Priority Health	BILLING POLICY No. 003
CARDIOLOGY	
Date of origin: July 2024	**Review dates: 08/2024, 09/2024, 09/2024, 11/2024, 2/2025, 6/2025, 2/2026, 9/2026**

POLICY OVERVIEW
This policy provides guidelines for billing, coding, and documentation associated with cardiology services, ensuring claims are processed according to contractual agreements and industry standards.

DEFINITION
Permanent cardiac pacemakers are self-contained, battery operated, implanted devices that send electrical stimulation to the heart through one or more implanted leads.

- **Single chamber**: Lead is placed in the atrium OR ventricle of the heart.
- **Dual chamber**: Leads are placed in the atrium AND ventricle of the hear.

FOR MEDICARE
For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination **(PSOD) must be completed**. Get additional details on PSODs in our Provider Manual.

Applicable Medicare non-coverage modifiers:

- **GA**: Waiver of liability statement issued as required by payer policy, individual case
- **GZ**: Item or service expected to be denied as not reasonable and necessary

Get additional details on when to bill modifiers GA and GZ in our Provider Manual.

POLICY NAVIGATION
Click the links below to navigate through this policy:

- Single chamber and dual chamber pacemakers
- Leadless pacemakers
- Cardioverter defibrillators – Implantable, automated external and wearable
- Peripheral arterial revascularization
- Angioplasty and stenting: Coronary and non-coronary
- Coronary artery bypass grafting (non-emergent)
- Implantable cardiac monitoring
- Valve replacement

Single chamber and dual chamber pacemakers

MODIFIERS

- **KX**: Requirements specified in the medical policy have been met

- **SC**: Medically necessary service or supply

IMPLANTS, REBATES AND RECALLS

If an implant needs to be replaced and there's a rebate (partial credit) or recall, there are specific billing requirements that must be followed.

- Revenue codes billed (0275)
- Specific implant device that aligns with revenue code (C Code)
- Value code – FD (Credit received from manufacturer for a replaced medical device)
- Condition code
  - **49**: Product replacement within the product lifecycle
  - **50**: Product replacement for known recall of a product
- Diagnoses that address the specific complication or need for replacement

See our Surgical devices and implants policy for details.

Leadless pacemakers

DEFINITION

A Leadless Pacemaker is a one-piece device that's implanted into a single heart chamber heart through a vein.

PLACE OF SERVICE (POS)

In accordance with Medicare, Priority Health will follow similar POS restrictions. If a claim is billed with a POS outside of what is listed below, the claim will be denied:

- **POS 06**: Indian Health Service Provider Based Facility
- **POS 21**: Inpatient hospital
- **POS 22**: On Campus-Outpatient Hospital
- **POS 26**: Military Treatment Facility

Cardioverter defibrillators – Implantable, automated external and wearable

IMPLANTABLE CARDIOVERTER DEFIBRILLATORS

Definition

An implantable cardioverter defibrillator (ICD) is a device that's surgically placed under the skin of your chest. The device is a battery/pulse generator and thin wires, called leads or electrodes. The leads are placed into the chambers of your heart. The battery powered device can deliver an electric shock to correct life-threatening arrhythmia and prevent sudden cardiac arrest. (Get more information from Cleveland Clinic and MedlinePlus Medical Encyclopedia.)

For Medicare

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination **(PSOD) must be completed**. Find more information on PSODs in our Provider Manual.

Place of service (POS)

In accordance with Medicare, Priority Health will follow similar POS restrictions. If a claim is billed with a POS outside of what is listed below, the claim will be denied.

- **POS 19**: Off Campus- Outpatient Hospital
- **POS 21**: Inpatient hospital
- **POS 22**: On Campus-Outpatient Hospital
- **POS 26**: Military Treatment Facility

Documentation requirements
Priority Health follows standard CMS documentation requirements. Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements that are necessary of any applicable NCD or LCD.

Modifiers
In accordance with Medicare, modifier Q0 should be reported on claims where members are receiving a defibrillator for the primary prevention of sudden cardiac arrest as they are enrolled in a qualifying data collection system.

Q0 – Investigational clinical service provided in a clinical research study that is in an approved clinical research study

See CMS guidance for specific diagnosis codes also required with use of this modifier.

AUTOMATED EXTERNAL CARDIOVERTER DERIBRILLATOR
Definition
An AED is a lightweight, battery-operated, portable device that checks the heart's rhythm and can send a shock to the heart to restore normal rhythm.

