

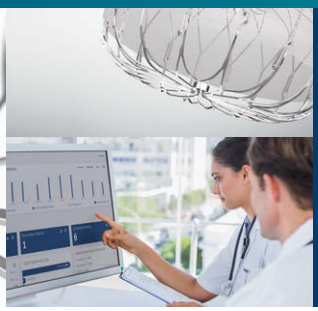

Boston Scientific
Advancing science for life™

WATCHMAN FLX™ Pro

LEFT ATRIAL APPENDAGE CLOSURE DEVICE

Reimbursement Guide

This comprehensive guide provides an overview of the coding, coverage and payment landscape for the WATCHMAN FLX Pro LAAC Device.

For questions regarding WATCHMAN FLX Pro LAAC Device reimbursement, please contact:

Email: WATCHMAN.Reimbursement@bsci.com

Please go to www.watchmandownloadcenter.com for additional resources.

The FDA Approved the WATCHMAN FLX Pro LAAC Device on September 7, 2023.

To access the WATCHMAN FLX Pro LAAC Device approval document, visit the FDA website

See page 2 for important information about the uses and limitations of this document.

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WATCHMAN FLX Pro Left Atrial Appendage Closure Device 2025 Reimbursement Guide

See page 2 for important information about the uses and limitations of this document.

Important Information

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.

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.

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.

Coding Summary

	Hospital Inpatient	Physician
Coding	ICD-10-PCS Procedure Code **02L73DK**	CPT® Code **33340**
Payment	**MS-DRG 273** or **MS-DRG 274** **MS-DRG 317** (Concomitant with Cardiac Ablation)	14.00 Work RVUs 22.87 Total RVUs
Diagnosis Codes	**ICD-10-CM Diagnosis Codes** **I48.91** Unspecified Atrial Fibrillation **I48.20** Chronic Atrial Fibrillation, Unspecified* **I48.21** Permanent Atrial Fibrillation **I48.0** Paroxysmal Atrial Fibrillation **I48.11** Longstanding Persistent Atrial Fibrillation **I48.19** Other Persistent Atrial Fibrillation	
Coverage	**Original Medicare** – CMS National Coverage Determination (NCD 20.34) establishes uniform coverage criteria[1] **Medicare Advantage** – Medicare Advantage plans must cover all the services that Original Medicare covers. The NCD 20.34 coverage criteria for Original Medicare also provides coverage to Medicare Advantage Patients[2] **Private Payers** – Coverage dependent on individual payer policy	

*The unspecified code is **NOT COVERED** under the NCD for LAAC. LAAC claims reported with this diagnosis code will be denied. Some private payers have included this ICD-10-CM code in their coverage policy

1 https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=281

2 https://www.medicare.gov/what-medicare-covers/what-medicare-health-plans-cover/medicare-advantage-plans-cover-all-medicare-services

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ICD-10-CM Diagnosis Codes

ICD-10-CM Atrial Fibrillation Diagnosis Coding

Use of the following codes is required to facilitate claims processing for services associated with an AF diagnosis, including Left Atrial Appendage Closure (LAAC).

ICD-10-CM Codes
I48.91 Unspecified Atrial Fibrillation
I48.20 Chronic Atrial Fibrillation, Unspecified*
I48.21 Permanent Atrial Fibrillation
I48.0 Paroxysmal Atrial Fibrillation
I48.11 Longstanding Persistent Atrial Fibrillation
I48.19 Other Persistent Atrial Fibrillation

*The unspecified code is **NOT COVERED** under the NCD for LAAC. LAAC claims reported with this diagnosis code will be denied.

See page 2 for important information about the uses and limitations of this document.

Hospital Reimbursement

Medicare classifies WATCHMAN FLX Pro LAAC Device procedures as Inpatient-only. The "Two-Midnight Rule" is not applicable for procedures restricted to the Inpatient Only (IPO) list.

ICD-10-PCS	MS-DRG Description
02L73DK	Occlusion of left atrial appendage with intraluminal device, percutaneous approach

MS-DRG	MS-DRG Description	FY 2026 National Average Payment*
MS-DRG 273	Percutaneous Intracardiac Procedures with MCC	$30,020
MS-DRG 274	Percutaneous Intracardiac Procedures without MCC	$23,953
MS-DRG 317	Concomitant Left Atrial Appendage Closure and Cardiac Ablation	$48,656

*Centers for Medicare and Medicaid Services FY2026 Hospital Inpatient Prospective Payment System, Final Rule; July 2025. Rates Effective October 1, 2025. FY 2026 IPPS Final Rule Home Page | CMS

Inpatient Readmissions

When an inpatient hospital WATCHMAN FLX Pro LAAC Device admission follows a previous inpatient admission for a related or unrelated procedure, readmission policies may apply. A quality review may be triggered and warrant a case review to evaluate combining the inpatient admissions. Each case is specific to clinical circumstances for each admission.

https://www.cms.gov/search/cms?keys=design+and+development+of+DRG+groups

https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2020-ICD-10-PCS-Guidelines.pdf

See page 2 for important information about the uses and limitations of this document.

Hospital Reimbursement
Continued

Transesophageal Echocardiogram (TEE) — Baseline and Follow-Up

CPT Code	Description	APC	CY 2025 National Average Payment*
93312	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement,image acquisition, interpretation and report.	5524	$548

*Commercial payment will vary and will be at discretion of the payer.

Computed Tomography (CT) — Baseline and Follow-Up

CPT Code	Description	APC	CY 2025 National Average Payment*
75572	Computed tomography, heart, with contrast structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed).	5572	$357
75574	Computed tomography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assess-ment of cardiac function, and evaluation of venous structures, if performed).		

*Cardiac CT procedures moved from APC 5571 to APC 5572 starting in CY2025.

See page 2 for important information about the uses and limitations of this document.

