DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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- "**Inpatient Rehabilitation Facility Prospective Payment System**" Fact Sheet, ICN 006847, downloadable

MLN Matters® Number: MM8525 | Related Change Request (CR) #: CR 8525

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National Coverage Determination (NCD) for Single Chamber and Dual Chamber Permanent Cardiac Pacemakers

Note: This article was revised on May 26, 2015, to add a reference to MLN Matters® Article MM9078 that advises physicians, providers and suppliers of specific implementation detail that is available for the August 13, 2013, National Coverage Decision. All other information remains unchanged.

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers who submit claims to Medicare Claims Administration Contractors (A/B Medicare Administrative Contractors (A/B MACs)) for cardiac pacemaker services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8525 which allows payment for nationally covered implanted permanent cardiac pacemakers, single chamber or dual chamber, for the indications outlined in the "Medicare National Coverage Determinations Manual" (Chapter 1, Part 1, Section 20.8, Cardiac Pacemakers) and the "Medicare Claims Processing Manual"

(Chapter 32, Section 320, Billing Requirements for Cardiac Pacemakers: Single and Dual Chamber) which were revised by and included as attachments to CR 8525. CR 8525 is effective for claims with dates of service on or after August 13, 2013. Make sure that your billing personnel know about these changes.

Background

Permanent cardiac pacemakers refer to a group of self-contained, battery operated, implanted devices that send electrical stimulation to the heart through one or more implanted leads. Single chamber pacemakers typically target either the right atrium or right ventricle. Dual chamber pacemakers stimulate both the right atrium and the right ventricle.

The implantation procedure is typically performed under local anesthesia and requires only a brief hospitalization. A catheter is inserted into the chest, and the pacemaker's leads are threaded through the catheter to the appropriate chamber(s) of the heart. The surgeon then makes a small "pocket" in the pad of the flesh under the skin on the upper portion of the chest wall to hold the power source. The pocket is then closed with stitches.

On August 13, 2013, the Centers for Medicare & Medicaid Services (CMS) issued a National Coverage Determination (NCD). In this NCD, CMS concluded that implanted permanent cardiac pacemakers, single chamber or dual chamber, are reasonable and necessary for the treatment of non-reversible symptomatic bradycardia due to sinus node dysfunction and second and/or third degree atrioventricular block. Symptoms of bradycardia are symptoms that can be directly attributable to a heart rate less than 60 beats per minute (for example: syncope, seizures, congestive heart failure, dizziness, or confusion).

The following indications <u>are covered</u> for implanted permanent single chamber or dual chamber cardiac pacemakers:

1. Documented non-reversible symptomatic bradycardia due to sinus node dysfunction.
2. Documented non-reversible symptomatic bradycardia due to second degree and/or third degree atrioventricular block.

The following indications <u>are non-covered</u> for implanted permanent single chamber or dual chamber cardiac pacemakers:

1. Reversible causes of bradycardia such as electrolyte abnormalities, medications or drugs, and hypothermia.
2. Asymptomatic first degree atrioventricular block.
3. Asymptomatic sinus bradycardia.
4. Asymptomatic sino-atrial block or asymptomatic sinus arrest.
5. Ineffective atrial contractions (e.g., chronic atrial fibrillation or flutter, or giant left atrium) without symptomatic bradycardia.
6. Asymptomatic second degree atrioventricular block of Mobitz Type I unless the QRS complexes are prolonged or electrophysiological studies have demonstrated

that the block is at or beyond the level of the His Bundle (a component of the electrical conduction system of the heart).

7. Syncope of undetermined cause.
8. Bradycardia during sleep.
9. Right bundle branch block with left axis deviation (and other forms of fascicular or bundle branch block) without syncope or other symptoms of intermittent atrioventricular block.
10. Asymptomatic bradycardia in post-myocardial infarction patients about to initiate long-term beta-blocker drug therapy.
11. Frequent or persistent supraventricular tachycardias, except where the pacemaker is specifically for the control of tachycardia.
12. A clinical condition in which pacing takes place only intermittently and briefly, and which is not associated with a reasonable likelihood that pacing needs will become prolonged.

MACs will determine coverage under the Social Security Act (Section 1862(a)(1)(A); see **http://www.ssa.gov/OP_Home/ssact/title18/1862.htm**) for any other indications for the implantation and use of single chamber or dual chamber cardiac pacemakers that are not specifically addressed in this NCD.

Note: MACs will accept the inclusion of the KX modifier on the claim line(s) as an attestation by the practitioner and/or provider of the service that documentation is on file verifying the patient has non-reversible symptomatic bradycardia (symptoms of bradycardia are symptoms that can be directly attributable to a heart rate less than 60 beats per minute (for example: syncope, seizures, congestive heart failure, dizziness, or confusion)).