WEARABLE CARDIOVERTER DEFIBRILLATOR
Definition
A vest worn under clothing next to the skin. Pads on the vest monitor your heart and can deliver high-energy charges to treat dangerous arrhythmias or cardiac arrest. Get more information from the National Heart, Lung and Blood Institute.

Documentation requirements
Priority Health follows standard CMS DME documentation requirements. This listing **isn't all inclusive**. See CMS guidance for a complete listing of requirements,

- Standard Written Order (SOW)
- Written Orders Prior to Delivery (WOPD) if applicable
- Information from the treating practitioner concerning the patient's diagnosis
- Description of the item(s) provided to the member in sufficient detail
- If billing an unlisted code: Include the name of the item, the manufacturer, and specific information on why you're using an unlisted HCPCS code. See additional information here.
- Current treatment plan and updated recommendations

HCPCS modifiers
Priority Health follows standard CMS bundling rules. Documentation must support modifier application.

- **EY**: No physician or other licensed health care provider order for this item or service

- **GA**: Waiver of liability statement issued as required by payer policy, individual case. Get more information about the GA modifier in our Provider Manual.
- **KF**: Item designated by FDA as class III device
- **KX**: Requirements specified in the medical policy have been met

REFERENCES

- Claims Processing Instructions for National Coverage Determination (NCD) 20.4 Implantable Cardiac Defibrillators (ICDs) (CMS)
- Medicare Claims Processing Manual: Chapter 32 – Billing Requirements for Special Services
- Surgery and Procedure Services Documentation Requirements (Noridian Healthcare Solutions)
- Standard Documentation Requirements for All Claims Submitted to DME MACs (CMS)
- Medicare Claims Processing Manual: Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Peripheral arterial revascularization

DEFINITION

Revascularization repairs narrowing or blockages in your leg arteries to allow blood flow. This may be done using the following methods:

- **Angioplasty**: Minimally invasive procedures to treat narrow or blocked arteries in locations other than the heart. During the procedure, a catheter is inserted into the vessel to locate the area of blockage. A balloon is then sent to the blocked area on another catheter, opening the blockage.
- **Stent**: Metal mesh tube placed in the newly opened vessel to keep it open.
- **Atherectomy**: Minimally invasive procedure to remove plaque from narrow or blocked arteries. Types of atherectomies include Excisional, Laser ablation, Orbital and Rotational.
- **Bypass**: Use of one of your veins or an artificial graft to reroute the blood flow around a blocked artery.
- **Endarterectomy**: Cutting into the artery and removing the plaque inside it.

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get additional details on PSOD.

MEDICAL POLICY

Priority Health has contracted with TurningPoint Healthcare Solutions LLC (TurningPoint) for management of some cardiac services. Medical necessity for these procedures will be governed by the applicable TurningPoint clinical guidelines. To access these guidelines, log into your **prism** account. Under the Authorizations menu, click **Authorization Criteria Lookup** then the **TurningPoint link**.

POLICY SPECIFIC INFORMATION

Priority Health follows CMS coverage and billing requirements/guidance. Review any applicable NCD, LCD and LCAs for specific requirements. Be sure to consult CPT to review all coding instructions before assigning codes.

- There are multiple conditions that cause vascular obstructions (i.e., thrombosis, embolism, atherosclerosis). Treatment would correspond to the condition cause (i.e., thrombectomy, embolectomy, endarterectomy). The most comprehensive code describing services performed at given site/vessel is the **only** code that should be reported.
- Only one type of bypass procedure may be performed at a site of obstruction.

- If a procedure is started with one material but completes the graft with another material, only report the code describing the completed procedure.
- Bypass graft includes blood vessel repair. CPT 35201-35286 shouldn't be reported with a bypass graft code for the same anatomic site.
- Postoperative hemorrhage (CPT 35800-35860) may only be reported when patient requires a trip back to the operating room for treatment. Specific modifier should also be used.
- CPT 35800-35860 **shouldn't** be applied on the initial operative session for postoperative hemorrhage treatment.
- Devices must be FDA approved to be considered for payment.
- If an endarterectomy is required during a bypass procedure, to insert the graft, only the code for the bypass may be reported.

Place of service (POS)
Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get additional information.

