Medtronic

REIMBURSEMENT GUIDE
LINQ FAMILY OF ICMs

Hospital & Physician Coding, Coverage, & Payment

Reveal LINQ™ ICM LINQ II™ ICM

February 2021

Medtronic

HOSPITAL & PHYSICIAN REIMBURSEMENT GUIDE
LINQ FAMILY OF ICMs

This guide has been developed to help you understand Medicare coverage, coding, and payment for the LINQ family of Insertable Cardiac Monitors (ICMs).

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OVERVIEW
LINQ FAMILY OF ICMs

The LINQ family of ICMs are subcutaneous cardiac rhythm monitors (SCRMs), also known as implantable loop recorders (ILRs). The reimbursement information contained in this document refers to policies for all SCRM/ILRs.

FDA-cleared Indications

The Reveal LINQ™ and LINQ II™ Insertable Cardiac Monitors (ICMs), referred to throughout this Guide as the "LINQ family of ICMs", are insertable, automatically activated and patient-activated monitoring systems that record subcutaneous ECG and are indicated in the following cases:

- Patients with clinical syndromes or situations at increased risk of cardiac arrhythmias
- Patients who experience transient symptoms such as dizziness, palpitation, syncope, and chest pain that may suggest a cardiac arrhythmia

The device has not been tested specifically for pediatric use.

2021 UPDATES FOR LINQ FAMILY OF ICMs

Supervision Requirements Update

- Effective January 1, 2021, CMS permits non-physician practitioners [such as nurse practitioners (NPs) and physician assistants (PAs)] to **supervise** diagnostic tests (including CIED management) ONLY in states where it is allowed by state law and scope of practice.[2] In all other states only a physician can supervise diagnostic tests.
- Previously, CMS permitted non-physician practitioners to order diagnostic tests (including CIED management) but the regulations did not address whether these practitioners could supervise others who furnished diagnostic tests.

Coding Update

- In late 2020, the American Medical Association (AMA) CPT® Editorial Panel announced approval of a new Category III CPT® code to describe remote programming of subcutaneous cardiac rhythm monitors. The new code will be effective July 1, 2021.
- The existence of a Category III CPT® code does not guarantee payment. Individual payers will determine payment based upon their own criteria and policies.

Code	Description
0650T	Programming device evaluation (remote) of subcutaneous cardiac rhythm monitor system with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified healthcare professional.

PRIOR AUTHORIZATION

Seeking prior authorization (sometimes referred to as pre-authorization, pre-certification, or prior approval) from the patient's payer for the insertion of a subcutaneous cardiac rhythm monitor (SCRM)/implantable loop recorder (ILR) device for all payers other than traditional Medicare is encouraged. Traditional Medicare does not require, nor does it provide, prior authorization.

This section is not intended as a guide through prior authorization, but rather depicts a simplified version of the prior authorization process for your convenience. The requirements vary by payer. Check with the payer regarding their specific processes. All interactions with private payers should be performed by specially trained personnel. A prior authorization does not guarantee coverage.

Definition

Prior authorization is approval from a health plan that may be required prior to a service or prescription in order for that service or prescription to be potentially covered by the plan.

Steps in the Prior Authorization Process

Step 1: Collect Information

- Collect all patient, physician, and payer information.
  - Patient's name
  - Insurance ID card/payer information
  - Physician/facility information (NPI and Tax ID numbers)
- Obtain patient consent to release patient information to their insurance company (if required).
- Identify diagnosis and corresponding facility and/or physician billing codes.
- Include documentation supporting the need for the intended procedure or service and any prior testing with results.

Step 2: Contact the Payer

- Confirm eligibility and benefits.
- Inquire about coverage for the intended procedure or service.
- Determine payer policy requirements for prior authorization. If prior authorization is not required, inquire if a predetermination can be filed.