Hospital Reimbursement
Continued

Transesophageal Echocardiogram (TEE) — Intraoperative

CPT Code	Description	APC	CY 2025 National Average Payment*
93355	Echocariography, transesophageal (TEE) for guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s) (e.g.,TAVR, transcatheter pulmonary valve replacement, mitral valve repair, para-valvular regurgitation repair, left atrial appendage occlusion/closure, ventricular septal defect closure) (peri-and intra-procedural), real-time image acquisition and documentation, guidance with quantitative measurements, probe manipulation, interpretation, and report, including diagnostic transesophageal echocardio-graphy and, when performed, administration of ultrasound contrast, Doppler, color flow, and 3D.	Not Applicable – N Status Indicator	Bundled Service

*Commercial payment will vary and will be at discretion of the payer.

Intracardiac Echocardiography (ICE) - Intraoperative

CPT Code	Description	APC	CY 2025 National Average Payment*
+93662	Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure).	Not Applicable – N Status Indicator	Bundled Service

*Commercial payment will vary and will be at discretion of the payer.

CMS CY2025 Hospital Outpatient Prospective Payment – Notice of Final Rulemaking (NFRM): CMS-1809-FC. Effective through December 31, 2025.

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Physician Reimbursement

WATCHMAN FLX Pro LAAC Device Procedure

CPT Code	Description	RVU	CY 2025 National Average Payment*
33340	Percutaneous transcatheter closure of the left atrial appendage with implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, radiological supervision and interpretation.	14.00 Work RVUs 22.87 Total RVUs	$740

*Commercial payment will vary and will be at discretion of the payer.

Same Physician Performing Implant and Intraoperative TEE
CPT Codes 33340 (WATCHMAN FLX LAAC Device) and 93355 (Intraoperative TEE) cannot be billed by the same physician.

Medicare – National Correct Coding Policy Manual, Physician Version 23.0/Policy Narratives (1/1/2017): Chapter I General Correct Coding Policies, Excerpt – Section E.

Concomitant Cardiac Ablation and WATCHMAN FLX LAAC Procedure

CPT™ Code	Description	RVU	FY 2025 National Average Payment*
33340	Percutaneous transcatheter closure of the left atrial appendage with implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, radiological supervision and interpretation	14.00 work RVUs 22.87 Total RVUs	$1,267**
93656	Comprehensive electrophysiologic evaluation with transseptal catheterizations, insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia including left or right atrial pacing/recording, and intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography with imaging supervision and interpretation, right ventricular pacing/recording, and His bundle recording, when performed	17.00 work 27.72 Total RVUs	

*Commercial payment will vary and will be at the discretion of the payer.

**MPPR payment Calculation: $896.64 + (739.76*.5) = $1,266.52

See page 2 for important information about the uses and limitations of this document.

Physician Reimbursement

Continued

Medicare's Multiple Procedure Payment Reduction (MPPR) policy applies when CPT codes 33340 (LAAC) and 93656 (AF ablation) are reported by the same physician during a single operative session. Under the MPPR, the highest paying procedure is paid at 100% of the global fee schedule allowable, and procedures #2-5 are paid at 50% of the global fee schedule allowable.

Medicare Claims Processing Manual Chapter 12, Physicians/Nonphysician Practitioners, Section 40.6 - Claims for Multiple Surgeries
The Multiple Procedure Rule. AAPC Knowledge Center. https://www.aapc.com/blog/27973-understanding-the-multiple-procedure-rule/.

Co-Surgeon Billing

CPT Code + Modifier	Description
33340-62	Left atrial appendage closure can be billed by two surgeons by appending the -62 modifier to 33340 (eg. 33340-62).

- If two surgeons are required to perform a specific portion of the procedure, each surgeon bills for the procedure with a modifier of "-62"
- Each operator is required to submit their own post-operative note and must report 33340-62
- The fee schedule amount applicable to the payment for each co-surgeon is 62.5% of the global surgery fee amount

Transesophageal Echocardiogram (TEE) — Baseline and Follow-Up

CPT Code	Description	RVU	CY 2025 National Average Payment*
93312	Echocardiography, transeso-phageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report.	2.30 Work RVUs 6.97 Total Non-Facility RVUs 3.12 Total Facility RVUs (-26)	Global $225 Professional $101

*Commercial payment will vary and will be at discretion of the payer. Global includes professional and technical services. Professional only includes services reported with -26 modifier.

See page 2 for important information about the uses and limitations of this document.

Physician Reimbursement

Continued

Computed Tomography (CT) — Baseline and Follow-Up

CPT Code	Description	RVU	CY 2025 National Average Payment*
75572	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venuous structures, if performed).	1.75 Work RVUs 6.94 Total Non-Facility RVUs 2.44 Total Facility RVUs (-26)	Global $224 Professional $79
75574	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)	2.40 Work RVUs 9.84 Total Non-Facility RVUs 3.37 Total Facility RVUs (-26)	Global $318 Professional $109

*Commercial payment will vary and will be at discretion of the payer. Global includes professional and technical services. Professional only includes services reported with -26 modifier.

See page 2 for important information about the uses and limitations of this document.

Physician Reimbursement
Continued

Transesophageal Echocardiogram (TEE) — Intraoperative

CPT Code	Description	RVU	CY 2025 National Average Payment*
93355	Echocardiography, transesophageal (TEE) for guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s) (e.g.,TAVR, transcatheter pulmonary valve replacement, mitral valve repair, paravalvular regurgitation repair, left atrial appendage occlusion/ closure, ventricular septal defect closure) (peri-and intra-procedural), real-time image acquisition and documentation, guidance with quantitative measurements, probe manipulation, interpretation, and report, including diagnostic transesophageal echocardiography and, when performed, administration of ultrasound contrast, Doppler, color flow, and 3D.	4.66 Work RVUs 6.60 Total RVUs	$213

*Commercial payment will vary and will be at discretion of the payer. Code 93355 RVU for global payment only, no separate professional component applies.

Same Physician Performing Anesthesia and Intraoperative TEE

CPT Codes 01926 (Anesthesia) and 93355 (Intraoperative TEE) can not be billed by the same physician.

Medicare – National Correct Coding Policy Manual, Physician Version 23.0/Policy Narratives (1/1/2017): Chapter I General Correct Coding Policies, Excerpt – Section E.