Documentation requirements
Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Modifiers

- **Modifier 78**: Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period
- **Modifier 59**: Distinct Procedural Service
- **Modifier XU**: Unusual nonoverlapping service, the use of a service that is distinct because it does not overlap usual components of the main service
- **Modifier XS**: Separate structure, a service that is distinct because it was performed on a separate organ/structure

REFERENCES

- Medicare 2024 NCCI Policy Manual – Chapter 5 (CMS)
- Medicare Program Integrity Manual – Chapter 13 (CMS)
- Leg Revascularization (Cleveland Clinic)

Angioplasty and stenting: Coronary and non-coronary

CORONARY ANGIOPLASTY AND STENTING

Definition
Coronary angioplasty or percutaneous coronary intervention (PCI) is a non-surgical procedure to treat the stenotic coronary arteries of the heart. During the procedure, a deflated balloon or other device on a catheter is fed from the inguinal artery or radial artery up through blood vessels to the blockage in the heart. The balloon is inflated at the blockage to open the artery. A stent may be placed to keep the blockage site open. Imaging may be used.

For Medicare
For indications that do not meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get additional details on PSOD.

Medical policy

Priority Health has contracted with TurningPoint Healthcare Solutions LLC (TurningPoint) for management of some cardiac services. Medical necessity for these procedures will be governed by the applicable TurningPoint clinical guidelines. To access these guidelines, log into your **prism** account. Under the Authorizations menu, click **Authorization Criteria Lookup** then the **TurningPoint link**.

Policy specific information

Percutaneous coronary interventions (PCI) procedure codes are created on progressive hierarchies. The more intensive services are inclusive of the lesser intensive services. The codes include the work of:

- Accessing and selectively catheterizing the vessel
- Passing through the lesion
- Radiological supervision and interpretation related to the procedure performed

Coding information

- If one lesion extends from one target vessel into another target vessel but can be revascularized with a single intervention treating the two vessels, only a single code should be reported even though you are treating more than one vessel.
- Angiography performed during the procedure to monitor the intervention isn't separately billable.
- Deployment of a device for embolic protection is considered inclusive and not separately billable.
- An intervention is billed as a single procedure regardless of the number of lesions treated in the vessel.

Documentation requirements

All documentation must support the performed medical procedure and need for the procedure and include the following which **isn't** an all-inclusive listing:

- Relevant medical history
- Physical examination
- Results of pertinent diagnostic tests/procedures
- Description of the procedure performed including additional devices/medications used
- Outcome of the procedure
- Documentation of complications or reason procedure was not completed
- Comparison with relevant studies/procedures
- Diagnosis of the condition of the patient or the reason the test was performed
- Documentation of reason a service was repeated

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. Review CMS NCCI for additional information.

The following modifiers should be applied to identify with vessel is being treated by PCI:

- **LD**: Left anterior descending coronary artery
- **LC**: Left circumflex coronary artery
- **RC**: Right coronary artery
- **LM**: Left main artery
- **RI**: Rasmus intermedius artery

References

- LCD - Percutaneous Coronary Interventions (L34761) (CMS)

- Article - Billing and Coding: Percutaneous Coronary Interventions (A57479) (CMS)
- Medicare 2024 NCCI Policy Manual – Chapter 11 (CMS)

NON-CORONARY ANGIOPLASTY AND ENDOVASCULAR STENTING

Definition

Non-coronary angioplasty or percutaneous transluminal angioplasty (PTA) are minimally invasive procedures to treat narrow or blocked arteries in locations other than the heart. During the procedure a catheter is inserted into the vessel to locate the area of blockage. A balloon is then sent to the blocked area on another catheter, opening the blockage. A stent may be placed to keep the artery open after balloon removal.

For Medicare

For indications that do not meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get additional details on PSOD.

Medical policy

Priority Health has contracted with TurningPoint Healthcare Solutions LLC (TurningPoint) for management of some cardiac services. Medical necessity for these procedures will be governed by the applicable TurningPoint clinical guidelines. To access these guidelines, log into your **prism** account. Under the Authorizations menu, click **Authorization Criteria Lookup** then the **TurningPoint link**.

- **91636**: Category III Current Procedural Terminology
- **91495**: Carotid and Intracranial Artery Stenting

Policy specific information

Priority Health follows CMS coverage and billing requirements/guidance. Review any applicable NCD, LCD and LCAs for specific requirements.

