The CardioMEMS™ HF System Reimbursement Guide and FAQ is intended to provide educational material tied to the reimbursement of the CardioMEMS™ HF System when used consistently with the product's labeling. This guide includes information regarding coverage, coding and payment, as well as general education regarding appealing denied claims and supporting documentation.

In addition, Abbott offers a reimbursement hotline, which provides live coding and billing information from dedicated reimbursement specialists. Hotline support is available from 8 a.m. to 5 p.m. Central Time, Monday through Friday at 855-569-6430 or email hce@abbott.com.

This guide and all supporting documents are available for download at https://www.cardiovascular.abbott/us/en/hcp/reimbursement.html. Hotline reimbursement assistance is provided subject to the disclaimers set forth in this guide.

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COVERAGE FOR THE CARDIOMEMS™ HF SYSTEM

Coverage refers to the criteria and policies under which a payer determines what services and procedures it will reimburse. Coverage is usually described in medical policies and is payer-specific. Medicare provides coverage for “medically reasonable and necessary” services. Medicare provides guidance through National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). Currently, there is no NCD related to the CardioMEMS™ HF System. Check with your local Medicare Administrative Contractor (MAC) regarding any LCDs related to the CardioMEMS™ HF System. The MS DRG New Technology Add-On Payment for CardioMEMS™ HF System has expired and CMS has replaced those payments with permanent payment mechanisms in both the inpatient and outpatient hospital settings.

Commercial insurers' coverage policies will vary, and we are aware of some payers maintaining non-coverage policies for hemodynamic monitoring. We strongly encourage healthcare professionals (HCPs) to contact their payer(s) directly with questions regarding medical policies or guidelines for the CardioMEMS™ HF System. In addition, we provide general guidance with respect to private payers. Please contact us at (855) 569-6430 or at hce@abbott.com.

CARDIOMEMS™ HF SYSTEM CODING - WHAT'S NEW IN 2019?

The American Medical Association (AMA) created new CPT® codes to further describe services related to pulmonary artery pressure implantation and remote monitoring effective on January 1, 2019. These CPT® codes will make it easier for documenting and reporting the CardioMEMS™ HF System procedures as well as providing defined physician payment.

IMPLANT PROCEDURE

Physicians will report with 33289 for the CardioMEMS™ HF System implant procedure described by the CPT® code descriptor:

“Transcatheter implantation of a wireless pulmonary artery pressure sensor for long term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography.”

CPT® code 33289 replaces reporting with the following code combination prior to January 1, 2019: 93451, +93568, and 93799.

PULMONARY ARTERY PRESSURE REMOTE MONITORING

Physicians will report 93264 for CardioMEMS™ HF System remote monitoring based on the CPT® code descriptor:

“Remote monitoring of a wireless pulmonary artery pressure sensor for up to 30 days including at least weekly downloads of pulmonary artery pressure recordings, interpretation(s), trend analysis, and report(s) by a physician or other qualified health care professional.”

Based on the CPT® code requirements, physicians should not report 93297 or 93299 with 93264. This code is billable every 30 days when the requirements of the CPT® code is met.

The code defines weekly review of patients’ PA pressures to ensure the clinician work associated with monitoring results in maintaining pressures in optimal range to avoid decompensation and resulting HF hospitalizations.

PAYMENT CONSIDERATIONS—PHYSICIAN

Physicians anticipate being paid for services provided to patients that are medically reasonable and necessary. Commercial payers may require prior authorization to justify medical necessity for the CardioMEMS™ HF System implant procedure due to lack of defined coverage policies or existing non-coverage policies. Please note that traditional Medicare does not allow for prior authorization.

Prior authorization requests and claims must be submitted with supporting documentation and may be subject to a Medical Director review. Supporting documentation should include the following:

- A cover letter describing the service rendered, why the service was needed — medical necessity.
- Operative report that details the procedure.
- Medical necessity for the procedure.
- Any complicating circumstances (such as complexity of symptoms and concurrent problems).

The appeals process (e.g., traditional appeal and/or expedited review) provides an opportunity to request a case exception for review of medical necessity of the patient’s claim. For more information or assistance with commercial payer or Medicare appeals or resubmission processes, please contact our Reimbursement Hotline at (855) 569-6430.

Payers may request technical information about the CardioMEMS™ HF System and clinical justification for its use either generally or in a particular case. Such requests may be made by “suspending the claim for development” (i.e., placing the processing of the claim on hold, pending receipt of further information), or by issuing a denial of the claim to elicit additional information through the appeals process. Physicians should be prepared to provide well documented responses to payer questions.

