

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13716	Date: April 3, 2026
	Change Request 14311

Transmittal 13672 issued March 09, 2026, is being rescinded and replaced by Transmittal 13716, dated April 3, 2026 to add Type of Bills (TOBs) 12X, 13X, 85X to the Claims Processing Manual (CPM) and a note regarding HCPCS codes C1824 and C1898 are not separately paid, as the payment is packaged and considered part of the eligible comprehensive procedure. Clarification language added on processing claims with HCPCS code K1030 by updating Pub. 100-04 Policy section, Business Requirements (BRs) 14311 - 04.3, adding BRs 14311 - 04.3.1, 14311 - 04.3.2 and 14311 - 04.4.1, this correction also updates Pub. 100-04 IOM. There are no changes to publication Pub 100-03. All other information remains the same.

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)
R	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
R	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: 13716	Date: April 3, 2026	Change Request: 14311
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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.

The A/B MACs (A) shall establish local fee schedule amounts to pay claims for HCPCS K1030, when applicable, and payment should be made in accordance with the payment rules associated with each local payment determination (e.g., an item determined to be an expensive item of DME that is reasonable and necessary and not otherwise excluded from coverage by statute, regulations, an NCD or program instructions, must be paid on a capped rental basis in accordance with regulations at 42 CFR 414.229). Program instructions on DMEPOS gap-fill pricing are available in publication 100-04, Medicare Claims Processing Manual, chapter 23, section 60.3 and 60.3.1.

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 MAC	Shared-System Maintainers				Other
		A	B	HH H		FIS S	MC S	VM S	CW F	
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 instructions.	X	X							
14311 - 04.2	<p>Contractors shall process CCM claims submitted with the following with the following criteria:</p> <ul style="list-style-type: none"> Type of Bill (TOB) 11X, and International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) codes: <ul style="list-style-type: none"> Insertion/replacement 0JH60AZ 0JH63AZ 0JH80AZ 0JH83AZ 02H63MZ 02HK3MZ, and Value code D4 with the 8-digit National Clinical Trial (NCT) number, and 	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HH H		FIS S	MC S	VM S	CW F	
	I50.814 I50.82 I50.83 I50.84 I50.89 I50.9									
14311 - 04.3	<p>Contractors shall process CCM claims submitted with the following criteria:</p> <ul style="list-style-type: none"> • TOB 12X, 13X, or 85X • Current Procedural Terminology (CPT) codes: <p>Insertion/Replacement procedures</p> <p>0408T</p> <p>0409T</p> <p>0410T</p> <p>0411T</p> <p>Removal procedures</p> <p>0412T</p> <p>0413T</p> <p>0414T</p> <p>Repositioning procedures</p> <p>0415T</p> <p>0416T</p>	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HH H		FIS S	MC S	VM S	CW F	
	I50.89 I50.9									
14311 - 04.3.1	Contractors shall establish local fee schedule amounts to pay claims for HCPCS K1030, when applicable.	X								
14311 - 04.3.2	Contractors shall suspend claims containing HCPCS K1030 for reason code W7061 until the installation of the July 2026 release and apply the following contractor bypass: BP1 = 061 CB SI = A CB PI = 2 CB DF = 1 CB LID/RF = 0 CB PF = 0 CP PAF1 = 00 CB PMF = 2 CB PAF2 = 00	X								
14311 - 04.4	Contractors shall process CCM claims submitted with the following criteria: <ul style="list-style-type: none"> Place of Service (POS) 11, 19, 21, 22, 24, 26, 71, or 72 		X				X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HH H		FIS S	MC S	VM S	CW F	
	I50.813 I50.814 I50.82 I50.83 I50.84 I50.89 I50.9									
14311 - 04.4.1	Contractors shall establish local fee schedule amounts to pay claims for HCPCS K1030, when applicable.		X							
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 submitted 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).		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HH H		FIS S	MC S	VM S	CW F	
	Remittance Advice Remark Code (RARC) MA50: Missing/incomplete/invalid Investigational Device 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: <ul style="list-style-type: none"> • 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 	X	X			X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HH H		FIS S	MC S	VM S	CW F	
	<ul style="list-style-type: none"> I50.813 I50.814 I50.82 I50.83 I50.84 I50.89 I50.9, and Z00.6 (reported as other diagnosis) 									
14311 - 04.10.1	<p>Contractors shall use the following messages when denying claims:</p> <p>CARC 167: “This (these) diagnosis(es) is (are) not covered”.</p> <p>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.</p> <p>Group Code – CO (Contractual Obligation) or PR (Patient Responsibility) dependent upon liability.</p> <p>Use PR when:</p> <ul style="list-style-type: none"> On institutional claims, Occurrence Code 32 is present 	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HH H		FIS S	MC S	VM S	CW F	
	<p>(claim level) or Q0 (line level) on professional claims and the line level for institutional claims</p> <p>Medicare Summary Notice (MSN) 15.20: “The following policies were used when we made this decision: NCD 20.39”.</p> <p>Spanish Version – “Las siguientes políticas fueron utilizadas cuando se tomó esta decisión: NCD 20.39</p>									
14311 - 04.11	<p>Contractors shall return as unprocessable claims for CCM services when services were billed in other than POS 11, 19, 21, 22, 24, 26, 71, or 72 and use the following messages:</p> <p>CARC 58: Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.</p> <p>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.</p>		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HH H		FIS S	MC S	VM S	CW F	
	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: 0

Medicare Claims Processing Manual

Chapter 32 -Billing Requirements for Special Services

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Transmittals for Chapter 32

412 - Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease (AD)

412.1 - Coding Information

412.2 - Claim Processing Instructions

412.3 – Messaging

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. 13716; Issued: 04-03-26; Effective: 10-28-25; Implementation: 04-06-26)

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. 13716; Issued: 04-03-26; Effective: 10-28-25; Implementation: 04-06-26)

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

NOTE: *HCPCS codes C 1824 and C1898 are not separately paid, as the payment is packaged and considered part of the eligible comprehensive procedure.*

K1030- External recharging system for battery (internal) for use with implanted cardiac contractility modulation generator, replacement only. Contractors shall establish local fee schedule amounts to pay claims for HCPCS K1030, when applicable.

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. 13716; Issued: 04-03-26; Effective: 10-28-25; Implementation: 04-06-26)

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 11, 19, 21, 22, 24, 26, 71, or 72*
- 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. 13716; Issued: 04-03-26; Effective: 10-28-25; Implementation: 04-06-26)

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

- TOB 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*

OR

- 012X, 013X, or 085X; and*
- one of the CPT codes listed in section 416.1*
- one of the HCPCS codes listed in section 416.1*
- 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 (as other diagnosis), and*
- One of the ICD-10-CM diagnosis codes listed in section 416.1 (as principal diagnosis)*

416.4 Messages

(Rev. 13716; Issued: 04-03-26; Effective: 10-28-25; Implementation: 04-06-26)

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) 11, 19, 21, 22, 24, 26, 71, or 72 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