Verbal authorization may be given based on the information above. Written authorization is preferred. Whether authorization is verbal or written, obtain an authorization number. For written authorization, provide any required prior authorization form(s) for the payer and/or a letter of medical necessity along with supporting documentation and prior testing results.

Step 3: Send the Requested Information

Gather all requested materials and mail, fax, or submit online through the payer website to the department responsible for the prior authorization decisions.

Step 4: Follow-up

Call the payer to verify receipt of the prior authorization request and continue to follow up routinely with the payer until a coverage decision has been made and communicated back to you.

Step 5: Re-verify Eligibility

When the prior authorization has been granted, obtain the prior authorization number and expiration date for your files and request an official approval correspondence. Re-verify the patient's eligibility to confirm that the patient is still covered by this payer and that the patient's plan has not changed.

Step 6: If Necessary, Appeal

If the prior authorization is denied, the physician and patient must decide if they want to appeal the decision. For an appeal, be prepared to:

- Review the denial and any information provided by the payer. If no information is provided, request information from the payer regarding their appeal process.
- Send an appeal letter and any required materials as directed by the payer.
- Verify the payer received appeal materials.
- File the appeal within the time limit set by the payer as listed in the denial letter.
- Patients can also submit a personal appeal to their payer or contact their employer for assistance.

COVERAGE FOR LINQ FAMILY OF ICMs

Traditional Medicare Coverage

For traditional Medicare patients, Medicare has not issued a national coverage determination nor have any contractors issued any local coverage determinations for subcutaneous cardiac rhythm monitors (SCRMs)/implantable loop recorders (ILRs). In the absence of a formal coverage policy, the Social Security Act allows for coverage for Reveal LINQ and LINQ II FDA-labeled indications when the local contractors determine it is medically reasonable and necessary.[3] Traditional Medicare does not require, nor does it provide, prior authorization, and no prior testing requirements are specified. It is the provider's responsibility to document "reasonable and necessary."[4]

Medicare Advantage Coverage

Medicare Advantage plans are required to cover at least what is covered by Traditional Medicare. Therefore, Medicare coverage policies apply to both traditional Medicare and Medicare Advantage (MA) plans.[5] MA plan administrators may have policies and additional requirements such as prior testing and prior authorization. Medtronic recommends that you review the specific payer coverage policies applicable to your patient to verify all the criteria for coverage are met and/or to request a prior authorization. Asking about coverage or requesting authorization after an implant procedure may result in unpaid claims, leaving both the hospital and the physician without compensation.

Non-Medicare Payer Coverage

Non-Medicare payers typically determine coverage for procedures based on any applicable medical policies and prior authorization when indicated. Not all published policies apply to all patients covered by a particular payer. Medtronic recommends that you review the specific payer coverage policies applicable to your patient to verify all the criteria for coverage are met and to request a prior authorization. Asking about coverage or requesting authorization after an implant procedure may result in unpaid claims, leaving both the hospital and the physician without compensation.

Best Practices for Documentation to Substantiate Coverage

Documentation in the patient's medical record must support the medical necessity of all procedures being performed. Some factors to consider including in that documentation might be:

- Any prior incidents, signs, or symptoms that might suggest a history of possible arrhythmia
- Patients who experience transient symptoms such as dizziness, palpitation, syncope, and chest pain that may suggest a cardiac arrhythmia
- Use/type/duration/findings of any prior cardiac monitoring, including any in-hospital cardiac telemetry/monitoring, and/or other prior diagnostic testing
- Any significant risk factors or comorbidities that may affect clinical management
- Any functional impairment that might limit ability to use or activate a monitoring device
- Other alternative diagnostic and/or therapeutic modalities that were considered for this patient but not selected for use
- Potential use and/or impact of the data acquired from the SCRM/ILR on the clinical management of this patient

CODING
LINQ FAMILY OF ICMs

The coding information below does not replace seeking coding advice from the payer and/or your own coding staff. The ultimate responsibility for correct coding lies with the provider of services. All diagnosis and procedure codes must be supported by clear documentation within the medical record.[6]

CPT® Codes

The following CPT®[1] codes describe procedures associated with subcutaneous cardiac rhythm monitors (SCRMs)/implantable loop recorders (ILRs). Services rendered will dictate the appropriate coding. These codes may be used by physicians for all services and may be used by facilities when services are rendered in the outpatient hospital or ambulatory surgery center setting. It is the physician's discretion as to what codes to report based on what procedures were performed.

