CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13538	**Date: December 19, 2025**
	Change Request 14311

SUBJECT: Cardiac Contractility Modulation (CCM) for Heart Failure (HF)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to inform contractors that effective October 28, 2025, contractors shall pay claims for CCM.

EFFECTIVE DATE: October 28, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 6, 2026

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	32/Table of Contents
N	32/416/Cardiac Contractility Modulation (CCM) for Heart Failure (HF)
N	32/416/1/Coding Requirements for Cardiac Contractility Modulation (CCM) for Heart Failure (HF)
N	32/416/2/Claims Processing Instructions for Cardiac Contractility Modulation (CCM) for Heart Failure (HF) Professional Claims
N	32/416/3/Claims Processing Instructions for Cardiac Contractility Modulation (CCM) for Heart Failure (HF) Institutional Claims
N	32/416/4/Messages

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question

and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 13538	Date: December 19, 2025	Change Request: 14311

SUBJECT: Cardiac Contractility Modulation (CCM) for Heart Failure (HF)

EFFECTIVE DATE: October 28, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 6, 2026

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to inform contractors that effective October 28, 2025, contractors shall pay claims for CCM.

II. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to make contractors aware of coverage for CCM used for the treatment of HF effective October 28, 2025.

B. Policy: Effective October 28, 2025, the Centers for Medicare & Medicaid Services (CMS) covers CCM used for the treatment of HF under Coverage with Evidence Development (CED) according to the criteria outlined in the National Coverage Determination (NCD) manual, chapter 1, section 20.39.

Consistent with section 1142 of the Act, Agency for Healthcare Research and Quality (AHRQ) supports clinical research studies that CMS determines meet all the criteria and standards identified above.

CCM used for the treatment of HF is not covered for patients outside of a CMS-approved study.

Nothing in this NCD would preclude coverage of CCM through NCD 310.1 (Clinical Trial Policy) or through the Investigational Device Exemption (IDE) Policy.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14311 - 04.1	Contractors shall allow claims for CCM used in the treatment of HF under CED according to the criteria outlined above. Please refer to the NCD Manual, Pub. 100-03, chapter 1, section 20.39 for coverage and Pub. 100-04, chapter 32, section 416 for claims processing	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	instructions.									
14311 - 04.2	Contractors shall process CCM claims submitted with the following with the following criteria: • Type of Bill (TOB) 11X, and • International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) codes: Insertion/replacement 0JH60AZ 0JH63AZ 0JH80AZ 0JH83AZ 02H63MZ 02HK3MZ, and • Value code D4 with the 8-digit National Clinical Trial (NCT) number, and • Condition code 30, and • ICD-10-CM diagnosis Z00.6 (reported as other diagnosis), and	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	• ICD-10-CM principal diagnosis is one of the following: I50.1 I50.20 I50.21 I50.22 I50.23 I50.30 I50.31 I50.32 I50.33 I50.40 I50.41 I50.42 I50.43 I50.810 I50.811 I50.812 I50.813 I50.814 I50.82 I50.83 I50.84 I50.89									

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	I50.9									
14311 - 04.3	Contractors shall process CCM claims submitted with the following with the following criteria: • TOB 12X, 13X, or 85X and • Current Procedural Terminology (CPT) codes: Insertion/Replacement procedures 0408T 0409T 0410T 0411T Removal procedures 0412T 0413T 0414T Repositioning procedures 0415T 0416T Programming procedures	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	0417T 0418T, and • Healthcare Common Procedure Coding System codes (HCPCS): C1824 C1898 K1030, and • Value code D4 with the 8-digit with the NCT number, and • Condition code 30 (claim level or modifier Q0 (line level), and • ICD-10-CM diagnosis Z00.6 (reported as other diagnosis), and • ICD-10-CM principal diagnosis is one of the following: I50.1 I50.20 I50.21 I50.22									

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	I50.23 I50.30 I50.31 I50.32 I50.33 I50.40 I50.41 I50.42 I50.43 I50.810 I50.811 I50.812 I50.813 I50.814 I50.82 I50.83 I50.84 I50.89 I50.9									
14311 - 04.4	Contractors shall process CCM claims submitted with the following criteria: • Place of Service (POS) 19, 21, 22, or 26		X				X			