- Devices must be FDA approved to be considered for payment.
- Service must be one that meets, but does not exceed the patient's medical need

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get additional information.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements that are necessary of any applicable NCD or LCD.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. Review CMS NCCI for additional information.

References

- Percutaneous Transluminal Angioplasty (PTA) (CMS)
- Non-Coronary Vascular Stents (CMS)
- Billing and Coding: Non-Coronary Vascular Stents (CMS)
- Percutaneous Transluminal Angioplasty – Atherectomy (Johns Hopkins Medicine)

- Angioplasty (Cleveland Clinic)
- Medicare Program Integrity Manual – Chapter 13 (CMS)

Coronary artery bypass grafting (non-emergent)

DEFINITION

Coronary artery bypass grafting (CABG) is performed to restore blood flow around a blocked heart artery. The procedure involves taking a healthy blood vessel from the chest or the leg. The vessel is connected below the blocked heart artery improving blood flow to the heart muscle.

FOR MEDICARE

For indications that do not meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get additional details on PSOD.

MEDICAL POLICY

Priority Health has contracted with TurningPoint Healthcare Solutions LLC (TurningPoint) for management of some cardiac services. Medical necessity for these procedures will be governed by the applicable TurningPoint clinical guidelines. To access these guidelines, log into your **prism** account. Under the Authorizations menu, click **Authorization Criteria Lookup** then the **TurningPoint link**.

POLICY SPECIFIC INFORMATION

- Only the most comprehensive code describing the procedure should be reported.
- CABG procedures using venous grafts include the procurement of the venous graft. Ligation of the saphenous veins should not be reported separately in this instance.
- Surgical removal of superficial or deep implants (i.e., sternal wires) on reoperation for CABG isn't separately reportable, if integral to the procedure.

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get additional information.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. See our Provider Manual for information on modifier use.

REFERENCES

- Coronary artery bypass surgery (Mayo Clinic)
- Medicare NCCI Policy Manual – Chapter 5 (CMS)
- Medicare NCCI Policy Manual – Chapter 1 (CMS)

Implantable cardiac monitoring

DEFINITION

An implantable cardiac monitor also known as an implantable loop recorder, is a device that is placed just under the skin of the chest during a minor surgery. The implanted device records your heartbeat continuously for up to three years.

FOR MEDICARE

For indications that do not meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get additional details on PSOD.

MEDICAL POLICY

Priority Health has contracted with TurningPoint Healthcare Solutions LLC (TurningPoint) for management of some cardiac services. Medical necessity for these procedures will be governed by the applicable TurningPoint clinical guidelines. To access these guidelines, log into your **prism** account. Under the Authorizations menu, click **Authorization Criteria Lookup** then the **TurningPoint link**.

- **91636**: Category III Current Procedural Terminology (CPT) Codes

POLICY SPECIFIC INFORMATION

The below detailed codes can be used to capture provided services: insertion, removal, programming, and interrogation. Be sure to carefully review all CPT codes for a complete description for the most accurate code assignment.

- **33285**: Insertion, subcutaneous cardiac rhythm monitor, including programming
- **33286**: Removal, subcutaneous cardiac rhythm monitor
- **93285**: Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal programmed values with analysis, review and report by a physician or other qualified health care professional, subcutaneous cardiac rhythm monitor system
- **93291**: Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter, subcutaneous cardiac rhythm monitor system, including heart rhythm derived data analysis
- **93298**: Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s), and report(s) by a physician or other qualified health care professional
    - Can only be reported 1x per 30 days
    - Less than 10 days of service would be included in the work associated with the relevant E/M service code.
- **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 permanently programmed values with analysis, review and report by a physician or other qualified health care professional. See medical policy 91636 for more information.
- **E0616**: Implantable cardiac event recorder with memory, activator and programmer

- **C1764** (facility only code): Event recorder, cardiac (implantable)

Place of service
Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get additional information.

Documentation requirements
Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Modifiers

- **26**: Professional component
- **TC**: Technical component

RESOURCES

- Implantable loop recorder (Mayo Clinic)
- CPT Assistant October 2019/Volume 29 Issue 10

Valve replacement

DEFINITION
The valve replacement surgical procedure is performed when one of the heart valves (Tricsupid, Pulmonary, Mitral or Aortic) become damaged or diseased and don't work the way they should. The valve may be repaired with a ring to support the damaged valve, or the valve can be removed and replaced. Replacement valves may be artificial (synthetic based) or tissue (bovine or porcine sources).