See page 2 for important information about the uses and limitations of this document.

Physician Reimbursement

Continued

Intracardiac Echocardiography (ICE) — Intraoperative

CPT Code	Description	RVU	CY 2025 National Average Payment*
+93662	Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)	1.44 Work RVUs (-26) 2.05 Total RVUs (-26)	$67

*Commercial payment will vary and will be at discretion of the payer. Code 93662 RVU for professional payment only. Professional only includes services reported with -26 modifier.

CMS CY2025 Physician Fee Schedule (PFS) Final Rule: CMS 1807-F, including related PFS addenda. Conversion Factor used in calculations = $32.3465. Effective through December 31, 2025.

See page 2 for important information about the uses and limitations of this document.

Professional Claim Billing

1 **CPT Code 33340** Percutaneous transcatheter closure of the left atrial appendage with implant, including fluoroscopy transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, radiological supervision and interpretation

2 **Principal ICD-10-CM Diagnosis Code** (one of the following):

- I48.0 – Paroxysmal atrial fibrillation
- I48.11 – Longstanding persistent atrial fibrillation
- I48.19 – Other persistent atrial fibrillation
- I48.20 – Chronic atrial fibrillation, unspecified*
- I48.21– Permanent atrial fibrillation
- I48.91 – Unspecified atrial fibrillation

3 **Place of Service Code of 21** – Inpatient hospital

4 **Secondary Diagnosis Code Z00.6** – Encounter for exam of participant in clinical research program to indicate a patient is participating in LAAO Registry

5 **Modifier Q0** – Indicating the procedure is an investigational clinical service provided in an approved clinical research study

6 **Clinical Trial Number** – CT 02699957

The 8-digit clinical trial registry number preceded by the alpha characteristic "CT", is placed in field/item 19 of the CMS 1500 claim form or in the electronic claim equivalent 837p in Loop 2300 REF02(REF01=P4)(this is actually field/item 23).

*The unspecified code is NOT COVERED under the CMS NCD for LAAC. Some private payers have included this ICD-10 code in their coverage policy

See page 2 for important information about the uses and limitations of this document.

CMS 1500 Claim Example for WATCHMAN FLX™ Pro LAAC Device

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. 0d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

12. SIGNING THIS FORM. ...ase of any medical or other information necessary ...

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services

SIGNE

14. ... 16. DATES FROM ... OCCUPATION DD YY

17. ... 18. HOSPIT... FROM ... SERVICES DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. I480 B. Z006 C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER CT02699957

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01	01	17	01	02	17	21		33340	Q0	A,B		1		NPI	
2															NPI	
3																
4																
5																
6															NPI	

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Item 21A designates the primary diagnosis codes as required by Medicare. One of the following diagnosis codes are allowed:
I48.0-Paroxysmal atrial fibrillation
I48.11-Longstanding persistent atrial fibrillation
I48.19-Other persistent atrial fibrillation
I48.20-Chronic atrial fibrillation, unspecified*
I48.21-Permanent atrial fibrillation
I48.91-Unspecified atrial fibrillation
*The unspecified code is NOT COVERED under the CMS NCD for LAAC. Some private payers have included this ICD-10 code in their coverage policy

Item 21B designates the secondary ICD-10-CM diagnosis code Z00.6 (Encounter for examination of participant in clinical research program) to indicate the patient is participating in the LAAO registry.

Item 23 designates the National Clinical Trial (NCT) number for the Left Atrial Appendage Occlusion (LAAO) registry.

Item 24B designates place of service (POS) 21 for inpatient hospital as required by Medicare.

Item 24D designates the CPT Code 33340 for the WATCHMAN™ FLX LAAC Device.

Item 24D designates the HCPCS modifier Q0 (Investigational service provided in a clinical research study) to indicate the patient is participating in the LAAO registry.

Sources:
Items 21A-21B & 24B-24D) CMSMedicare Claims Processing Transmittal 3515; Medlearn Matters Number MM9638 Item 23-1) CMS Medicare Medlearn Matters Number MM9638; Claims Processing Transmittal 2955
Item 23-2) Left Atrial Appendage Occlusion Registry, clinicaltrials.gov; https//www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/LAAC.html
Item 24D) Official AMA CPT code description 33340 Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation.

IC-420005-AD

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Institutional Hospital Claims Billing

1 **ICD-10-PCS Procedure Code 02L73DK** Occlusion of Left Atrial Appendage with Intraluminal Device, Percutaneous Approach

2 **Principal ICD-10-CM Diagnosis Code** of one of the following:

- I48.0 – Paroxysmal atrial fibrillation
- I48.11 – Longstanding persistent atrial fibrillation
- I48.19 – Other persistent atrial fibrillation
- I48.20 – Chronic atrial fibrillation, unspecified*
- I48.21 – Permanent atrial fibrillation
- I48.91 – Unspecified atrial fibrillation

3 **Secondary Diagnosis Code Z00.6 –** Encounter for exam of participant in clinical research program to indicate a patient is participating in LAAO Registry

4 **Condition Code 30** – Qualifying Clinical Trial

5 **Value Code D4 –** Clinical Trial Number (NCT 02699957) is listed on the CMS website: clinicaltrials.gov

*The unspecified code is **NOT COVERED** under the CMS NCD for LAAC. Some private payers have included this ICD-10-CM code in their coverage policy

https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/LAAC

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R3515CP.pdf

https://www.cms.gov/medicare/coordination-benefits-recovery/overview/icd-code-lists

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CMS Inpatient UB-04 Claim Example for WATCHMAN FLX™ Pro LAAC Device

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
04/28/2017		03/20/2017					30			

31–34 OCCURRENCE CODE / DATE	35–36 OCCURRENCE SPAN CODE / FROM / THROUGH	37

38	39 VALUE CODES CODE	39 VALUE CODES AMOUNT	40 VALUE CODES	41 VALUE CODES
	D4	02699957		

42 REV. CD.	43	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49

50	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID

58	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL

66 DX	67	67A	B	C	D	E	F	G	H	68
	I480	Z006								

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE / DATE	a. OTHER PROCEDURE CODE / DATE	b. OTHER PROCEDURE CODE / DATE	75	76 ATTENDING NPI / QUAL / LAST / FIRST
02L73DK 03/20/2017				

c. OTHER PROCEDURE CODE / DATE	d. OTHER PROCEDURE CODE / DATE	e. OTHER PROCEDURE CODE / DATE	77 OPERATING NPI / QUAL / LAST / FIRST

CREATION DATE

TOTALS

Item 18 designates the condition code which indicates a qualifying clinical trial.