CPT® Code[1]	CPT® Code Description[1]
Subcutaneous Cardiac Rhythm Monitor Procedures (Includes Loop Recorders)	
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming
33286	Removal, subcutaneous cardiac rhythm monitor
Subcutaneous Cardiac Rhythm Monitor Interrogation — In person	
93291	Interrogation device evaluation (in person) with analysis, review, and report by a physician or other qualified healthcare professional, includes connection, recording, and disconnection per patient encounter; subcutaneous cardiac rhythm monitor system, including heart rhythm-derived data analysis
Subcutaneous Cardiac Rhythm Monitor Programming — In person	
93285	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, review, and report by a physician or other qualified healthcare professional; subcutaneous cardiac rhythm monitor system
Subcutaneous Cardiac Rhythm Monitor Interrogation — Remote	
93298	Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s), and report(s) by a physician or other qualified healthcare professional
G2066	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, implantable loop recorder system, or subcutaneous cardiac rhythm monitor system, remote data acquisition(s), receipt of transmissions and technician review, technical support, and distribution of results
Subcutaneous Cardiac Rhythm Monitor Programming — Remote	
0650T (Effective July 1, 2021)	Programming device evaluation (remote) of subcutaneous cardiac rhythm monitor system, with iterative adjustment of the implantable device to test the function of the device and select optimal permanently programmed values with analysis, review and report by a physician or other qualified healthcare professional

HCPCS Codes (C-codes)

Medicare provides device C-codes for hospital use in billing Medicare for medical devices in the outpatient setting.[7] The following HCPCS device C-code relates to the implantation of subcutaneous cardiac rhythm monitors.

HCPCS Code	HCPCS Code Description
C1764	Event recorder, cardiac (implantable)

ICD-10-PCS Procedure Codes

Hospitals assign ICD-10-PCS codes for procedures performed during an inpatient admission. The following ICD-10-PCS codes describe commonly performed subcutaneous cardiac rhythm monitor procedures.

ICD-10-PCS Code[8]	ICD-10-PCS Code Description
Insertion of monitoring device	
0JH632Z	Insertion of monitoring device into chest subcutaneous tissue and fascia, percutaneous approach
Removal of monitoring device	
0JPT32Z	Removal of monitoring device from trunk subcutaneous tissue and fascia, percutaneous approach
0JPT02Z	Removal of monitoring device from trunk subcutaneous tissue and fascia, open approach

ICD-10-CM Diagnosis Codes

Hospitals and other providers assign ICD-10-CM codes to indicate a patient's diagnosis or clinical status. The following is a list of examples of possible ICD-10-CM diagnosis codes that may relate to indications associated with subcutaneous cardiac rhythm monitor procedures. This is not an all-inclusive list and the diagnosis codes reported should be based on documentation appropriate to individual patient presentation.

ICD-10-CM Diagnosis Code[9]	ICD-10-CM Diagnosis Code Description
Stroke and Transient Ischemic Attack	
I63.0-I63.9	Acute ischemic stroke
G45.0-G45.3, G45.8-G45.9	Transient cerebral ischemic attacks and related syndromes
I69.30-I69.998	Sequelae of cerebral infarction (late effect of ischemic stroke) and other cerebrovascular disease
Z86.73	Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits
Suspected Arrhythmia: Syncope/Pre-syncope	
R00.2	Palpitations
R42	Dizziness and giddiness (light-headedness)
R55	Syncope and collapse (pre-syncope)
R94.31	Abnormal electrocardiogram (ECG) (EKG)