Transcatheter aortic valve replacement (TAVR), also referred to as transcatheter aortic valve implantation (TAVI), is a minimally invasive procedure used to treat aortic stenosis. During the procedure, a bioprosthetic valve is delivered through a catheter and implanted within the native aortic valve opening to restore normal blood flow.

FOR MEDICARE
For indications that do not meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get additional details on PSOD.

MEDICAL POLICY
Priority Health has contracted with TurningPoint Healthcare Solutions LLC (TurningPoint) for management of some cardiac services. Medical necessity for these procedures will be governed by the applicable TurningPoint clinical guidelines. To access these guidelines, log into your **prism** account. Under the Authorizations menu, click **Authorization Criteria Lookup** then the **TurningPoint link**.

- **91597**: Transcatheter Heart Valve Procedures
- **91636**: Category III Current Procedural Terminology (CPT) Codes
- **91606**: Clinical Trials

See a list of medical policies in our Provider Manual.

POLICY SPECIFIC INFORMATION

Be sure to carefully review all CPT codes for complete description for the most accurate code assignment. Details listed in selected CPT code must be supported by documentation.

Consult CMS NCCI rules and NCD/LCD where applicable.

If service is performed as part of a clinical trial, get more information in our Provider Manual.

- If a superficial or deep implant removal is performed as an integral part of another procedure, CPT 20670 and 20680 is considered inclusive and not separately reportable.
- Fluoroscopic and/or ultrasound guidance is included in transcatheter aortic and mitral valve replacement procedures. Codes for these services should not be separately reported.
- Transthoracic, transesophageal echocardiography and doppler echocardiography are not separately reportable by the physician performing the transcatheter aortic and mitral valve replacement.
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- **Transcatheter Aortic Valve Replacement (TAVR) CPT Coding**

CPT code	code description
33361	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach
33362	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach
33363	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach
33364	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach
33365	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (e.g., median sternotomy, mediastinotomy)
33366	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg, left thoracotomy)
33367	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (e.g., femoral vessels) (List separately in addition to code for primary procedure)
33368	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (e.g., femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure)
33369	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (e.g., aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure)
33370	Transcatheter placement and subsequent removal of cerebral embolic protection device(s), including arterial access, catherization, imaging, and radiological supervision and interpretation, percutaneous (List separately in addition to code for primary procedure) (investigational)

TAVR Hospital inpatient coding

ICD-10 PCS procedure code	Description
02RF38Z	Replacement of aortic valve with zooplastic tissue, percutaneous approach

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information.

- POS 21 will be used for TAVR (Transcatheter aortic valve replacement) and mitral valve TEER services. All other POS codes will be denied. See the Medicare claims processing manual chapter 32 for additional information.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. See our Provider Manual for more information.

- **Modifier 62**: Two surgeons. See our documentation requirements for use of this modifier.
- **Modifier Q0**: Investigational clinical service provided in a clinical research study that's in an approved clinical research study

RESOURCES

- Heart valve repair or replacement surgery (Hopkins Medicine)
- Medicare Claims Processing Manual – Chapter 32 – Billing Requirements for Special Services (CMS)
- NCD – Transcatheter Aortic Valve Replacement (TAVR) (CMS)
- NCD – Transcatheter Mitral Valve Repair (TMVR) (CMS)
- Medicare National Coverage Determinations Manual – Chapter 1, Part 4 (Sections 200-310.1) – Coverage Determinations (CMS)
- Medicaid Provider Manual – Section 6.3 (MDHHS)

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding

accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Update(s) made
Aug. 6, 2024	Added "Cardioverter defibrillators – Implantable, automated external and wearable" section
Sept. 10, 2024	Added sections for: • Peripheral arterial revascularization • Angioplasty and stenting: Coronary and non-coronary • Coronary artery bypass grafting (non-emergent) • Implantable cardiac monitoring
Sept. 16, 2024	Added "Valve replacement" section
Nov. 11, 2024	Added "Place of service" section
Feb. 4, 2025	Added "Disclaimer" section
June 4, 2025	No changes made
Feb.17, 2026	No changes made
Sept. 21, 2026	Added "policy overview" section, added guidelines for Transcatheter Aortic Valve Replacement (TAVR) under the "Valve Replacement" section