Item 39 designates the value code and National Clinical Trial (NCT) number for the Left Atrial Appendage Occlusion (LAAO) registry.

Item 66/67 designates the primary diagnosis codes as required by Medicare. One of the following diagnosis codes is allowed:
I48.0-Paroxysmal atrial fibrillation
I48.11-Longstanding persistent atrial fibrillation
I48.19-Other persistent atrial fibrillation
I48.20-Chronic atrial fibrillation, unspecified*
I48.21-Permanent atrial fibrillation
I48.91-Unspecified atrial fibrillation

*The unspecified code is NOT COVERED under the CMS NCD for LAAC. Some private payers have included this ICD-10 code in their coverage policy

Item 67A designates the secondary ICD-10-CM diagnosis code Z00.6 (Encounter for examination of participant in clinical research program) to indicate the patient is participating in the LAAO registry.

Item 74 designates the principal ICD-10 PCS code. Code 02L73DK (Occlusion of Left Atrial Appendage with Intraluminal Device, Percutaneous Approach) represents the designated code for the WATCHMAN FLX™ Pro LAAC Device.

Sources:
- Left Atrial Appendage Occlusion Registry, clinicaltrials.gov, https://www.cms.gov/medicare/coverage/evidence/left-atrial-closure
- CMS Manual System, Pub 100-04 Claim Processing, Transmittal 3515; https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3515CP.pdf

IC-471408-AB

See page 2 for important information about the uses and limitations of this document.

Institutional Hospital Claims Billing

Continued

Device C-Code

The WATCHMAN FLX Pro LAAC Device is classified by Medicare as an "Inpatient Only" procedure therefore no HCPCS device category C-code exists for WATCHMAN FLX Pro LAAC Device.

- A hospital may assign its own internal charge code, associated with an appropriate revenue code, to record the cost of the device.
- If a device category C-code is required by the hospital charging system, please review the web link below for the CMS approved list as of October 1, 2024.

https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/coding-questions

See page 2 for important information about the uses and limitations of this document.

Discontinued or Aborted Procedure Billing

Discontinued or Aborted Procedures vary based on patient case details and physician documentation. The following scenario represents only one type of case. Consult AHA Coding Clinic and Official Coding Guidelines in the event of other clinical scenarios.

Scenario:
The WATCHMAN device is inserted/implanted and removed during the same encounter.

Discontinued or aborted procedures vary based on case details and physician documentation of the procedure. Always consult AHA Coding Clinic and/or other authoritative resources for appropriate coding and billing.

Inpatient Facility
02H73DZ: Insertion of intraluminal device into LA, percutaneous approach,

AND

02PA3DZ: Removal of intraluminal device from heart, percutaneous approach

Outpatient Facility
33340-74: Modifier -74 is used on the CPT® code when a procedure is discontinued after it has started, and the patient has received anesthesia.

Professional Services
33340-53

Code assignment is based upon the physician work performed. If, for example, the physician was only able to perform the vascular access, consider reporting code 93452 for the procedure completed.

If the physician performed all the work along with a valid attempt to place the WATCHMAN device, then the planned procedure 33340 with a modifier -53 may be reported.

Modifier -53 is used when a procedure is discontinued for extenuating circumstances such as complications that threaten the patient's safety, including anatomical difficulties.

2020 ICD-10 PCS Official Guidelines for Coding and Reporting (page 76), Guideline B6.1a.

American Hospital Association (AHA) Coding Clinic for ICD-10-CM/PCS, Fourth Quarter 2017: Page 104; Fourth Quarter ICD-10 2018 Page: 94

See page 2 for important information about the uses and limitations of this document.

Concomitant Procedure Billing

	Description	FY26 CMS National Rate[1]
MS-DRG 317	Concomitant Left Atrial Appendage Closure and Cardiac Ablation	$48,656

1. Centers for Medicare and Medicaid Services FY2026 Hospital Inpatient Prospective Payment System, Final Rule; July 2025. Rates Effective October 1, 2025. FY 2026 IPPS Final Rule Home Page | CMS

Hospital Claims Billing

Concomitant cardiac ablation and LAAC

1 **ICD-10-PCS codes 02583ZF (PFA) or 02583ZZ (thermal ablation) and 02L73DK**
Use the cardiac ablation code (PFA or thermal) as the principal procedure

2 **Principal ICD-10-CM diagnosis code** of one of the following:

- I48.0 – Paroxysmal atrial fibrillation
- I48.11 – Longstanding persistent atrial fibrillation
- I48.19 – Other persistent atrial fibrillation
- I48.20 – Chronic atrial fibrillation, unspecified*
- I48.21 – Permanent atrial fibrillation
- I48.91 – Unspecified atrial fibrillation

3 **Secondary diagnosis ICD-10 diagnosis code of Z00.6** – Encounter for examination for normal comparison and control in clinical research program

4 **Condition code 30** – Specifying participation in a Qualifying Clinical Trial

5 **Value code D4** – Clinical Trial Number (NCT 02699957) listed on clinicaltrials.gov

*The unspecified code is **NOT COVERED** under NCD 20.34 for LAAC. LAAC claims reported with this diagnosis code will be denied by Medicare.