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	• CPT codes: Insertion/Replacement procedures 0408T 0409T 0410T 0411T Removal procedures 0412T 0413T 0414T Repositioning procedures 0415T 0416T Programming procedures 0417T 0418T • HCPCS C1824 C1898 K1030, and									

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	• Modifier Q0, and • ICD-10-CM diagnosis Z00.6 (reported as other diagnosis), and • ICD-10-CM principal diagnosis is one of the following: I50.1 I50.20 I50.21 I50.22 I50.23 I50.30 I50.31 I50.32 I50.33 I50.40 I50.41 I50.42 I50.43 I50.810 I50.811 I50.812									

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	I50.813 I50.814 I50.82 I50.83 I50.84 I50.89 I50.9									
14311 - 04.5	Contractors shall Return to Provider (RTP) CCM claims when TOB is not equal to 11X, 12X, 13X, or 85X.	X				X				
14311 - 04.6	Contractors shall RTP CCM claims not submited with condition code 30 (claim level) or modifier Q0 (line level).	X				X				
14311 - 04.7	Contractors shall RTP CCM claims not submitted with value code D4 and the 8-digit NCT number is not present.	X				X				
14311 - 04.8	Contractors shall return as unprocessable CCM line-items on claims in a clinical research study when billed without the clinical trial number using the following messages: Claim Adjustment Reason Code (CARC) 16: Claim/service lacks information or has submission/billing error(s). Remittance Advice Remark Code (RARC) MA50: Missing/incomplete/invalid Investigational Device		X							

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	Exemption number or clinical trial number. Group Code: CO (Contractual Obligation)									
14311 - 04.9	Contractors shall return as unprocessable line-items on CCM claims in a clinical research study when billed without modifier Q0 using the following messages: CARC 4: The procedure code is inconsistent with the modifier used. RARC N519: Invalid combination of HCPCS modifiers. Group Code: CO (Contractual Obligation)		X				X			
14311 - 04.10	Contractors shall deny CCM claims not submitted with the following ICD-10-CM diagnosis as a principal diagnosis: • I50.1 • I50.20 • I50.21 • I50.22 • I50.23 • I50.30 • I50.31 • I50.32 • I50.33 • I50.40 • I50.41 • I50.42 • I50.43 • I50.810 • I50.811 • I50.812 • I50.813 • I50.814 • I50.82 • I50.83	X	X			X				

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	• I50.84 • I50.89 • I50.9, and • Z00.6 (reported as other diagnosis)									
14311 - 04.10.1	Contractors shall use the following messages when denying claims: CARC 167: "This (these) diagnosis(es) is (are) not covered". RARC N386: "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD. Group Code – CO (Contractual Obligation) or PR (Patient Responsibility) dependent upon liability. Use PR when: • On institutional claims, Occurrence Code 32 is present (claim level) or Q0 (line level) on professional claims	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	and the line level for institutional claims Medicare Summary Notice (MSN) 15.20: "The following policies were used when we made this decision: NCD 20.39". Spanish Version – "Las siguientes políticas fueron utilizadas cuando se tomó esta decisión: NCD 20.39									
14311 - 04.11	Contractors shall return as unprocessable claims for CCM services when services were billed in other than POS 19, 21, 22, or 26 and use the following messages: CARC 58: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. RARC N386: This decision was based on National Coverage Determination (NCD) 20.39. An NCD provides a coverage determination as to whether a particular item or service is covered. An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.		X							

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	Group Code: CO (Contractual Obligation)									
14311 - 04.12	Contractors shall not search their files for CCM claims processed with DOS or discharge dates between October 28, 2025, and the implementation date of this change request. However, MACs shall adjust those claims that are brought to their attention.	X	X							

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A, A/B MAC Part B

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
5, 6, 7	Contractors shall utilize existing reason codes.