ICD-10-CM Diagnosis Code[9]	ICD-10-CM Diagnosis Code Description
Suspected Arrhythmia: Atrial Fibrillation	
R00.2	Palpitations
R06.02	Shortness of breath
R07.89	Other chest pain (includes chest pressure, discomfort, and tightness)
R07.9	Chest pain, unspecified
R42	Dizziness and giddiness (light-headedness)
R53.83	Other fatigue (includes lack of energy, tiredness)
R55	Syncope and collapse (includes fainting, pre-syncope, and near-collapse)
R94.31	Abnormal electrocardiogram (ECG) (EKG)
Monitoring of Known Atrial Fibrillation	
I48.0	Paroxysmal atrial fibrillation
I48.11	Longstanding persistent atrial fibrillation
I48.19	Other persistent atrial fibrillation
I48.20	Chronic atrial flutter, unspecified
I48.21	Permanent atrial fibrillation
I48.91	Unspecified atrial fibrillation
Z79.01	Long-term (current) use of anticoagulants

ICD-10-CM Diagnosis Code[9]	ICD-10-CM Diagnosis Code Description
Monitoring of Other Known Arrhythmias	
I47.0	Reentry ventricular arrhythmia
I47.1	Supraventricular tachycardia
I47.2	Ventricular tachycardia
I47.9	Paroxysmal tachycardia, unspecified
I48.3	Typical atrial flutter
I48.4	Atypical atrial flutter
I48.92	Unspecified atrial flutter
I49.01	Ventricular fibrillation
I49.02	Ventricular fibrillation
I49.1	Atrial premature depolarization (premature atrial beats and contractions)
I49.2	Junctional premature depolarization
I49.3	Ventricular premature depolarization (premature ventricular contractions)

PAYMENT
LINQ FAMILY OF ICMs

The following information reflects the Medicare national allowable amount published by CMS and does not include Medicare payment reductions resulting from sequestration adjustments to the amount payable to the provider, as mandated by the Budget Control Act of 2011. The Medtronic Customer Economics and Reimbursement teams can provide current site-specific information upon request.

Physician Coding and Payment[10]

Effective Jan. 1, 2021–Dec. 31, 2021

Physicians use CPT® codes to represent procedures and services performed in all places of service. Under Medicare's methodology for physician payment, each CPT® code is assigned a value, known as relative value units (RVUs). RVUs are part of how Medicare determines a payment amount.

Procedure	CPT® Code[1]	Modifier	CPT® Description	2021 Medicare National Non-facility		2021 Medicare National Facility	
				Total RVUs[10]	Payment Rate[10]	Total RVUs[10]	Payment Rate[10]
Subcutaneous Cardiac Rhythm Monitor Procedures (includes Loop Recorders)	33285		Insertion, subcutaneous cardiac rhythm monitor, including programming	149.03	$5,200	2.58	$90
	33286		Removal, subcutaneous cardiac rhythm monitor	4.04	$141	2.55	$89
Subcutaneous Cardiac Rhythm Monitor Interrogation — In person	93291		Interrogation device evaluation (in person) with analysis, review, and report by a physician or other qualified healthcare professional, includes connection, recording, and disconnection per patient encounter; subcutaneous cardiac rhythm monitor system, including heart rhythm-derived data analysis	1.41	$49	N/A	N/A
	93291	26		0.53	$18	0.53	$18
	93291	TC		0.88	$31	N/A	N/A

Procedure	CPT® Code[1]	Modifier	CPT® Description	2021 Medicare National Non-facility		2021 Medicare National Facility	
				Total RVUs[10]	Payment Rate[10]	Total RVUs[10]	Payment Rate[10]
Subcutaneous Cardiac Rhythm Monitor Programming — In person	93285		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, review, and report by a physician or other qualified healthcare professional; subcutaneous cardiac rhythm monitor system	1.73	$60	N/A	N/A
	93285	26		0.75	$26	0.75	$26
	93285	TC		0.98	$34	N/A	N/A