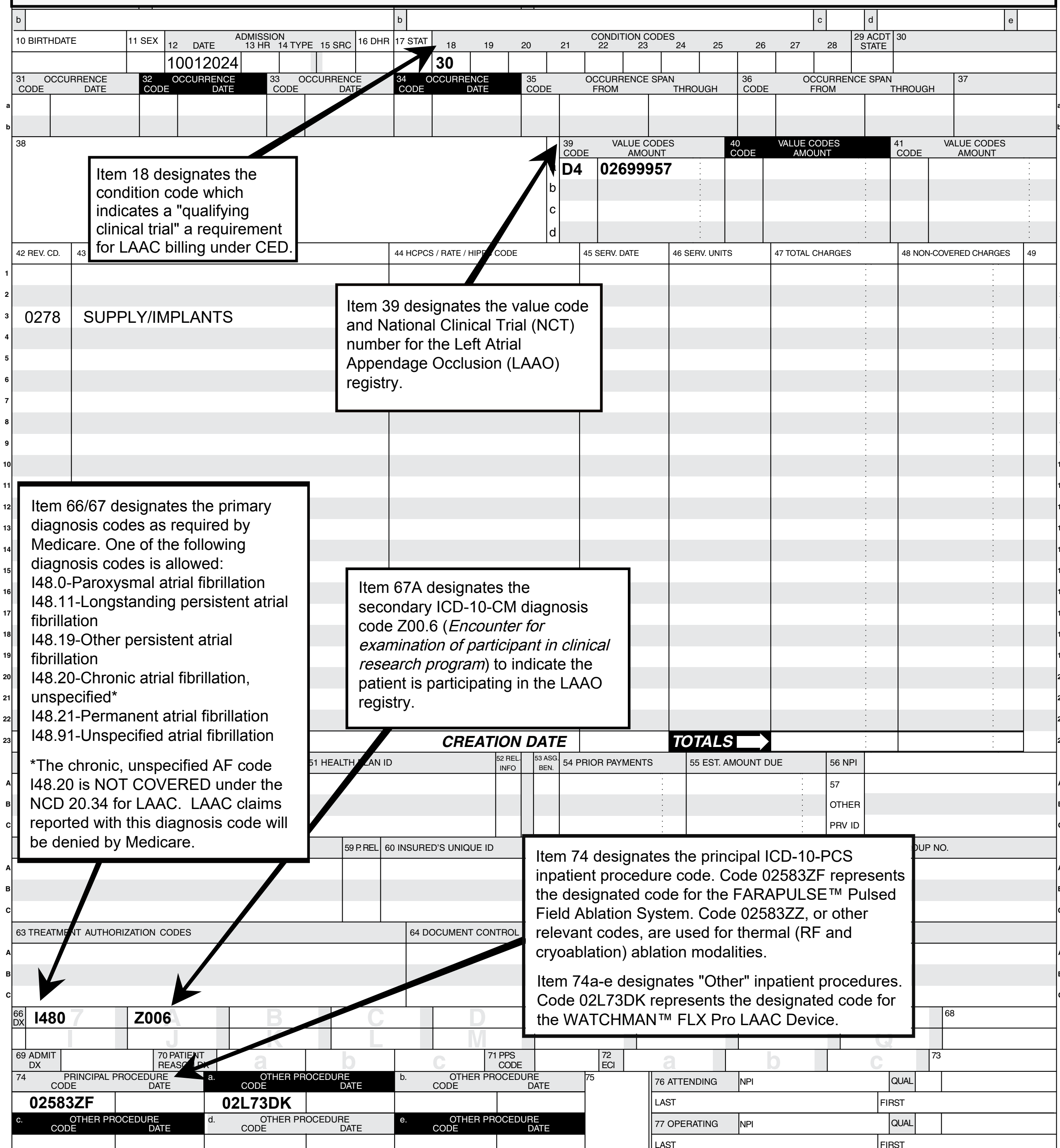
https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/LAAC

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R3515CP.pdf

https://www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-CM.html

See page 2 for important information about the uses and limitations of this document.

CMS UB-04 Claim Example for Cardiac Ablation and WATCHMAN™ FLX Pro LAAC ("Ablate & Close") - Hospital Bill Type 11x (inpatient)



Sources:
1. Left Atrial Appendage Occlusion Registry, clinicaltrials.gov, https://www.cms.gov/medicare/coverage/evidence/left-atrial-closure
2. Items 18, 39, 66, 74) CMS Manual System, Pub 100-04 Claim Processing, Transmittal 3515; https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3515CP.pdf
3. Item 74) CMS 2024 ICD-10-PCS description: 02L73DK *Occlusion of Left Atrial Appendage with Intraluminal Device, Percutaneous Approach*
4. Item 74a) CMS 2024 ICD-10-PCS description: 02583ZF *Destruction of Conduction Mechanism using Irreversible Electroporation, Percutaneous Approach*

See page 2 for important information about the uses and limitations of this document.

Professional Billing Best Practices for Concomitant Procedures

When a WATCHMAN procedure is performed during the same operative episode as a cardiac ablation procedure to treat atrial fibrillation, Medicare applies a Multiple Procedure Payment Reduction to the professional services.

- **Multiple Procedure Payment Reduction** – payment adjustment rule for multiple procedures applies to the service. The WATCHMAN FLX Pro LAAC Device procedure is assigned a '2' which indicates that standard payment adjustment rules for multiple procedures apply.
  - 100 percent of the fee schedule amount for the highest valued procedure; and
  - 50 percent of the fee schedule amount for the second through the fifth highest valued procedures

The Multiple Procedure Rule. AAPC Knowledge Center. https://www.aapc.com/blog/27973-understanding-the-multiple-procedure-rule/.

When a WATCHMAN procedure is performed on a separate date of service as another procedure, the Medicare Global Days policy applies.