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

Medicare Claims Processing Manual
Chapter 32 -Billing Requirements for Special Services

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(Rev 13538.; Issued:12-19-2025)

Transmittals for Chapter 32

416- Cardiac Contractility Modulation (CCM) for Heart Failure (HF)

416.1 Coding Requirements for Cardiac Contractility Modulation (CCM) for Heart Failure (HF)

416.2 Claims Processing Instructions for Cardiac Contractility Modulation (CCM) for Heart Failure (HF) Professional Claims

416.3 Claims Processing Instructions for Cardiac Contractility Modulation (CCM) for Heart Failure (HF) Institutional Claims

416.4 Messages

*416 - **Cardiac Contractility Modulation (CCM) for Heart Failure (HF)***
(Rev 13538.; Issued:12-19-2025: Effective: 10-28-2025, Implementation: 04-05-2026)

Effective October 28, 2025, the Centers for Medicare & Medicaid Services (CMS) covers CCM used for the treatment of HF under Coverage with Evidence Development (CED) according to the criteria outlined in NCD manual, chapter 1, section 20.39. Consistent with section 1142 of the Act, AHRQ supports clinical research studies that CMS determines meet all the criteria and standards identified above.

CCM used for the treatment of HF is not covered for patients outside of a CMS-approved study.

416.1 Coding Requirements for Cardiac Contractility Modulation (CCM) for Heart Failure (HF)
(Rev 13538.; Issued:12-19-2025: Effective: 10-28-2025, Implementation: 04-05-2026)

The following CPT codes are applicable for CCM:

Insertion/Replacement procedures

0408T - Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes

0409T- Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator only

0410T- Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; atrial electrode only

0411T- Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; ventricular electrode only

Removal procedures

0412T-Removal of permanent cardiac contractility modulation system; pulse generator only
0413T- Removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)
0414T- Removal and replacement of permanent cardiac contractility modulation system pulse generator only

Repositioning procedures

0415T- Repositioning of previously implanted cardiac contractility modulation transvenous electrode (atrial or ventricular lead)
0416T- Relocation of skin pocket for implanted cardiac contractility modulation pulse generator

Programming procedures

0417T- Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable cardiac contractility modulation system

0418T- Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable cardiac contractility modulation system

The following PCS codes are applicable for insertion/replacement for CCM:

0JH60AZ- Insertion of Contractility Modulation Device into Chest Subcutaneous Tissue and Fascia, Open Approach

0JH63AZ- Insertion of Contractility Modulation Device into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach

0JH80AZ- Insertion of Contractility Modulation Device into Abdomen Subcutaneous Tissue and Fascia, Open Approach

0JH83AZ- Insertion of Contractility Modulation Device into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach

02H63MZ- Insertion of cardiac lead into right atrium, percutaneous approach (when specified as a lead for a contractility modulation device)

02HK3MZ- Insertion of cardiac lead into right ventricle, percutaneous approach (when specified as a lead for a contractility modulation device)

The following HCPCS codes are applicable for CCM:

C1824- Generator, cardiac contractility modulation (implantable)

C1898- Lead, pacemaker, other than transvenous VDD single pass

K1030- External recharging system for battery (internal) for use with implanted cardiac contractility modulation generator, replacement only

The following ICD-10-CM diagnosis codes are applicable for CCM:

I50.1- Left ventricular failure, unspecified
I50.20- Acute combined systolic (congestive) and diastolic (congestive) heart failure
I50.21- Acute systolic (congestive) heart failure
I50.22- Chronic systolic (congestive) heart failure
I50.23- Acute on chronic systolic (congestive) heart failure
I50.30- Unspecified diastolic (congestive) heart failure
I50.31- Acute diastolic (congestive) heart failure
I50.32- Chronic diastolic (congestive) heart failure
I50.33- Acute on chronic diastolic (congestive) heart failure
I50.40- Unspecified combined systolic (congestive and diastolic (congestive) heart failure
I50.41- Acute combined systolic (congestive) and diastolic (congestive) heart failure
I50.42- Chronic combined systolic (congestive) and diastolic (congestive) heart failure
I50.43- Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure

I50.810- Right heart failure, unspecified
I50.811- Acute right heart failure
I50.812- Chronic right heart failure
I50.813- Acute on chronic right heart failure
I50.814- Right heart failure due to left heart failure
I50.82- Biventricular heart failure
I50.83- High output heart failure
I50.84- End stage heart failure
I50.89- Other heart failure
I50.9- Heart failure, unspecified