Procedure	CPT® Code[1]	Modifier	CPT® Description	2021 Medicare National Non-facility		2021 Medicare National Facility	
				Total RVUs[10]	Payment Rate[10]	Total RVUs[10]	Payment Rate[10]
Subcutaneous Cardiac Rhythm Monitor Interrogation — Remote	93298		Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s), and report(s) by a physician or other qualified healthcare professional	0.77	$27	0.77	$27
	G2066		Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, implantable loop recorder system, or subcutaneous cardiac rhythm monitor system, remote data acquisition(s), receipt of transmissions and technician review, technical support, and distribution of results	Contractor-priced*			

Procedure	CPT® Code[1]	Modifier	CPT® Description	2021 Medicare National Non-facility		2021 Medicare National Facility	
				Total RVUs[10]	Payment Rate[10]	Total RVUs[10]	Payment Rate[10]
Subcutaneous Cardiac Rhythm Monitor Programming — Remote	0650T (Effective July 1, 2021)		Programming device evaluation (remote) of subcutaneous cardiac rhythm monitor system, with iterative adjustment of the implantable device to test the function of the device and select optimal permanently programmed values with analysis, review and report by a physician or other qualified healthcare professional	Contractor-priced*			

26 — Professional Component TC — Technical Component

*Contractor-priced codes are not assigned a rate on a national level. Local contractors will determine the reimbursement amount on a case-by-case basis.

Hospital Outpatient Payment[11]

Effective Jan. 1, 2021–Dec. 31, 2021

Hospitals use CPT® codes for outpatient services. The procedure codes below apply to services performed in the hospital outpatient setting.

Under Medicare's Ambulatory Payment Classification (APC) methodology for hospital outpatient payment, each CPT® code is assigned to an ambulatory payment class. Each APC has a relative weight that is then converted to a flat payment amount.

CPT® Code[1]	CPT® Description	2021 APC[11]	APC Title[11]	Status Indicator[11]	Relative Weight[11]	2021 Medicare National Unadjusted Rate[11]
Subcutaneous Cardiac Rhythm Monitor Procedures (Includes Loop Recorders)						
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	5222	Level 2 Pacemaker and Similar Procedures	J1	98.46	$8,153
33286	Removal, subcutaneous cardiac rhythm monitor	5071	Level 1 Excision/ Biopsy/ Incision and Drainage	Q2	7.51	$622

CPT® Code[1]	CPT® Description	2021 APC[11]	APC Title[11]	Status Indicator[11]	Relative Weight[11]	2021 Medicare National Unadjusted Rate[11]
Subcutaneous Cardiac Rhythm Monitor Programming — In person						
93285	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, review, and report by a physician or other qualified healthcare professional; subcutaneous cardiac rhythm monitor system	5741	Level 1 Electronic Analysis of Devices	Q1	0.45	$37
93291	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified healthcare professional, includes connection, recording and disconnection per patient encounter; subcutaneous cardiac rhythm monitor system, including heart rhythm derived data analysis	5731	Level 1 Minor Procedures	Q1	0.30	$25

CPT® Code[1]	CPT® Description	2021 APC[11]	APC Title[11]	Status Indicator[11]	Relative Weight[11]	2021 Medicare National Unadjusted Rate[11]
Subcutaneous Cardiac Rhythm Monitor Interrogation — Remote						
93298	Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s), and report(s) by a physician or other qualified healthcare professional	N/A	N/A	M	N/A	Physician Only
G2066	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, implantable loop recorder system, or subcutaneous cardiac rhythm monitor system, remote data acquisition(s), receipt of transmissions and technician review, technical support, and distribution of results	5741	Level 1 Electronic Analysis of Devices	Q1	0.45	$37
Subcutaneous Cardiac Rhythm Monitor Programming — Remote						
0650T (Effective July 1, 2021)	Programming device evaluation (remote) of subcutaneous cardiac rhythm monitor system, with iterative adjustment of the implantable device to test the function of the device and select optimal permanently programmed values with analysis, review and report by a physician or other qualified healthcare professional	N/A	N/A	N/A	N/A	N/A