- **Global Days –** time frames that apply to payment for each surgical procedure that describes the applicability of the global concept to the service.
  - **WATCHMAN FLX Pro LAAC Device is assigned a 000 global surgery payment indicator.** Therefore, only the preoperative and postoperative services related to the procedure for the day of surgery apply. Any services after the day of surgery depending upon physician documented medical necessity of the service and timing.

https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx

Physician Claims Billing

Concomitant Cardiac Ablation and LAAC; same physician

1 **CPT® codes 93656 and 33340** Use the pulmonary vein isolation ablation code 33340 (use for either PFA or a thermal ablation modality) as the principal procedure and append modifier -51 to each specifying multiple services

2 **Primary ICD-10-CM diagnosis code** of one of the following:

- I48.0 – Paroxysmal atrial fibrillation
- I48.11 – Longstanding persistent atrial fibrillation
- I48.19 – Other persistent atrial fibrillation
- I48.20 – Chronic atrial fibrillation, unspecified*
- I48.21 – Permanent atrial fibrillation
- I48.91 – Unspecified atrial fibrillation

*The unspecified code is **NOT COVERED** under NCD 20.34 for LAAC. LAAC claims reported with this diagnosis code will be denied by Medicare.

See page 2 for important information about the uses and limitations of this document.

Professional Billing Best Practices for Concomitant Procedures

Continued

3 **Place of Service code of 21 on both services** – Designates both services as inpatient due to CMS restriction of LAAC procedure to the Inpatient Only services list (IPO)

4 **Secondary diagnosis code Z00.6** – Encounter for examination for normal comparison and control in clinical research program

5 **Modifier Q0** – Investigational service provided in a clinical research study to indicate patient participation in the LAAO registry

6 **Clinical trial number** – CT 02699957

*The 8-digit clinical trial registry number preceded by the alpha characteristic "CT", is placed in field/item 19 of the CMS 1500 claim form or in the electronic claim equivalent 837p in Loop 2300 REF02(REF01=P4) (this is actually field/item 23).

See page 2 for important information about the uses and limitations of this document.

CMS 1500 Claim Example for Cardiac Ablation and WATCHMAN™ FLX Pro LAAC ("Ablate & Close") - EP performs both AF Ablation and LAAC

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. R ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IM COD

ANOTHER HEALTH BENEFIT PLAN? NO *If yes*, complete items 9, 9a, and 9d.

12. ng THIS any med r to the

S OR AUTHORIZED PERSON'S SIGNATURE I authorize f medical benefits to the undersigned physician or supplier for escribed

DATE ATE

14. ATIENT L M DD ON YY

17. 17a. 17b. NPI

18. HOSPITALIZATION MM DD FROM YY

19. ADDITIONAL CLAIM INFORMATION (De ignated by NUCC)

20. OUTSIDE LAB? YES O

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY A-L to service line below (24E) ICD Ind. 0

A. I480 B. Z00.6 C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER CT02699957

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10	01	24	10	02	24	21		93656		A		1		NPI	
2	10	01	24	10	02	24	21		33340	51 Q0	A,B		1		NPI	
3															NPI	
4																
5																
6															NPI	

Item 21A designates the primary diagnosis code as required by the CMS NCD for LAAC (20.34). One of the following ICD-10 codes are allowed:

- I48.0-Paroxysmal atrial fibrillation
- I48.11-Longstanding persistent atrial fibrillation
- I48.19-Other persistent atrial fibrillation
- I48.20-Chronic atrial fibrillation, unspecified*
- I48.21-Permanent atrial fibrillation
- I48.91-Unspecified atrial fibrillation

*The chronic, unspecified AF code I48.20 is NOT COVERED under the NCD 20.34 for LAAC. LAAC claims reported with this diagnosis code will be denied by Medicare.

Item 21B designates the secondary ICD-10-CM diagnosis code Z00.6 (*Encounter for examination of participant in clinical research program*) to indicate the patient is participating in the LAAO registry.

Item 23 designates the National Clinical Trial (NCT) number for the Left Atrial Appendage Occlusion (LAAO) registry. Do not use 'CT' on the electronic claim.

Item 24B designates place of service (POS) 21 for inpatient hospital as required by Medicare policy when billing CPT code 33340.

Item 24D designates CPT Code 93656 for the FARAPULSE™ Pulsed Field Ablation System and 33340 for the WATCHMAN™ FLX Pro LAAC Device.

Item 24D designates the CPT code modifier Q0 (*Investigational service provided in a clinical research study*) to indicate the patient is participating in the LAAO registry.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sources:

1. ICD-10-CM 2024. The complete official code set.
2. 2024 Current Procedural Terminology. American Medical Association, copyright ©2023.
3. Items 21A-21B & 24B-24D) CMS Medicare Claims Processing Transmittal 3515; Medlearn Matters Number MM9638
4. Item 23) CMS Medicare Medlearn Matters Number MM9638; Claims Processing Transmittal 2955; Atrial Appendage Occlusion Registry, clinicaltrials.gov; https://www.cms.gov/medicare/coverage/evidence/left-atrial-closure

SIGNED DATE a. NPI b. a. NPI b.

NUCC Instruction Manual available at: www.nucc.or

See page 2 for important information about the uses and limitations of this document.

Reimbursement Considerations for Concomitant Cardiac Ablation and LAAC: Commercial Payer Implications

Site of Service

Unlike Medicare and Medicare Advantage plans where LAAC and therefore concomitant LAAC + AF ablation are on the "Inpatient Only" services list, commercial payers may choose to authorize and reimburse for LAAC procedures and/or concomitant AF ablation + LAAC procedures when performed in the inpatient ***or outpatient*** setting of care.

	Medicare FFS/MA*		Commercial	
	Inpatient (IP)	**Outpatient (OP)**	**Inpatient (IP)**	**Outpatient (OP)**
Concomitant AF ablation + LAAC	Covered	Not Covered	Potentially Covered (PA/PD required)	Potentially Covered (PA/PD required)

*MA plans may not cover concomitant cases in an OP site of service due to LAAC IPO status in Medicare, however MA plans frequently do require prior authorization (PA) or pre-determination (PD).

Establishing Contractually Agreed upon Reimbursement Rates for Concomitant Procedures

Hospitals will need to pursue contracting with commercial payers for concomitant AF ablation + LAAC procedures in both settings of care, despite there not being a Medicare mechanism nor any publicly available payment rate for concomitant procedures in the outpatient setting of care. It's critical to confirm with the hospital that commercial payer contracts are updated to reflect mutually agreed-upon reimbursement frameworks and amounts for both standalone LAAC procedures as well as for concomitant procedures in either an inpatient or an outpatient site of service.

