CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10635	**Date: March 23, 2021**
	Change Request 12104

SUBJECT: Claims Processing Instructions for National Coverage Determination (NCD) 20.4 Implantable Cardiac Defibrillators (ICDs)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to inform the MACs of the follow-on instructions incorporating shared system changes for claims processing for Implantable Cardiac Defibrillators with dates of service on or after February 15, 2018.

EFFECTIVE DATE: February 15, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2021

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
R	32/270/Implantable Cardiac Defibrillators (ICDs)
R	32/270/270.1/Coding Requirements for ICDs
R	32/270/270.2/Special Editing for Inpatient Claims
N	32/270/270.3/Denial Messaging

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: 10635	Date: March 23, 2021	Change Request: 12104

SUBJECT: Claims Processing Instructions for National Coverage Determination (NCD) 20.4 Implantable Cardiac Defibrillators (ICDs)

EFFECTIVE DATE: February 15, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2021

I. GENERAL INFORMATION

A. Background: An Implantable Cardiac Defibrillator (ICD) is an electronic device designed to diagnose and treat life-threatening Ventricular Tachyarrhythmias (VTs). The device consists of a pulse generator and electrodes for sensing and defibrillating. This therapy has been shown in trials to improve survival and reduce sudden cardiac death in patients with certain clinical characteristics.

Section 20.4 of the Medicare National Coverage Determinations (NCD) Manual establishes conditions of coverage for ICDs. In 1986, the Centers for Medicare & Medicaid Services (CMS) first issued an NCD providing limited coverage of ICDs and the policy has been expanded over the years. CMS last reconsidered this NCD in 2005.

B. Policy: Effective for claims with dates of service on or after February 15, 2018, CMS will cover ICDs for the following patient indications. Please see section 20.4 of the NCD Manual for the full list of coverage criteria.

1. Patients with a personal history of sustained VT or cardiac arrest due to Ventricular Fibrillation (VF).

2. Patients with a prior Myocardial Infarction (MI) and a measured Left Ventricular Ejection Fraction (LVEF) ≤ 0.30.

3. Patients who have severe ischemic dilated cardiomyopathy but no personal history of sustained VT or cardiac arrest due to VF, and have New York Heart Association (NYHA) Class II or III heart failure, LVEF$\leq 35\%$.

4. Patients who have severe non-ischemic dilated cardiomyopathy but no personal history of cardiac arrest or sustained VT, NYHA Class II or III heart failure, LVEF $\leq 35\%$, and been on optimal medical therapy for at least three (3) months.

5. Patients with documented familial, or genetic disorders with a high risk of life-threatening tachyarrhythmias (sustained VT or VF), to include, but not limited to, long QT syndrome or hypertrophic cardiomyopathy.

6. Patients with an existing ICD may receive an ICD replacement if it is required due to the end of battery life, Elective Replacement Indicator (ERI), or device/lead malfunction.

For indications 2 - 5 above, a formal shared decision making encounter must occur between the patient and a physician (as defined in Section 1861(r)(1) of the Social Security Act (the Act)) or qualified non-physician practitioner (meaning a physician assistant, nurse practitioner, or clinical nurse specialist as defined in

§1861(aa)(5) of the Act) using an evidence-based decision tool on ICDs prior to initial ICD implantation. NOTE: The shared decision making encounter may occur at a separate visit.

Exceptions to waiting periods for patients that have had a Coronary Artery Bypass Graft (CABG), or Percutaneous Coronary Intervention (PCI) with angioplasty and/or stenting within the past three (3) months, or had an MI within the past 40 days:

Cardiac Pacemakers: Patients who meet all CMS coverage requirements for cardiac pacemakers, and who meet the criteria in NCD 20.4 for an ICD, may receive the combined devices in one procedure, at the time the pacemaker is clinically indicated;

Replacement of ICDs: Patients with an existing ICD may receive an ICD replacement if it is required due to the end of battery life, ERI, or device/lead malfunction.