Ambulatory Surgical Center (ASC) Payment

Effective Jan. 1, 2021–Dec. 31, 2021[12]

ASCs use CPT® codes for their services. Medicare payment for procedures performed in an ambulatory surgery center is generally based on Medicare's ambulatory payment classification (APC) methodology for hospital outpatient payment. However, comprehensive APCs are used only for hospital outpatient services and are not applied to procedures performed in ASCs. Alternately, payment for some CPT codes is based on the physician fee schedule payment, particularly for procedures commonly performed in the physician office.

Each CPT code designated as an approved procedure in an ASC is assigned a comparable relative weight as under the hospital outpatient APC system. This is then converted to a flat payment amount using a formula unique to ASCs. Multiple procedures can be paid for each claim. Certain ancillary services, such as imaging, may also be reimbursed when they are integral to an approved surgical procedure. Some of these ancillary services are not separately payable. There is no separate payment for these devices in the ASC setting; their payment is included in the payment for the procedure.

CPT® Code[1]	CPT® Description	Subject to Multiple Procedure Discounting[12]	2021 Medicare National Unadjusted Payment Rate[12]
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	Y	$7,046
33286	Removal, subcutaneous cardiac rhythm monitor	N	$316

All other applicable CPT codes for SCRM are not payable in the ASC setting, and are not listed here.

Hospital Inpatient Payment

Effective Oct. 1, 2020–Sept. 30, 2021[13]

Medicare reimbursement for inpatient hospital services is based on a classification system known as Medicare severity diagnosis related groups (MS-DRGs). MS-DRG assignment is determined by patient diagnoses and procedures. Only one MS-DRG is assigned per hospital admission, and one payment is made for all procedures and supplies related to that inpatient stay. MS-DRG assignment may be affected when one or more secondary diagnoses that are included in the major complication or comorbidity (MCC) or complication or comorbidity (CC) lists, which are maintained by CMS. Each MS-DRG has a relative weight that is then converted to a flat payment amount. Only one MS-DRG is assigned for each inpatient stay, regardless of the number of procedures performed. The MS-DRGs shown are those typically assigned to the following scenarios

MS-DRG[14]	MS-DRG Description	FY2021 MS-DRG Medicare National Unadjusted Payment Rate[13]
SCRM Insertion during an Admission for Cryptogenic Stroke		
040	Peripheral/cranial nerve and other nervous system procedures with MCC	$25,439
041	Peripheral/cranial nerve and other nervous system procedures with CC or peripheral neurostimulator	$15,112
042	Peripheral/cranial nerve and other nervous system procedures without CC/MCC	$12,115

MS-DRG[14]	MS-DRG Description	FY2021 MS-DRG Medicare National Unadjusted Payment Rate[13]
SCRM Insertion during an Admission for Syncope		
260	Cardiac pacemaker revision except device replacement with MCC	$23,038
261	Cardiac pacemaker revision except device replacement with CC	$12,799
262	Cardiac pacemaker revision except device replacement without CC/MCC	$10,979

CC — Complication or Comorbidity MCC — Major Complication or Combidity

FREQUENTLY ASKED QUESTIONS

Insertion & Removal Coding and Payment

1 When subcutaneous cardiac rhythm monitor (SCRM)/implantable loop recorder (ILR) insertion is performed in the outpatient hospital during the same episode of care as another procedure (for example, cardiac ablation), how is payment affected?