Z00.6- encounter for examination for normal comparison and control in a clinical research program (reported as other diagnosis)

416.2 Claims Processing Instructions for Cardiac Contractility Modulation (CCM) for Heart Failure (HF) Professional Claims

(Rev 13538.; Issued:12-19-2025: Effective: 10-28-2025, Implementation: 04-05-2026)

Professional claims for CCM in a clinical research study shall be covered when billed with:

- *one of the HCPCS/CPT codes listed in section 416.1*
- *one of the ICD-10 diagnosis codes listed in section 416.1*
- *ICD-10 Z00.6 (as other diagnosis code)*
- *Place of Service 19, 21, 22, or 26*
- *the 8-digit clinical trial identifier number*
- *Modifier Q0*

416.3 Claims Processing Instructions for Cardiac Contractility Modulation (CCM) for Heart Failure (HF) Institutional Claims

(Rev 13538.; Issued:12-19-2025: Effective: 10-28-2025, Implementation: 04-05-2026)

Institutional claims for CCM in a clinical research study shall be covered when billed with:

- *11X*
- *one of the PCS codes listed in section 416.1*
- *one of the ICD-10 diagnosis codes listed in section 416.1*
- *ICD-10 Z00.6 (as other diagnosis code)*
- *Condition code 30*
- *Value Code D4 to indicate the 8-digit clinical trial identifier number*

416.4 Messages

(Rev 13538.; Issued:12-19-2025: Effective: 10-28-2025, Implementation: 04-05-2026)

Contractors shall use the following messages when denying CCM claims submitted with missing/incorrect ICD-10 diagnosis code:

Claim Adjustment Reason Code (CARC) 167: "This (these) diagnosis(es) is (are) not covered".

Remittance Advice Remark Code (RARC) N386: "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. If you do not have web access, you may contact the contractor to request a copy of the NCD.

Group Code – CO (Contractual Obligation) or PR (Patient Responsibility) dependent upon liability.

Use PR when:

- *On institutional claims, Occurrence Code 32 (claim level) is present. Modifier Q0 (line level).*

Medicare Summary Notice (MSN) 15.20: "The following policies were used when we made this decision: NCD 20.39".

Spanish Version – "Las siguientes políticas fueron utilizadas cuando se tomó esta decisión: NCD 20.39.

Contractors shall return as unprocessable line-items on CCM claims in a clinical research study when billed without the clinical trial number using the following messages:

CARC 16: Claim/service lacks information or has submission/billing error(s).

RARC MA50: Missing/incomplete/invalid Investigational Device Exemption number or clinical trial number.

Group Code: CO

Contractors shall return as unprocessable line-items on CCM claims containing one of the CPT or HCPCS codes mentioned in Section 415.1 when billed without modifier Q0 using the following messages:

CARC 4: The procedure code is inconsistent with the modifier used.

RARC N519: Invalid combination of HCPCS modifiers.

Group Code: CO

Contractors shall return as unprocessable claims for CCM services when services were billed in other than Place of Service (POS) 19, 21, 22, or 26 and use the following messages:

CARC 58: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.

Remittance Advice Remark Code (RARC) N386: "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. If you do not have web access, you may contact the contractor to request a copy of the NCD.

Group Code: CO

NCD:	20.39
NCD Title:	Cardiac Contractility Modulation (CCM) for Heart Failure
IOM:	https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c32.pdf
MCD:	https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=Y&NCAId=317
	CMS reserves the right to add or remove codes associated with its NCDs in order to implement those NCDs in the most efficient manner within the confines of the policy

