). 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.

Resources

For additional information

Visit our website: www.Medtronic.com/crhfreimbursement

Email us: rs.healthcareeconomics@medtronic.com

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

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References

[1] CPT codes and descriptions only are copyright ©2021 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/medicaremedicare-fee-service-paymenthospitaloutpatientppshospital-outpatient-regulations-and-notices/cms-1736-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] 2022 ICD-10 Procedure Coding System (ICD-10-PCS). cms.gov. https://www.cms.gov/medicare/icd-10/2022-icd-10-pcs. Updated October 19, 2021. Accessed November 23, 2021.

[6] The The Medicare Physician Fee Schedule (MPFS) 2022 National payment rates based on information published in the MPFS final rule CMS-1751-F and updates from legislation signed December 10, 2021.

PFS Federal Regulation Notices. cms.gov https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1751-f Accessed November 23, 2021.

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.

[7] Medtronic Cardiac Rhythm and Heart Failure comprehensive coding reference materials are available at: www.medtronic.com/crhfreimbursement

[8] 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

[9] 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

[10] 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

[11] Global Surgery Booklet cms.gov https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/GloballSurgery-ICN907166.pdf

[12] 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

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[14] CMS.gov. Quarterly PTP and MUE Version Update Changes. Available at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Version_Update_Changes

[15] 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

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

[17] Medicare Claims Processing Manual Chapter 4 - Part B Hospital. Available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf

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

[19] The OPPS 2022 National payment rates based on information published in the OPPS/ASC final rule CMS-1753-FC and corresponding Addendum B table which was published on November 16, 2021.

Hospital Outpatient Regulations and Notices. cms.gov. https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientpps/cms-1753-fc Accessed November 23, 2021.

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.

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

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