For patients that are candidates for heart transplantation on the United Network for Organ Sharing (UNOS) transplant list awaiting a donor heart, coverage of ICDs, as with cardiac resynchronization therapy, as a bridge-to-transplant to prolong survival until a donor becomes available, is determined by the local Medicare Administrative Contractors (MACs).

All other indications for ICDs not currently covered in accordance with this decision may be covered under Category B Investigational Device Exemption (IDE) trials (42 CFR 405.201).

NOTE: Effective February 15, 2018, coverage policy is no longer contingent on participation in a trial/study/registry. Therefore, claims with DOS on an after February 15, 2018, no longer require trial-related coding **unless they are associated with a Category B IDE trial, in which case Z00.6 must be appended to the claim.**

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
12104.1	For outpatient and professional claims with dates of service on or after February 15, 2018, contractors shall accept and pay outpatient and professional ICD services that meet the coverage criteria outlined in the NCD, Section 20.4 using the following	X	X			X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	procedure/HCPCS codes: Group 1 Device Codes (DEFIBRILLATOR SPECIFIC CODES): 33223, 33230, 33231, 33240, 33241, 33243, 33244, 33249, 33262, 33263, 33264, 33270, 33271, 33272, 33273, and G0448 Group 2 Device Codes (DUAL DEVICE DEFIBRILLATOR/ PACEMAKER CODES): 33202, 33203, 33215, 33216, 33217, 33218, 33220, 33224, and 33225									
12104.2	Effective for outpatient institutional claims Type of Bills (TOB) 012x, 013x, and 85x and professional claims Place of Service (POS) codes 19, 21, 22, and 26 with dates of service on or after February 15, 2018, that contain a procedure/HCPCS code from Group 1; contractors shall accept one (1) of the following three (3) conditions for diagnosis codes for ICD services: Group 1- ICD-10 DIAGNOSIS CODES I42.1, I42.2, I45.6, I45.81, I45.89, I46.2, I46.9, I47.2, I49.01, I49.02, I49.3, I49.9, T82.110A, T82.111A, T82.118A, T82.119A, T82.120A, T82.121A, T82.128A, T82.129A, T82.190A, T82.191A, T82.198A, T82.199A, T82.7XXA, Z45.02, Z86.74, (Z00.6, ONLY in the context of a Category B IDE trial denoted by the presence of an IDE number) OR, 1 of the following:	X	X			X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	I25.2, I25.5, I42.0, I42.6, I42.7, I42.8 AND, paired with 1 of the following: I50.21, I50.22, I50.23, I50.41, I50.42, I50.43 OR Z76.82 AND, paired with: I50.84									
12104.3	Effective for outpatient institutional claims TOB 012x, 013x, and 85x and professional claims (POS) codes 19, 21, 22, and 26 with dates of service on or after February 15, 2018, that contain a procedure code from Group 2; contractors shall accept one (1) of the following three (3) conditions for diagnosis codes for ICD services: Group 2 - ICD-10 Diagnosis Codes G90.01, I42.1, I42.2, I44.0, I44.1, I44.2, I44.30, I44.7, I45.10, I45.19, I45.2, I45.3, I45.6, I45.81, I45.89, I46.2, I46.9, I47.1, I47.2, I47.9, I48.11, I48.19, I48.3, I48.4, I48.91, I48.92, I49.01, I49.02, I49.3, I49.5, I49.9, Q24.6, T82.110A, T82.111A, T82.118A,	X	X			X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	T82.119A, T82.120A, T82.121A, T82.128A, T82.129A, T82.190A, T82.191A, T82.198A, T82.199A, T82.7XXA, Z45.02, Z86.74. (Z00.6, ONLY in the context of a Category B IDE trial denoted by the presence of an IDE number) OR I25.2, I25.5, I42.0, I42.6, I42.7, I42.8 AND, paired with: I50.21, I50.22, I50.23, I50.41, I50.42, I50.43 OR Z76.82 AND paired with: I50.84 Note: G90.01, I44.0, I44.1, I44.2, I44.30, I44.7, I45.10, I45.19, I45.2, I45.3, I47.1, I47.9, I48.11, I48.19, I48.3, I48.4, I48.91, I48.92, I49.5 and Q24.6 indicate pacemaker diagnosis codes									