HOSPITAL INPATIENT CODING AND PAYMENT

For FY 2019, the CardioMEMS™ HF System's implant procedure generally will map to MS-DRG 264 (other circulatory system O.R. procedures) when reported with ICD10PCS code 02HQ30Z or 02HR30Z.

HOSPITAL OUTPATIENT CODING AND PAYMENT

Beginning in CY 2017, CMS created comprehensive APC 5200 to represent the CardioMEMS™ HF System implant which includes procedures for the right heart catheterization with the wireless pulmonary artery pressure device and associated angiography. A C-APC represents a bundled payment that includes the primary service and all adjunct services to support the delivery of the primary service. As a result, both the CPT® code 33289 and HCPCS code C2624 should be reported together when implating the CardioMEMS™ HF System. The C-APC payment replaced the transitional APC pass-through payment status (TAPTS) that expired by statute on December 31, 2016.
Prior authorizations are for certain services and/or procedures that require review and approval, prior to being provided. Some services and/or procedures that require prior authorization include inpatient admissions, selected surgical procedures and certain outpatient procedures. When care is performed or coordinated by your Primary Care Physician (for those in the HMO and POS Plans), the network provider is responsible for obtaining prior authorization.

The physician who schedules an admission or orders the procedure is responsible for obtaining prior authorization. Providers should contact the payer to confirm if prior authorization is required.

If you have additional questions regarding the prior authorization process, please contact Abbott’s reimbursement hotline at 855-569-6430.

**APPEALING A DENIED CLAIM**

An appeal is a request for review of a denied claim or service. Claims may be denied for a variety of reasons, including the result of health plan errors, inaccurate patient or claim information submission, inaccurate coding and/or payer coverage policy. The reason for denial can be found in the denial letter and/or the Provider Remittance Advice (PRA).

Depending on the payer, the level of appeal may be considered a reconsideration, redetermination, grievance or appeal. Additionally, each payer may have different administrative requirements for each of these levels based on their own definitions. We suggest contacting the payer directly to verify the appeal requirements, including what forms are required, what supporting documentation is required (including if a letter of medical necessity is required), the time limits for requesting an appeal and an explanation of the specific appeal process.

If the payer does not have a required appeal form, submit an appeal letter. The appeal letter should be tailored to the reason for the denial. It should clearly articulate why the procedure was medically necessary for the patient. In addition, the appeal letter may include a corrected claim, product information, patient information, clinical data and other requested supporting documentation.

The more complete and detailed the appeal, the more likely it is to be successful in securing payment. The specificity of the medical necessity information and the documentation provided are critical to the success of the appeal. It is also important that the provider attach any medical documentation that may support the medical necessity of the procedure.

Another resource that providers and patients can pursue beyond the appeal process is an expedited external review. An external review is part of the health insurance claims denial process and occurs when an independent third party reviews an individual’s claim to determine whether or not the insurance company is obligated to pay. An external review is performed after the appellant has exhausted the insurance company's internal review process without success. Please contact Abbott’s Patient Therapy Access team if you would like more information or assistance with this process.
If you have additional questions regarding the process to appeal a denied claim, please contact Abbott’s reimbursement hotline from 8 a.m. to 5 p.m. Central Time, Monday through Friday at 855-569-6430.

CODING AND BILLING QUESTIONS—GENERAL

What are the ICD-10-CM diagnosis codes for FDA-approved indications for the CardioMEMS™ HF System?

The CardioMEMS™ HF System is approved for wirelessly measuring and monitoring pulmonary artery (PA) pressure and heart rate in NYHA Class III heart failure patients who have been hospitalized for heart failure in the previous year. ICD-10 codes set I50.x apply to heart failure patients, and should be reflective of the broader HF population, some of whom may be indicated for the CardioMEMS™ HF System procedure.

Will CardioMEMS™ HF System patients have coinsurance responsibility for remote services performed?

It depends on the patient’s insurance. Please verify with your patient’s health plan.

CODING AND BILLING QUESTIONS—PHYSICIAN

Is there a CPT‡ code that specifically describes the insertion of the CardioMEMS™ HF System Pulmonary Artery (PA) Pressure Sensor?

Yes, the AMA has created a new CPT‡ code 33289 which describes the implant of a wireless pulmonary artery sensor monitor. This code will replace C9741 for outpatient billing as well as the three codes physicians used in 2018: the right heart catheterization code, angiography code, and the unlisted code. As many of you are aware the unlisted code has no work RVUs associated with for physician payment and it is left to the discretion of the payer for the individual consideration of reimbursement. This new code will simplify the billing process and ensure that physicians are reimbursed appropriately and reliably for the work they’re doing.