ICD-10 CM	ICD-10 DX Description
	Dual Diagnosis Requirement **1. Principal Dianosis**
I50.1	Left ventricular failure, unspecified
I50.20	Unspecified systolic (congestive) heart failure
I50.21	Acute systolic (congestive) heart failure
I50.22	Chronic systolic (congestive) heart failure
I50.23	Acute on chronic systolic (congestive) heart failure
I50.30	Unspecified diastolic (congestive) heart failure
I50.31	Acute diastolic (congestive) heart failure
I50.32	Chronic diastolic (congestive) heart failure
I50.33	Acute on chronic diastolic (congestive) heart failure
I50.40	Unspecified combined systolic (congestive) and diastolic (congestive) heart failure
I50.41	Acute combined systolic (congestive) and diastolic (congestive) heart failure
I50.42	Chronic combined systolic (congestive) and diastolic (congestive) heart failure
I50.43	Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure
I50.810	Right heart failure, unspecified
I50.811	Acute right heart failure
I50.812	Chronic right heart failure
I50.813	Acute on chronic right heart failure
I50.814	Right heart failure due to left heart failure
I50.82	Biventricular heart failure
I50.83	High output heart failure
I50.84	End stage heart failure
I50.89	Other heart failure
I50.9	Heart failure, unspecified
	Dual Diagnosis Requirement **2. Reported as other diagnosis**
Z00.6	Encounter for examination for normal comparison and control in clinical research program

NCD:	20.39
NCD Title:	Cardiac Contractility Modulation (CCM) for Heart Failure
IOM:	https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c32.pdf
MCD:	https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=Y&NCAId=317
	CMS reserves the right to add or remove codes associated with its NCDs in order to implement those NCDs in the most efficient manner within the confines of the policy

ICD-10	ICD-10 PCS Description
0JH60AZ	Insertion of Contractility Modulation Device into Chest Subcutaneous Tissue and Fascia, Open Approach
0JH63AZ	Insertion of Contractility Modulation Device into Chest Subcutaneous Tissue and Fascia, Percutaneous Approach
0JH80AZ	Insertion of Contractility Modulation Device into Abdomen Subcutaneous Tissue and Fascia, Open Approach
0JH83AZ	Insertion of Contractility Modulation Device into Abdomen Subcutaneous Tissue and Fascia, Percutaneous Approach
02H63MZ	Insertion of Cardiac Lead into Right Atrium, Percutaneous Approach
02HK3MZ	Insertion of Cardiac Lead into Right Ventricle, Percutaneous Approach

NCD:	20.39									
NCD Title:	Cardiac Contractility Modulation (CCM) for Heart Failure **(CR14311)**									
IOM:	https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c32.pdf									
MCD:	https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=Y&NCAId=317									
Part A	**Rule Description Part A**	**HCPCS/CPT Part A**	**Frequency Limitations**	**TOB (Part A)**	**Revenue Code Part A**	**Modifier Part A**	**Provider Specialty**	**Proposed MSN Message Part A**	**Proposed CARC Message Part A**	**Proposed RARC Message Part A**
Part A	Effective October 28, 2025, the Centers for Medicare & Medicaid Services (CMS) covers CCM used for the treatment of HF under Coverage with Evidence Development (CED) according to the criteria outlined in NCD manual, chapter 1, section 20.39. Consistent with section 1142 of the Act, AHRQ supports clinical research studies that CMS determines meet all the criteria and standards identified above. CCM used for the treatment of HF is not covered for patients outside of a CMS-approved study. Please refer to the NCD Manual, Pub. 100-03, Section 20.39 for coverage and Pub. 100-04 Chapter 32, Section 416 for claims processing instructions.									
Part A	Effective 10/28/25, **A/MACs and FISS** shall process CCM claims submitted with the following with the following criteria: ·Type of Bill (TOB) 11X -ICD-10-CM dual diagnosis requirements-see ICD Diagnosis tab -Insertion/replacement ICD-10-PCS codes listed on ICD Procedures tab -Value code D4 with the 8-digit National Clinical Trial number (NCT) -Condition code 30 Contractors shall Return to Provider (RTP) CCM claims when TOB is not equal to 11X, 12X, 13X, or 85X. Contractors shall RTP CCM claims not submitted with condition code 30 (claim level) or modifier Q0 (line level). Contractors shall RTP CCM claims not submitted with value code D4 and the 8 digit NCT number is not present.	See ICD Procedures		11X						
Part A	Effective 10/28/25, **A/MACs and FISS** shall process CCM claims submitted with the following with the following criteria: ·Type of Bill (TOB) 12X, 13X, or 85X -ICD-10-CM dual diagnosis requirements-see ICD Diagnosis tab -CPT & HCPCS codes provided in Column C -Value code D4 with the 8-digit National Clinical Trial number (NCT) -Condition code 30 -Modifier Q0	Insertion/Replacement procedures 0408T 0409T 0410T 0411T Removal procedures 0412T 0413T 0414T Repositioning procedures 0415T 0416T Programming procedures 0417T 0418T Healthcare Common Procedure Coding System codes (HCPCS): C1824 C1898 K1030		12X 13X 85X						
	A/MACs shall Return to Provider (RTP) CCM claims when TOB is not equal to 11X, 12X, 13X, or 85X. **A/MACs** shall RTP CCM claims not submitted with condition code 30 (claim level) or modifier Q0 (line level). **A/MACs** shall RTP CCM claims not submitted with value code D4 and the 8 digit NCT number is not present.									
Part A	**A/MACs and FISS** shall deny CCM claims not submitted with the specified dual ICD-10-CM Diagnosis requirements. Group Code – CO or PR (Patient Responsibility) dependent upon liability. Use PR when: •On institutional claims, Occurrence Code 32 is present (claim level) or Q0 on professional claims and the line level for institutional claims ·Type of Bill (TOB) 11X							15.2	167	N386
		#NAME?								

