Implantable Cardiovascular Physiologic Monitor System

Frequently Asked Questions

Q: Is an order required for implantable cardiovascular physiologic monitor (ICPM) system heart failure remote monitoring?

A: Yes, a physician must order and document the medical necessity for remote monitoring.

Q: What are the documentation requirements to support medical necessity for ICPM heart failure remote monitoring?

A: Proper documentation is critical to reimbursement, should support medical necessity, and address the following questions:

- Is there an order for remote monitoring?
- Does the diagnosis support the reason for remote monitoring?
- What is the reason for pulling the report?
- What are the results and how do they aid in treatment of the patient?
- What is the plan of care based on the results?

Q: What diagnosis codes are appropriate for billing ICPM heart failure remote monitoring?

A: Medicare defines medical necessity as "services or items reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Once a patient is determined to meet the need for heart failure monitoring, the provider must explicitly document the initial and ongoing need for evaluation.

Q: What if the patient has "opted out" of remote monitoring and prefers to come in for in-person interrogations?

A: For in-person interrogations, CPT® 93290 – Interrogation device evaluation (in person) ICPM, is thought to be the relevant procedure.

Q: How many HeartLogic™ alerts are needed to bill during the 30-day monitoring period?

A: Billing for ICPM heart failure remote monitoring is based on an episode of care rather than an alert or data transmission for a specific date of service. The monitoring period must extend beyond 10 days from the initiation of monitoring. The billing period of 30 days includes any data transmissions and alerts as part of the services represented in the CPT® code definition.

Q: If a medical device representative performs the technical component how does that impact billing?

A: Because the medical device representative is not employed by the physician practice, the physician should not report the technical component of the device evaluation service. In that instance, only the professional component of the device evaluation service should be reported. For in- person interrogations, a -26 modifier may be required to designate a professional only service.

Q: If two different providers are each following the patient, one for rhythm remote monitoring and one for heart failure remote monitoring are they both eligible to bill?

A: Both physicians may bill for their professional component when performed.

If the physicians are NOT part of the same group practice, each may bill for the technical component when performed.

If the physicians ARE part of the same group practice, the technical components for rhythm remote monitoring (CPT 93296) and heart failure remote monitoring (CPT 93299) may not be reported in the same 30-day monitoring period. Only one of the two technical component services may be reported for the overlapping 30-day monitoring period.

See important notes on the uses and limitations of this information on page 2.

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Coding Resources for Rhythm Management:

http://www.bostonscientific.com/en-US/reimbursement/rhythm-management.html

Reimbursement Help Desk:

CRM.Reimbursement@bsci.com
1-800-CARDIAC (227-3422) EXT. 24114

Please note: this coding information may include codes for procedures for which Boston Scientific currently offers no cleared or approved products. In those instances, such codes have been included solely in the interest of providing users with comprehensive coding information and are not intended to promote the use of any Boston Scientific products for which they are not cleared or approved. The Health Care Provider (HCP) is solely responsible for selecting the site of service and treatment modalities appropriate for the patient based on medically appropriate needs of that patient and the independent medical judgement of the HCP. Health economic and reimbursement information provided by Boston Scientific Corporation is gathered from third-party sources and is subject to change without notice as a result of complex and frequently changing laws, regulations, rules, and policies. This information is presented for illustrative purposes only and does not constitute reimbursement or legal advice. Boston Scientific encourages providers to submit accurate and appropriate claims for services. It is always the provider's responsibility to determine medical necessity, the proper site for delivery of any services, and to submit appropriate codes, charges, and modifiers for services rendered. It is also always the provider's responsibility to understand and comply with Medicare national coverage determinations (NCD), Medicare local coverage determinations (LCD), and any other coverage requirements established by relevant payers which can be updated frequently. Boston Scientific recommends that you consult with your payers, reimbursement specialists, and/or legal counsel regarding coding, coverage, and reimbursement matters. Boston Scientific does not promote the use of its products outside their FDA approved label. Information included herein is current as of November 2018 but is subject to change without notice. Rates for services are effective January 1, 2019.

Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding, or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.

References

1. CPT Global codes include a technical and professional component. Technical and professional components are indicated by use of a modifier appended to the device monitoring code. Note: Modifiers may apply in some instances. Check the CPT Manual for further guidance. Medicare Claims Processing Manual, Chapter 13, Section 20.3.1, CMS http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm/104c.pdf Medicare Claims Processing Manual, Chapter 13, Section 20.3.1
2. Social Security Act: Title XVIII Health Insurance for the Aged and Disabled, section 1862(a)(1)(A), SSA http://www.ssa.gov/OP_Home/ssact/title18/1862.htm Social Security Act: Title XVIII Health Insurance for the Aged and Disabled, section 1862(a)(1)(A)
3. Medicare Claims Processing, Transmittal 135 CR 1658, CMS https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R135CP.pdf

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