



## 2020 ABBOTT REIMBURSEMENT GUIDE AND FAQ

# CardioMEMS™ HF System

Effective January 1, 2020

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 Standard Time, Monday through Friday, at 1-855-569-6430 or email [hce@abbott.com](mailto:hce@abbott.com).

This guide and all supporting documents are available for download at [www.cardiovascular.abbott/reimbursement](http://www.cardiovascular.abbott/reimbursement). 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 MACs 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 1-855-569-6430 or at [hce@abbott.com](mailto:hce@abbott.com).

## CARDIOMEMS HF SYSTEM CODING – WHAT’S NEW IN 2020?

### HOSPITAL TECHNICAL COMPONENT OF REMOTE MONITORING

The American Medical Association (AMA) deleted CPT<sup>®</sup> code 93299 used to report the technical component for hospital reporting of the CardioMEMS HF System remote monitoring. CMS finalized a new temporary Healthcare Common Procedure Coding System (HCPCS) code, G2066, to report this service in CY2020, which means that hospitals can continue to report this service as appropriate.

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.

## 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.
- Perative 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 1-855-569-6430.

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 FY2020, the CardioMEMS™ HF System's implant procedure generally will map to MS-DRG 264 (other circulatory system operating room procedures) when reported with ICD-10-PCS code 02HQ30Z or 02HR30Z.

## HOSPITAL OUTPATIENT CODING AND PAYMENT

Beginning in CY2017, CMS created Comprehensive Ambulatory Payment Classifications (C-APC) 5200 to represent the CardioMEMS HF System implant which includes procedures for the right heart catheterization with the wireless PA 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<sup>+</sup> code 33289 and HCPCS code C2624 should be reported together when implanting the CardioMEMS HF System.

## HOSPITAL PAYMENT CONSIDERATIONS – PRIVATE INSURERS

Payment to hospitals by private insurers takes many forms. Where there are contracted case rates or negotiated, fixed procedure prices, private insurer payment for the CardioMEMS HF System may follow the Medicare model, with the costs of the procedure included in the cost of some other primary diagnostic or therapeutic intervention. Other private payers may pay hospitals on a charge-related basis; however, payment may initially be based on submitted charges for the CardioMEMS HF System. It is best to review your private payer contracts annually and consider contacting them to negotiate rates that appropriately reflect the device and the procedure.

## NON-COVERED SERVICES

Medicare and some private payers will allow the HCP to seek and collect payment from patients for non-covered services, as long as the HCP first obtains the patient's written consent. This may be the case as it relates to non-coverage policies for the CardioMEMS HF System technology. Obtaining this consent helps protect the HCP's right to collect and bill the patient for services rendered when it is unknown whether or not the payer will provide coverage for the procedure. The consent must be signed and dated by the patient or legal guardian prior to the provision of the specific procedure(s) in question.

The written consent generally includes the following:

- The name of the procedure(s) and/or supplies requested for treatment.
- An estimate of the charges for the procedure(s).
- A statement of reason why the HCP believes the procedure(s) may not be covered.
- A statement indicating that if the planned procedure(s) are not covered by the payer, the patient member agrees to be responsible for the charges.

If the HCP does not obtain written consent, the provider must accept full financial liability for the cost of care. General agreements to pay, such as those signed by patients at the time of an office visit, are not considered written consent. A copy of the signed written consent form must be retained in the patient's medical records should questions arise at a later date.

For Medicare, an Advance Beneficiary Notice (ABN) is required in advance of the service being provided. Instructions for ABNs can be found at <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html>.

Each payer may have different requirements regarding patient consent, and it is strongly recommended to check with the payer on their specific requirements.

## SERVICES REQUIRING PRIOR AUTHORIZATION FOR PRIVATE PAYERS

Prior authorization, sometimes referred to as "pre-certification," is the process used to verify if a proposed service or procedure is appropriate and medically necessary. Whenever possible, prior authorization should occur before a procedure is furnished.

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 health maintenance organization and point-of-service 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 1-855-569-6430.

### 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.

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 Standard Time, Monday through Friday, at 1-855-569-6430.

### 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 PA pressure and heart rate in New York Heart Association 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 heart failure 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<sup>+</sup> code that specifically describes the insertion of the CardioMEMS™ PA Sensor?**

Yes, the AMA created a new CPT code 33289, effective January 1, 2019, which describes the implant of a wireless PA sensor monitor. This code replaced 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 relative value units associated with it for physician payment and it is left to the discretion of the payer for the individual consideration of reimbursement.

This new code simplifies the billing process and ensures that physicians are reimbursed appropriately and reliably for the work they're doing.