Physician Services Payment

Like CMS, commercial payers may require use of modifiers and/or apply a multiple procedure payment reduction when a physician performs more than one procedure on the same date of service. Consult your payer reimbursement policies.

Procedure	CPT® Code	Physician Work RVUs	Total RVUs*	2025 Medicare National Rate[3]
PVI/AF Ablation	93656	17.00	27.72	$897
LAAC	33340	14.00	22.87	$740

*Total RVUs are comprised of the physician work RVU (wRVU), practice expense RVU (PE RVU), and professional liability insurance RVU (PLI RVU).

3. CMS CY2025 Physician Fee Schedule (PFS) Final Rule: CMS 1807-F, including related PFS addenda. Conversion Factor used in calculations = $32.3465. Effective through December 31, 2025.

See page 2 for important information about the uses and limitations of this document.

Reimbursement Considerations for Concomitant Cardiac Ablation and LAAC

Continued

Productivity Contracting

From an employment contract perspective, it's important to understand whether wRVUs are being used to quantify physician productivity or to quantify reimbursable services. It's important that providers take time to review compensation agreements to assess if and how RVU reductions are applied along with the established reasoning and negotiate changes, as appropriate. The overall goal should be that the employer is providing an organizationally consistent opportunity for reasonable credit of work that is performed.

National Coverage Determination (NCD 20.34)

CMS issued the final decision memo that supports a National Coverage Determination (NCD) for Medicare beneficiaries undergoing Percutaneous Left Atrial Appendage (LAAC) Closure Therapy.

NCD 20.34 outlines specific criteria for WATCHMAN FLX LAAC Device eligibility.

Decision Memo for Percutaneous Left Atrial Appendage (LAA) Closure Therapy:

Using the camera on your phone, scan the QR code and visit the sites.

CMS.gov
Centers for Medicare & Medicaid Services

https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&NCAId=281

The criteria are highlighted below. Providers are encouraged to read the decision memo in its entirety for additional detail.

The patient must have:

- A $CHADS_2$ score ≥ 2 (Congestive heart failure, Hypertension, Age >75, Diabetes, Stroke/transient ischemia attack/thrombo-embolism) or CHA_2DS_2-VASc score ≥ 3 (Congestive heart failure, Hypertension, Age ≥ 65, Diabetes, Stroke/transient ischemia attack/thromboembolism, Vascular disease, Sex category)
- A formal shared decision-making interaction with an independent non-interventional physician using an evidence-based decision tool on oral anticoagulation in patients with NVAF prior to LAAC. Additionally, the shared decision-making interaction must be documented in the medical record.
- A suitability for short-term warfarin but deemed unable to take long term oral anticoagulation following the conclusion of shared decision making

See page 2 for important information about the uses and limitations of this document.

National Coverage Determination (NCD 20.34)

Continued

- The patient (preoperatively and postoperatively) is under the care of a cohesive, multidisciplinary team (MDT) of medical professionals
- The procedure must be furnished in a hospital with an established structural heart disease (SHD) and/or electrophysiology (EP) program
- The procedure must be performed by an interventional cardiologist(s), electrophysiologist(s) or cardiovascular surgeon(s) that meet the following criteria:
  - Has received training prescribed by the manufacturer on the safe and effective use of the device prior to performing LAAC; and
  - Has performed ≥ 25 interventional cardiac procedures that involve transseptal puncture through an intact septum; and
  - Continues to perform ≥ 25 interventional cardiac procedures that involve transseptal puncture through an intact septum, of which at least 12 are LAAC, over a two-year period.
- The patient is enrolled in, and the MDT and hospital must participate in a prospective, national, audited registry that:

  1) consecutively enrolls LAAC patients and

  2) tracks the annual outcomes for each patient for a period of at least four years from the time of the LAAC

Shared Decision Making Resources

Using the camera on your phone, scan the QR code and visit the sites.

ACP American College of Physicians
Leading Internal Medicine, Improving Lives

https://www.acponline.org/patients_families/products/brochures/afib_booklet.pdf

NICE National Institute for Health and Care Excellence

Patient decision aid

https://www.nice.org.uk/guidance/ng196

CardioSmart American College of Cardiology

http://www.acc.org/tools-and-practice-support/quality-programs/anticoagulation-initiative/anticoagulation-shared-decision-making-tool

See page 2 for important information about the uses and limitations of this document.

LAAO Registry™

CMS has certified the LAAO Registry (NCT02699957) as the national registry for data collection for LAAC procedures. The long-term data collection supports CMS's coverage with evidence development (CED) to ensure better visibility of safety and effectiveness of LAAC procedures.

Hospitals performing WATCHMAN FLX FLX Pro LAAC Device procedures must contact the National Cardiovascular Data Registry (NCDR®) at ncdr@acc.org or 1-800-257-4737 to enroll in the LAAO Registry™.

Using the camera on your phone, scan the QR code and visit the sites.

https://cvquality.acc.org/NCDR-Home/registries/hospital-registries/laao-registry

See page 2 for important information about the uses and limitations of this document.

Medicare Advantage

Medicare Advantage plans are administered by Medicare Advantage Organizations (MAO). Effective as of January 1, 2024, CMS mandates that Medicare Advantage plans align their coverage and site of service with Medicare FFS guidelines. CMS implements important utilization management policy and coverage criteria protections to ensure Medicare Advantage enrollees receive the same access to medically necessary care that they would receive in Traditional Fee-for-service Medicare.

https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-final-rule-cms-4201-f

Medicaid

Medicaid plans vary with respect to their coverage of the WATCHMAN FLX Pro LAAC Device. You may contact the Boston Scientific Reimbursement Support Line for information regarding state-specific coverage status.

Please contact:

WATCHMAN.Reimbursement@bsci.com

See page 2 for important information about the uses and limitations of this document.

Commercial Health Insurance

Patients often obtain health insurance from their employer, or purchase through an exchange. Commercial health insurance contractually requires prior authorization before services are rendered. The Commercial Health Insurance reviews applicable data and reviews for medical necessity. Their determination is communicated to the provider and patient in writing. This process can take up to two weeks.