Other key notes for billing:

- MACs will pay **professional** claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, provided the claim contains at least one of the CPT codes of 33206, 33207, or 33208 AND one of the following ICD-9-CM/ICD-10-CM diagnostic codes, and only when the claim is submitted with the KX modifier:
    - 426.0/I44.2
    - 426.12/I44.1
    - 426.13/I44.1
    - 427.81/I49.5, or
    - 746.86/Q24.6
- The following diagnosis codes can be covered at contractor discretion if submitted with at least one of the CPT codes and at least one of the diagnosis codes listed above along with the KX modifier:

- 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block
- 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block / I45.19 Other right bundle branch block
- 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia

- Contractors will return claim lines if the KX modifier is not present using the following message:
  - Claim Adjustment Reason Code (CARC) 4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
  - Remittance Advice Remarks Code (RARC) N517: Resubmit a new claim with the requested information.
- Effective for claims with dates of service on or after August 13, 2013, MACs will pay **outpatient institutional** claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, (codes C1785, C1786, C2619, or C2620) provided the claim contains the KX modifier, and contains at least one of the CPT codes 33206, 33207, or 33208, AND one of the following ICD-9-CM/ICD-10-CM diagnostic codes :
  - 426.0/I44.2
  - 426.12/I44.1
  - 426.13/I44.1
  - 427.81/I49.5, or
  - 746.86/Q24.6
- MACs will return outpatient institutional claims for implanted permanent cardiac pacemakers that do not meet the preceding requirements.
- The following diagnosis codes can be covered at contractor discretion if submitted with at least one of the CPT codes and diagnosis codes listed above:
  - 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block
  - 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block / I45.19 Other right bundle branch block
  - 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia

- Effective for claims with dates of service on or after August 13, 2013, MACs will pay **inpatient** claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, provided the claim contains one of the following ICD-9/ICD-10 diagnosis AND procedure codes:
    - 37.81/0JH604Z, 0JH634Z, 0JH804Z, 0JH834Z,
      37.82/0JH605Z, 0JH635Z, 0JH805Z, 0JH835Z, or
      37.83/0JH606Z, 0JH636Z, 0JH806Z, 0JH836Z, AND
    - 426.0/I44.2,
      426.12/I44.1,
    - 426.13/I44.1,
      427.81/I49.5, or
      746.86/Q24.6

- The following diagnosis codes can be covered at contractor discretion if submitted with at least one of the CPT codes and diagnosis codes listed above:
    - 426.10 Atrioventricular block, unspecified/ I44.30 Unspecified atrioventricular block
    - 426.4 Right bundle branch block/ I45.10 Unspecified right bundle-branch block / I45.19 Other right bundle branch block
    - 427.0 Paroxysmal supraventricular tachycardia/ I47.1 Supraventricular tachycardia

In addition, be aware of the following:

- MACs will deny claims for implanted dual chamber for one of the following CPT codes: 33206, 33207, or 33208 and contains at least one of the following ICD-9-CM/ICD-10-CM diagnosis codes (even if submitted with at least one of the acceptable diagnosis codes listed above):
    - 426.11/I44.0
    - 427.31/I48.1/I48.2/I48.91
    - 427.32/I48.2/I48.3/I48.4/ or I48.91
    - 427.89/I49.8/ R00.1
    - 780.2/R55.

MACs will use the following messages when denying claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, containing one of the following HCPCS and/or CPT codes: C1785, C1786, C2619, C2620, 33206, 33207, or 33208, and at least one diagnosis code from the list of ICD-9/ICD-10 diagnosis codes above:

- CARC 96: Non-covered charge(s).

- RARC N569: Not covered when performed for the reported diagnosis.
- Group Code - CO (contractual obligation), if claim received with GZ modifier indicating no signed Advance Beneficiary Notice (ABN) is on file or Group Code PR (Patient Responsibility) if occurrence code 32 indicating a signed ABN is on file or occurrence code 32 with modifier GA is present.

NCDs are binding on all MACs and contractors with the Federal government that review and/or adjudicate claims, determinations, and/or decisions, quality improvement organizations, qualified independent contractors, the Medicare appeals council, and administrative law judges (ALJs). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See the Social Security Act, Section 1869(f)(1)(A)(i), at **http://www.ssa.gov/OP_Home/ssact/title18/1869.htm** on the Internet.)

Additional Information

The official instruction, CR 8525, was issued to your MACs regarding this change via two transmittals. The first is the transmittal that updates the "NCD Manual" and it is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R170NCD.pdf** on the CMS website. The second transmittal updates the "Medicare Claims Processing Manual" and it is at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2986CP.pdf** on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.