CPT <sup>†</sup> CODE <sup>1</sup>	DESCRIPTION
33289	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

**Is there a defined physician payment rate for the CardioMEMS™ HF System implant?**

Yes, the new CPT<sup>†</sup> code 33289 2020 Medicare National Average Payment rate is \$345.

**What are the requirements for reporting CPT code 93264?**

According to 2020 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.

**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 2020 Medicare physician national payment rate for 93264?**

The 2020 national physician payment rate for 93264 is \$52 when performed in the physician's office and \$37 when performed in the hospital.<sup>2</sup>

**If a patient has multiple devices such as a CardioMEMS™ PA Sensor for pulmonary artery (PA) pressure monitoring and a device (e.g., CorVue/OptiVol<sup>®</sup>) for monitoring intrathoracic impedance, can the same provider bill for both remote monitoring periods represented by codes 93264 and 93297/G2066, respectively?**

According to the CPT code instructions, it states, "Do not report 93297 in conjunction with 93264, 93290, 93298." CPT code 93264 is used specifically for reporting remote monitoring of an implantable wireless PA pressure sensor.

We strongly suggest that clinicians verify with their billers and coders to determine if monitoring for intrathoracic impedance with the CorVue or OptiVol systems constitutes a distinct service that is different than the work done with remote monitoring via PA pressures. The Correct Coding Initiative (CCI) may allow for modifiers to be utilized when such circumstances exist based on medical necessity and supporting documentation. We advise that you follow up with your coders and payers to determine how they cover and treat the different mechanisms for reporting remote monitoring.

**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:

ICD-10-CM PROCEDURE CODE	DESCRIPTION
02HQ30Z	Insertion of Pressure Sensor Monitoring Device, Right Pulmonary Artery, monitoring device with pressure sensor
02HR30Z	Insertion of Pressure Sensor Monitoring Device, Left Pulmonary Artery, monitoring device with pressure sensor

**What are the HCPCS codes for reporting the CardioMEMS HF System implant in the hospital outpatient setting?**

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

CPT <sup>†</sup> CODE <sup>1</sup>	DESCRIPTION
33289	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
C2624	Implantable wireless pulmonary pressure sensor with delivery catheter, including all system components

**Is CPT<sup>†</sup> 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 CY2020 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 PA 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 the newly created HCPCS code G2066, they may be able to bill with this code based on medical appropriateness and documentation. HCPCS code G2066 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 MAC and private payers.

HCPCS CODE <sup>3</sup>	DESCRIPTION
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

HCPCS code G2066 is reimbursed under C-APC 5741 with a 2020 Medicare National Average Payment rate of \$36 when provided in the outpatient hospital.<sup>3</sup>

## IMPORTANT SAFETY INFORMATION

### CardioMEMS™ HF System

**Indications and Usage:** The CardioMEMS™ HF System is indicated for wirelessly measuring and monitoring pulmonary artery (PA) pressure and heart rate in New York Heart Association (NYHA) Class III heart failure patients who have been hospitalized for heart failure in the previous year. The hemodynamic data are used by physicians for heart failure management and with the goal of reducing heart failure hospitalizations.

**Contraindications:** The CardioMEMS HF System is contraindicated for patients with an inability to take dual antiplatelet or anticoagulants for one month post implant.

**Potential Adverse Events:** Potential adverse events associated with the implantation procedure include, but are not limited to, the following: Infection, Arrhythmias, Bleeding, Hematoma, Thrombus, Myocardial infarction, Transient ischemic attack, Stroke, Death, and Device embolization.

**Implant Risks:** As with any medical procedure, there are risks associated with the implantation of a sensor, although complications are very rare. Some of these risks include:

- Arrhythmias
- Bleeding
- Death
- Device embolization
- Hematoma
- Infection
- Myocardial infarction
- Stroke
- Thrombus
- Transient ischemic attack

## REFERENCES

1. Department of Health and Human Services, Centers for Medicare & Medicaid Services. CY2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F>. Published November 15, 2019. Accessed December 1, 2019.
2. Department of Health and Human Services, Centers for Medicare & Medicaid Services. Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2020 Rates. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2020-IPPS-Final-Rule-Home-Page-Items/FY2020-IPPS-Final-Rule-Regulations>. Published August 15, 2019. Accessed December 1, 2019.
3. Department of Health and Human Services, Centers for Medicare & Medicaid Services. Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1717-FC>. Published November 12, 2019. Accessed December 1, 2019.

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**Abbott**  
One St. Jude Medical Dr., St. Paul, MN 55117, USA, Tel: 1 651 756 2000  
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