NCD:	20.39									
NCD Title:	Cardiac Contractility Modulation (CCM) for Heart Failure **(CR14311)**									
IOM:	https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c32.pdf									
MCD:	https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=Y&NCAId=317									
Part B	**Rule Description Part B**	**HCPCS/CPT Part B**	**Frequency Limitations**	**POS (Part B)**	**n/a**	**Modifier Part B**	**Provider Specialty**	**Proposed MSN Message Part B**	**Proposed CARC Message Part B**	**Proposed RARC Message Part B**
Part B	Effective October 28, 2025, the Centers for Medicare & Medicaid Services (CMS) covers CCM used for the treatment of HF under Coverage with Evidence Development (CED) according to the criteria outlined in NCD manual, chapter 1, section 20.39. Consistent with section 1142 of the Act, AHRQ supports clinical research studies that CMS determines meet all the criteria and standards identified above. CCM used for the treatment of HF is not covered for patients outside of a CMS-approved study. Please refer to the NCD Manual, Pub. 100-03, Section 20.39 for coverage and Pub. 100-04 Chapter 32, Section 416 for claims processing instructions.									
Part B	Effective 10/28/25, **B/MACs and MCS** shall process CCM claims submitted with the following with the following criteria: ·POS codes listed in Column E -ICD-10-CM dual diagnosis requirements-see ICD Diagnosis tab -CPT & HCPCS codes provided in Column C -Modifier Q0	Insertion/Replacement procedures 0408T 0409T 0410T 0411T Removal procedures 0412T 0413T 0414T Repositioning procedures 0415T 0416T Programming procedures 0417T 0418T Healthcare Common Procedure Coding System codes (HCPCS): C1824 C1898 K1030		19 21 22 26						
Part B	**B/MACs and MCS** shall return as unprocessable CCM line-items on claims in a clinical research study when billed without the clinical trial number.Group Code: CO								16	MA50
Part B	**B/MACs and MCS** shall return as unprocessable line-items on CCM claims in a clinical research study when billed without modifier Q0 . Group Code: CO								4	N519
Part B	**B/MACs and MCS** shall deny CCM claims not submitted with the specified dual ICD-10-CM Diagnosis requirements. Group Code – CO or PR (Patient Responsibility) dependent upon liability. Use PR when: •On institutional claims, Occurrence Code 32 is present (claim level) or Q0 on professional claims and the line level for institutional claims							15.2	167	N386

NCD:	20.39									
NCD Title:	Cardiac Contractility Modulation (CCM) for Heart Failure **(CR14311)**									
IOM:	https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c32.pdf									
MCD:	https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=Y&NCAId=317									
Part B	**B/MACs and MCS** shall return as unprocessable claims for CCM services when services were billed in other than listed Place of Service (POS).			19 21 22 26					58	N386
	REVISION HISTORY									
	CR14311: New NCD and spreadsheet issued.									