Hospital Outpatient Payment:

- Medicare reimburses device-intensive procedures performed in the hospital outpatient setting using Comprehensive Ambulatory Payment Classifications (C-APCs) payment rates. Under C-APCs, if two procedures designated by Medicare as included in C-APCs are performed concurrently, the procedure with the highest-weighted C-APC will be paid to the hospital. C-APCs package all supplies and services during that episode into one single payment.
- When an AF ablation and SCRM/ILR implant are both performed, only one C-APC reimbursement will be paid to the hospital. In this case, the AF ablation C-APC amount will be paid, as it is the higher-weighted procedure. No additional reimbursement payment for inserting the SCRM/ILR would be made to the hospital.

Physician Payment:

- Medicare physician payment is determined using the multiple procedure reduction rule. For concurrent procedures, the physician will be reimbursed the full fee schedule amount for the highest-weighted procedure and will be reimbursed at 50% of the fee schedule amount for all additional procedures.
- When an AF ablation and SCRM/ILR implant are both performed at the same time, the AF ablation will be paid at 100% of the fee schedule amount and the SCRM/ILR reimbursement insertion will be paid at 50% of the fee schedule amount when the payer determines coverage criteria have been met.

2 Can non-physician practitioners (NPPs), such as nurse practitioners (NPs) and physician assistants (PAs), perform SCRM/ILR insertion & removal procedures?

On or after January 1, 2019, CMS may cover an insertion/removal when performed by an NPP if the following criteria are all fulfilled:

- The procedure is within the scope of practice of the license for the state in which the NPP practices.[15]
- Payer rules must be followed. Payers may or may not allow insertions by NPPs, and the NPP needs to research each payer to obtain policy requirements, supervision rules, and the approval process.
- The NPP must meet the credentialing and supervision requirements at the location where the implant will occur.
- Also consider whether malpractice insurance covers the NPP for performing the insertion/removal procedures. Refer to CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, for non-physician practitioner rules.[16]

3 When an insertion takes place in an office, how is the office reimbursed for the cost of the device?

The device cost is included in the global Medicare PFS non-facility amount paid to the office for the insertion procedure.

4 Is there a global surgical period that applies for the insertion or removal of SCRM/ILR?

No, these codes are considered minor surgical procedures, which do not have a global period.[10]

5 What code should be reported when SCRM/ILR requires repositioning?

CPT does not have an established code that accurately describes repositioning of SCRM/ILR . The provider may consider using either 17999 (Unlisted procedure, skin, mucous membrane and subcutaneous tissue) or 33999 (Unlisted procedure, cardiac surgery). When reporting either of these codes, a description of the procedure performed must also be included on the claim form. The payer will determine coverage.

6 What codes would be reported when an SCRM/ILR is replaced?

The removal would be reported with 33286 and the placement of the new SCRM/ILR is reported with 33285. There are CCI edits for this coding combination. A modifier would be required for the removal ONLY when there is documentation that supports billing both codes. The payer will determine coverage.

Monitoring Coding and Payment

7 What code is used to report the technical component of remote monitoring and how is it reimbursed?

In 2020, CPT 93299 was deleted and replaced with HCPCS G2066. For traditional Medicare patients, HCPCS G2066 is contractor-priced, meaning the code is not assigned a rate on a national level. Local contractors will determine the reimbursement amount on a case-by-case basis. For private payers, including Medicare Advantage, we recommend contacting the payer to determine appropriate coding and associated payment.

8 What code would be reported when an SCRM/ILR is programmed remotely?

Beginning July 1, 2021, CPT code 0650T will accurately describe remote programming of an SCRM/ILR. See "2021 UPDATES" section for more information.

9 What is the minimum number of days that the SCRM/ILR patient need to be remoted monitored for the services to be billable?

The patient must be monitored for a minimum of 10 days of the full 30-day service period to meet the requirements to bill.[17]

10 Can a provider bill additionally for each SCRM/ILR transmission reviewed during a remote monitoring period?

No, SCRM/ILR remote monitoring codes are time-based and represent all work that occurs over a 30-day period. There is one payment made for the 30-day episode, regardless of the number of times that data is transmitted and/or reviewed.[17]

11 Is billing affected if an SCRM/ILR patient receives an in-person interrogation evaluation during a 30-day remote monitoring period?