Commercial payers may choose to follow the NCD or establish their own policies for LAAC therapy. It is important review individual coverage policies and to seek prior authorization to establish medical necessity for WATCHMAN FLX Pro LAAC Device in advance of performing the procedure.

Please refer to the WATCHMAN Download Center for the most up-to-date list of WATCHMAN FLX Pro LAAC Device private payer coverage and for resources to support prior authorization and appeals.

Using the camera on your phone, scan the QR code and visit the sites.

https://www.watchman.com/hcp/watchman-download-center/health-economics-and-reimbursement.html

See page 2 for important information about the uses and limitations of this document.

Commercial Health Insurance

Continued

WATCHMAN FLX Pro LAAC Device Private Payer Coverage

Health Plan	Primary Service Area	Health Plan	Primary Service Area
AETNA	National	BCBS of FL (Florida Blues)	FL
AmeriHealth	PA, NJ, DC	BCBS of IL	IL
Arkansas Health	AR	BCBS of Kansas	KS
Anthem	National	BCBS of Kansas City	KS
Anthem Blue Cross of California	CA	BCBS of Louisiana	LA
Anthem Blue Cross of Colorado	CO	BCBS of MA	MA, RI
Anthem Blue Cross of Connecticut	CT	BCBS of MI	MI
Anthem Blue Cross of Indiana	IN	BCBS of MN	MN
Anthem Blue Cross of Kentucky	KY	BCBS of MS	MS
Anthem Blue Cross of Maine	ME	BCBS of MT	MT
Anthem Blue Cross of Missouri	MI	BCBS of NC	NC
Anthem Blue Cross of Nevada	NV	BCBS of ND	ND
Anthem Blue Cross of New Hampshire	NH	BCBS of NM	NM
Anthem Blue Cross of Nevada	NV	BCBS of Northeast NY	NY
Anthem Blue Cross of Ohio	OH	BCBS Western NY	NY
Anthem Blue Cross of Virginia	VA	BCBS of OK	OK
Anthem Blue Cross of Wisconsin	WI	BCBS of RI	RI
AvMed	FL	BCBS of SC	SC
Blue Cross Blue Shield of Georgia	GA	BCBS of TN	TN
Empire Blue Cross Blue Shield	NY	BCBS of TX	TX
Unicare	FL	BCBS of Wyoming	WY
BCBS of AL	AL	BCBS of Federal Employee Program	National
BCBS of AR	AR	Blue Cross ID	ID
BCBS Health Advantage	TX	Blue Shield CA	CA
BCBS of AZ	AZ	Capital Health Plan	FL

See page 2 for important information about the uses and limitations of this document.

Commercial Health Insurance

Continued

WATCHMAN FLX Pro LAAC Device Private Payer Coverage

Health Plan	Primary Service Area	Health Plan	Primary Service Area
Capital Bluecross	PA	Health New England	MA, CT
CareFirst BCBS	DC, MD, VA	Highmark BCBS	DE, PA, WV
CareSource	OH	Horizon BCBS	NJ
Centene	National	Humana	National
Arizona Complete	AZ	Independence Blue Cross	PA
Arkansas Total	AR	LifeWise	OR, WA
Buckeye Health	OH	Medica	MN
Coordinated Care	WA	Medical Mutual of Ohio	OH
Heath Net CA	CA	Nebraska Blue	NE
Health Net OR	OR	Optima (Sentara)	VA, OH, NC, WV, FI, MD, PA, SC, GA, CA
Magnolia Health	MS	Preferred One	MN
Peach State Health	GA	Premera Blue Cross	WA, AK, OR
PA Health and Wellness	PA	Prevera 360	WI
Cigna	National	Priority Health	MI
Coordinated Care Health Plan	WA	Regence Health Plan (Regence Blue Cross Blue Sheild)	IA, OH, UT, WA
Dean Health Plan	WI	Scott & White Health Plan	TX
Emblem Health	NY, CT, NJ, FI, PA, NC, MA, SC, GA, CA	Summa Health	OH, MD
Excellus	NY, CT	TriCare	National
Fallon	MA, NY, CT, FL, PA, SC	Tufts Health Plan	MA, RI, NY
Group Health	WA	UPMC	PA
Harvard Pilgrim	MA, ME, CT, NH, RI, VT, NY	United Healthcare	National
Hawaii Medical Services Association (HMSA)	HI	Univera	NY
Health Alliance of MI	MI	Wellmark Blue Cross Blue Shield	IA, SD

NOTE: Covered lives for Commercial and Federal plans is based on estimates available from Policy Reporter, and excludes those covered by Medicare Advantage plans and/or Medicaid.

See page 2 for important information about the uses and limitations of this document.

Additional Resources for Health Economics and Market Access Support

Boston Scientific's Health Economics and Market Access Team is pleased to offer a series of educational webinars to support customers in areas of coding, coverage and market access for their WATCHMAN FLX Pro LAAC Device programs. Please use the following website to register:

Using the camera on your phone, scan the QR code and visit the sites.

https://www.watchman.com/en-us-hcp/hema-webinars.html

The webinar topics below are available on-demand.

Coding and Claims for WATCHMAN FLX Pro LAAC Device procedure

- Understanding WATCHMAN FLX Pro LAAC Device assigned DRGs
- Importance of Documentation
- Review of claims processing for institution and physician

National Coverage Determination

- Patient eligibility criteria and shared decision-making
- Facility and Operator Requirements
- National LAAC Registry

Resources Supporting Prior Authorization, Appeals and Beyond

- Best practices and tools
- Review of Boston Scientific resources
- Commercial payor landscape for WATCHMAN FLX Pro LAAC Device coverage

Any questions regarding these webinars can be directed to WATCHMAN.Reimbursement@bsci.com

WATCHMAN FLX Pro Brief Summary
watchman.com/en-us-implanter/watchman-flx-pro-brief-summary.html

See page 2 for important information about the uses and limitations of this document.