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12104.4	Effective for ICD inpatient institutional claims TOB 011x with dates of service on or after February 15, 2018, contractors shall edit claims to meet one (1) of the following criteria: One of the following ICD-10 PCS code: 0JH608Z, 0JH609Z, 0JH638Z, 0JH639Z, 0JH808Z, 0JH809Z, 0JH838Z, 0JH839Z, 02H43KZ, 02H60KZ, 02H63KZ, 02H64KZ, 02H70KZ, 02H73KZ, 02H74KZ, 02HK0KZ, 02HK3KZ, 02HK4KZ, 02HL0KZ, 02HL3KZ, 02HL4KZ, 0JH60FZ, 0JH63FZ AND One of the following ICD-10 diagnosis codes: I42.1, I42.2, I45.6, I45.81, I45.89, I47.2, I49.3, I49.01, I49.02, I46.2, I46.9, I49.9, , Z45.02, Z86.74 OR The following ICD-10 diagnosis code: I25.2 or I25.5 And, one of the following ICD-10 diagnosis codes: I50.21, I50.22, I50.23, I50.41, I50.42, I50.43 OR One of the following ICD-10 diagnosis codes: I42.0, I42.6, I42.7, I42.8 And, one of the following ICD-10 diagnosis codes: I50.21, I50.22, I50.23, I50.41, I50.42, I50.43	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	OR The following ICD-10 diagnosis code: Z76.82 AND The following ICD-10 diagnosis code: I50.84 OR The following ICD-10 diagnosis code Z00.6 ONLY in the context of a Category B IDE trial denoted by the presence of an IDE number.									
12104.5	Contractors shall deny claims for ICD services when the service is not rendered to an inpatient or outpatient of a hospital, including critical access hospitals, hospital-based outpatient clinics, Ambulatory Surgery Center (ASC), or Military facilities as indicated by institutional claims TOB's 011x, 012x, 013x, and 85x and professional claims (POS) codes 19, 21, 22, and 26 using the following codes: Claim Adjustment Reason Code (CARC) 171 – Payment is denied when performed/billed by this type of provider in this type of facility. NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Remittance Advice Remark Code (RARC) N428 – Not covered when performed in this place of service. Group Code CO (Contractual Obligations) or PR (Patient Responsibility) dependent on liability. Medicare Summary Notice (MSN) 16.2 - This service cannot be paid when provided in this location/facility."	X	X							
12104.6	Contractors shall deny claims for ICD services that do not contain an appropriate diagnosis code from 12104.2, 12104.3, and 12104.4 use the following messages:	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	CARC 11 - The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD. Group Code CO (Contractual Obligations) or PR (Patient Responsibility) dependent on liability									
12104.6.1	(Continuation of Business Requirement (BR) 12104.6) MSN 15.19: “We used a Local Coverage Determination (LCD) to decide coverage for your claim. To appeal, get a copy of the LCD at www.cms.gov/medicare-coverage-database (use the MSN Billing Code for the CPT/HCPCS Code) and send with information from your doctor." Spanish Version - Usamos una Determinación de Cobertura Local (LCD) para decidir la cobertura de su reclamo. Para apelar, obtenga una copia del LCD en www.cms.gov/medicare-coverage-database (use el código de facturación de MSN para el código "CPT/HCPCS") y envíela con la información de su médico. MSN 15.20 - “The following polices were used when we made this decision: NCD 20.4.” Spanish Version – “Las siguientes políticas fueron utilizadas cuando se tomó esta decisión: NCD 20.4.” NOTE: Due to system requirement, the Fiscal Intermediary Shared System (FISS) has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	MSN. In addition to the codes listed above, contractors shall afford appeal rights to all denied parties.									
12104.7	Contractors shall not search their files for claims for ICD services with dates of service between February 15, 2018, and the implementation date of this change request. However, MACs should adjust those claims that are brought to their attention.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12104.8	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X	X			

