

# Transtelephonic Monitoring of Cardiac Pacemakers (NCD 20.8.1.1)

Guideline Number: MPG321.06

Approval Date: June 10, 2020

[Terms and Conditions](#)

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Related Medicare Advantage Coverage Summary

- [Cardiac Pacemakers and Defibrillators](#)

## Policy Summary

[See Purpose](#)

### Overview

Transtelephonic monitoring of pacemakers is furnished by hospital outpatient departments, physicians' offices and commercial suppliers.

Telephone monitoring of cardiac pacemakers as described below is medically effective in identifying early signs of possible pacemaker failure, thus reducing the number of sudden pacemaker failures requiring emergency replacement. Systems that monitor the pacemaker rate (bpm) in both the free-running and/or magnetic mode are effective in detecting subclinical pacemaker failure due to battery depletion. More sophisticated systems are also capable of detecting internal electronic problems within the pulse generator itself and other potential problems. In the case of dual-chamber pacemakers in particular, such monitoring may detect failure of synchronization of the ventricles and atria, and the need for adjustment and reprogramming of the device.

### Guidelines

#### Definition of Transtelephonic Monitoring

For transtelephonic monitoring services to be covered, the services must consist of the following elements:

- A minimum 30-second readable strip of the pacemaker in the free-running mode;
- A minimum 30 seconds of readable ECG strip; and
- Unless contraindicated, a minimum 30-second readable strip of the pacemaker in the magnetic mode

#### Frequency Guidelines for Transtelephonic Monitoring

The guidelines below constitute a system which UnitedHealthcare uses, in conjunction with their knowledge of local medical practices, to screen claims for transtelephonic monitoring prior to payment. It is important to note that they are not recommendations with respect to a minimum frequency for such monitoring's, but rather a maximum frequency (within which payment may be made without further claims development). As with previous guidelines, more frequent monitoring's may be covered in cases where UnitedHealthcare is satisfied that such monitoring's are medically necessary; e.g., based on the condition of the patient, or with respect to pacemakers exhibiting unexpected defects or premature failure. UnitedHealthcare

may seek written justification for more frequent monitoring's from the patient's physician and/or any monitoring service involved.

These guidelines are divided into two broad categories - Guideline I which will apply to the majority of pacemakers now in use, and Guideline II which will apply only to pacemaker systems (pacemaker and leads) for which sufficient long-term clinical information exists to assure that they meet the standards of the Inter-Society Commission for Heart Disease Resources (ICHHD) for longevity and end-of-life decay. (The ICHHD standards are: (1) 90% cumulative survival at 5 years following implant; and (2) an end-of-life decay of less than a 50% drop of output voltage and less than 20% deviation of magnet rate, or a drop of 5 beats per minute or less, over a period of 3 months or more.) UnitedHealthcare may consult with their medical advisers and other appropriate individuals and organizations (such as the North American Society of Pacing and Electrophysiology which publishes product reliability information) should questions arise over whether a pacemaker system meets the ICHHD standards.

The two groups of guidelines are then broken down into two general categories – single-chamber and dual-chamber pacemakers. UnitedHealthcare is aware that the frequency with which a patient is monitored may be changed from time-to-time for a number of reasons, such as a change in the patient's overall condition, the development of better information on the pacemaker's longevity or failure mode, a reprogramming of the patient's pacemaker, etc. Consequently, changes in the proper set of guidelines may be required. (Of particular importance is the reprogramming of a dual-chamber pacemaker to a single-chamber mode of operation. Such reprogramming would shift the patient from the appropriate dual-chamber guideline to the appropriate single-chamber guideline.)

### Guideline I

- Single-chamber pacemakers
  - 1st month – every 2 weeks
  - 2nd through 36th month – every 8 weeks
  - 37th month to failure – every 4 weeks
- Dual-chamber pacemaker
  - 1st month – every 2 weeks
  - 2nd through 6th month – every 4 weeks
  - 7th through 36th month – every 8 weeks
  - 37th month to failure – every 4 weeks

### Guideline II

- Single-chamber pacemakers
  - 1st month – every 2 weeks
  - 2nd through 48th month – every 12 weeks
  - 49th through 72nd month – every 8 weeks
  - Thereafter – every 4 weeks
- Dual-chamber pacemaker
  - 1st month – every 2 weeks
  - 2nd through 30th month – every 12 weeks
  - 31st through 48th month – every 8 weeks
  - Thereafter – every 4 weeks

## Pacemaker Clinic Services

### *General*

Pacemaker monitoring is also covered when done by pacemaker clinics. Clinic visits may be done in conjunction with transtelephonic monitoring or as a separate service; however, the services rendered by a pacemaker clinic are more extensive than those currently possible by telephone. They include, for example, physical examination of patients and reprogramming of pacemakers. Thus, the use of one of these types of monitoring does not preclude concurrent use of the other.

### *Frequency Guidelines*

As with transtelephonic pacemaker monitoring, the frequency of clinic visits is the decision of the patient's physician, taking into account, among other things, the medical condition of the patient. The following are recommendations for monitoring guidelines on lithium-battery pacemakers:

- For single-chamber pacemakers – twice in the first 6 months following implant, then once every 12 months.
- For dual-chamber pacemakers – twice in the first 6 months, then once every 6 months.

## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

**Coding Clarification:** CPT 93293 is the primary code for transtelephonic monitoring. Pacemaker monitoring (procedure codes 93279, 93280, 93281, 93288, 93294 and 93724) is covered by pacemaker clinics and may be done in conjunction with transtelephonic monitoring, remote monitoring, or as a separate service. The services rendered by a pacemaker clinic are more extensive than those currently possible by telephone. They include, for example, physical examination of patients and reprogramming of pacemakers.

CPT Code	Description
93293	Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with analysis, review and report(s) by a physician or other qualified health care professional, up to 90 days

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Modifier	Description
26	Professional component
TC	Technical component

## References

### CMS National Coverage Determinations (NCDs)

[NCD 20.8.1.1 Transtelephonic Monitoring of Cardiac Pacemakers](#)

### CMS Local Coverage Determinations (LCDs) and Articles

LCD	Article	Contractor	Medicare Part A	Medicare Part B
<a href="#">L34833 Cardiac Rhythm Device Evaluation</a>	<a href="#">A56602 Billing and Coding: Cardiac Rhythm Device Evaluation</a>	Novitas	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX

### CMS Benefit Policy Manual

[Chapter 1; § 40 Supplies, Appliances, and Equipment](#)

[Chapter 15; § 120 Prosthetic Devices](#)

### CMS Claims Processing Manual

[Chapter 3; § 10.4 Payment of Nonphysician Services for Inpatients](#)

[Chapter 12; § 30.4 Cardiovascular System \(Codes 92950-93799\)](#)

[Chapter 35; § 10.2B Transtelephonic and Electronic Monitoring Services](#)

## Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
04/01/2021	<b>Template Update</b> <ul style="list-style-type: none"><li>Reformatted policy; transferred content to new template</li></ul>
06/10/2020	<b>Supporting Information</b> <ul style="list-style-type: none"><li>Updated <i>References</i> section to reflect the most current information</li><li>Archived previous policy version MPG321.05</li></ul>

## Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the [References](#) section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

## Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document\* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided.

UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

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\*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the [Administrative Guide](#).