In-person interrogation services are not separately reportable during the same period when remote monitoring is being performed. Only the remote monitoring service is billable (CPT code 93298 for the professional service and G2066 for the technical service).[17] If the patient receives in-person interrogation services during the remote monitoring period, this is not separately reportable or payable.

12 Is billing affected if an SCRM/ILR patient receives an in-person programming evaluation during a 30-day remote monitoring period?

When an in-person programming evaluation is performed during the remote 30-day episode, the programming evaluation may be separately billed.[17] The payer will determine coverage based on documented medical necessity.

13 What components of an SCRM/ILR must be evaluated during interrogation evaluation services?

The required components are the same for both remote and in-person interrogation[17]:

- All programmed parameters
- Heart rate and rhythm during recorded episodes from both patient-initiated and device algorithm-detected events, when present

For additional information

Visit our website:
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1.866.877.4102

References

[1] CPT codes and descriptions only are copyright ©2020 American Medical Association. All rights reserved. No fee schedules are included in CPT. The American Medical Association assumes no liability for data contained or not contained herein.

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Brief Statement

Reveal LINQ™ and LINQ II™ Insertable Cardiac Monitors with Reveal LINQ™ Mobile Manager System

Indications

The Reveal LINQ and LINQ II Insertable Cardiac Monitors (ICMs) are insertable automatically activated and patient-activated monitoring systems that record subcutaneous ECG and are indicated in the following cases:

- Patients with clinical syndromes or situations at increased risk of cardiac arrhythmias
- Patients who experience transient symptoms such as dizziness, palpitation, syncope, and chest pain that may suggest a cardiac arrhythmia.

The device has not been tested specifically for pediatric use.

Reveal LINQTM Mobile Manager System
The Reveal LINQ Mobile Manager app is intended for programming and interrogating the Reveal LINQ and LINQ II Insertable Cardiac Monitors. The patient connector is intended to be used with Medtronic apps to interrogate, analyze, and/or program implantable Medtronic devices. The patient connector uses Bluetooth® technology to transmit data to the Reveal LINQ Mobile Manager app for further processing. The patient connector is intended for use by healthcare professionals in a clinical or hospital environment.

Contraindications
There are no known contraindications for the implant of the Reveal LINQ Insertable Cardiac Monitor. However, the patient's particular medical condition may dictate whether or not a subcutaneous, chronically implanted device can be tolerated.

Warnings and Precautions

Reveal LINQ and LINQ II Insertable Cardiac Monitors

Patients with the Reveal LINQ and LINQ II ICMs should avoid sources of diathermy, high sources of radiation, electrosurgical cautery, external defibrillation, lithotripsy, therapeutic ultrasound, and radiofrequency ablation to avoid electrical reset of the device, and/or inappropriate sensing as described in the Medical Procedure and EMI Warnings, Precautions, and Guidance manual. MRI scans should be performed only in a specified MR environment under specified conditions as described in the Reveal LINQ or LINQ II MRI Technical Manual.

Reveal LINQ Mobile Manager System

Before inserting the device, verify that the patient connector and tablet are fully charged. The patient connector and tablet may run out of power during the insertion procedure if they are not fully charged. You will not be able to program or interrogate the patient's device until the patient connector and the tablet have power.

Only use the patient connector to communicate with the intended implanted device.

Use of wireless devices — The patient connector incorporates radiofrequency (RF) communications components which may affect other devices and equipment in the medical environment.

Radiofrequency (RF) interference — Portable and mobile RF communications equipment can interfere with the operation of the patient connector. There is no guarantee that it will not receive interference or that any particular transmission from this system will be free from interference.

Security — Maintain adequate physical security of the patient connector to prevent unauthorized use that could lead to harm to patients.

Environmental precautions — To ensure safe and effective operation, use the device with care to avoid damage to the patient connector from environmental factors that may impair its function.

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