<table>
<thead>
<tr>
<th>CPT‡ CODE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>33289</td>
<td>Transcatheter implantation of wireless pulmonary artery pressure sensor for long term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography</td>
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Is there a defined physician payment rate for the CardioMEMS™ HF system implant?

Yes, the new CPT‡ code 33289 2019 Medicare National Average Payment rate is $343.

What are the requirements for reporting CPT‡ code 93264?

According to 2019 CPT‡ code manual, they provide additional parentheticals and/or criteria around code 93264 that include the following:

- Report 93264, only once per 30 days.
- Do not report 93264 if download(s), interpretation(s), trend analysis, and report(s) do not occur at least weekly during the 30-day time period.
- Do not report 93264 if review does not occur at least weekly during the 30-day time period.
- Do not report 93264 if monitoring period is less than 30 days.
- Do not report 93264 in conjunction with 93297 or 93299.

As a provider responsible for remote monitoring of CardioMEMS™ HF System patients, can I bill for remote monitoring if I perform this service?

Yes, this is a billable service when performed based on the CPT‡ code requirements established for code 93264. Providers can reasonably bill for services they provide to patients.

What is the 2019 Medicare physician national payment rate for 93264?

The 2019 national physician payment rate for 93264 is $52 when performed in the physician's office and $37 when performed in the hospital.

If a patient has multiple devices such as a CardioMEMS™ HF System Sensor for PA pressure monitoring and a device (e.g., CorVue/Optivol) for monitoring intrathoracic impedance, can the same provider bill for both remote monitoring periods represented by codes 93264 and 93297/93299, respectively?

According to the CPT‡ code instructions, it states, “Do not bill 93264 in conjunction with 93297 or 93299.” Therefore, if the same provider is monitoring for both PA pressures and intrathoracic impedance, they cannot bill for both monitoring periods. CPT‡ code instructions indicate, “For remote monitoring of an implantable wireless pulmonary artery pressure sensor, use 93264.”

CODING AND BILLING QUESTIONS—INPATIENT AND OUTPATIENT HOSPITAL

Is there an ICD-10-PCS procedure code available for the CardioMEMS™ HF System implant?

Yes. Hospital inpatient procedures may be billed using the ICD-10-PCS code sets:

<table>
<thead>
<tr>
<th>ICD-10-PCS PROCEDURE CODE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>02HQ30Z</td>
<td>Insertion of Pressure Sensor Monitoring Device, Right Pulmonary Artery, monitoring device with pressure sensor</td>
</tr>
<tr>
<td>02HR30Z</td>
<td>Insertion of Pressure Sensor Monitoring Device, Left Pulmonary Artery, monitoring device with pressure sensor</td>
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ICD-10-CM PROCEDURE CODE | DESCRIPTION |
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<td>02HR30Z</td>
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What are the HCPCS codes for reporting the CardioMEMSTM HF System implant in the hospital outpatient setting?

The HCPCS codes for reporting pulmonary artery sensor implant procedures in the hospital outpatient setting are:

<table>
<thead>
<tr>
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<tr>
<td>33289</td>
<td>Transcatheter implantation of wireless pulmonary artery pressure sensor for long term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography</td>
</tr>
<tr>
<td>C2624</td>
<td>Implantable wireless pulmonary pressure sensor with delivery catheter, including all system components</td>
</tr>
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Is CPT code 93264 reimbursed when the technical services (e.g., data acquisitions for technical support and distribution of results) are performed in the outpatient hospital?

Based on the CY2019 Medicare Outpatient Hospital Payment Final Rule, CPT code 93264 has a status indicator of “M” stating not payable in the outpatient hospital. CPT code 93264 is for physician reporting of remote monitoring of pulmonary artery pressures; therefore, there is no separate breakout of a professional or technical component for the hospital to bill the latter.

If the outpatient hospital acquires the PA pressure data for remote technical support and distribution of results, how should they report this service considering the above?

The outpatient hospital cannot bill for 93264 because it is not payable in this site of service (outpatient hospital status indicator “M.”). However, if the hospital meets the requirements of CPT code 93299, they may be able to bill with this code based on medical appropriateness and documentation. CPT code 93299 has a site of service differential payment when performed in the outpatient hospital versus when performed in the physician’s office setting. It is important to verify with your institution's coders and your Medicare Administrative Contractor and private payers.

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

CPT code 93299 is reimbursed under C-APC 5741 with a 2019 Medicare National Average Payment rate of $37 when provided in the outpatient hospital.
REFERENCES

1. Hospital Outpatient Prospective Payment-Final Rule with Comment Period and Final CY2019 Payment Rates. CMS-1695-FC: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1695-FC.html


4. CPT Copyright 2018 American Medical Association. All rights reserved.