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Fred Rooke, 404-562-7205 or Fred.Rooke@cms.hhs.gov (Institutional Claims) , Kajol Balani, 410-786-1000 or Kajol.Balani@cms.hhs.gov (Institutional Claims) , David Dolan, 410-786-3365 or David.Dolan@cms.hhs.gov (Coverage and Analysis Group) , Wanda Belle, 410-786-7491 or Wanda.Belle@cms.hhs.gov (Coverage and Analysis Group) , Yvette Cousar, 410-786-3417 or Yvette.Cousar@cms.hhs.gov (Professional Billing) , Patricia Brocato-Simons, 410-786-0261 or Patricia.BrocatoSimons@cms.hhs.gov (Coverage and Analysis Group)

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

VI. 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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(*Rev.10635, Issued: 03-23-2021)*

Transmittals for Chapter 32

270 – Implantable Cardiac Defibrillators *(ICDs)*
(Rev. *10635, Issued: 03-23-2021, Effective: 02-15-2018, Implementation: 07-6-2021*)

An Implantable Cardiac Defibrillator (ICD) is an electronic device designed to *diagnose* and treat life-threatening *Ventricular* Tachyarrhythmias (VTs). The device consists of a pulse generator and electrodes for sensing and defibrillating. *This therapy has been shown in trials to improve survival and reduce sudden cardiac death in patients with certain clinical characteristics.*

Section 20.4 of the Medicare National Coverage Determinations (NCD) Manual establishes conditions of coverage for ICDs. In 1986, the Centers for Medicare & Medicaid Services (CMS) first issued an NCD providing limited coverage of ICDs and the policy has been expanded over the years. CMS last reconsidered this NCD in 2005.

Effective for claims with dates of service on or after February 15, 2018, CMS will cover ICDs if the criteria under section 20.4 of the NCD Manual are met.

270.1 – Coding Requirements for *ICDs*
(Rev.10635, Issued: 03-23-2021, Effective: 02-15-2018, Implementation: 07-6-2021)

A. *For outpatient institutional and professional claims with dates of service on or after February 15, 2018, contractors shall accept and pay outpatient and professional ICD services that meet the coverage criteria outlined in the NCD Manual, Section 20.4, using the following procedure/HCPCS codes:*
Group 1 Device Codes (DEFIBRILLATOR SPECIFIC CODES):

33223, 33230, 33231, 33240, 33241, 33243, 33244, 33249, 33262, 33263, 33264, 33270, 33271, 33272, 33273, and G0448

Group 2 Device Codes (DUAL DEVICE DEFIBRILLATOR/ PACEMAKER CODES):

33202, 33203, 33215, 33216, 33217, 33218, 33220, 33224, and 33225

B. *Effective for Professional claims with dates of service on or after February 15, 2018, contractors shall accept the following International Classification of Disease (ICD) -10 diagnosis codes for ICD services:*

Group 1- ICD-10 Diagnosis Codes

I42.1, I42.2, I45.6, I45.81, I45.89, I46.2, I46.9, I47.2, I49.01, I49.02, I49.3, I49.9, T82.110A, T82.111A, T82.118A, T82.119A, T82.120A, T82.121A, T82.128A, T82.129A, T82.190A, T82.191A, T82.198A, T82.199A, T82.7XXA, Z45.02, Z86.74, and (Z00.6 ONLY in the context of a Category B IDE trial denoted by the presence of an IDE number)

Group 2 - ICD-10 Diagnosis Codes

G90.01*, I42.1, I42.2****, I44.0, I44.1, I44.2, I44.30, I44.7, I45.10, I45.19, I45.2, I45.3,*** *I45.6, I45.81, I45.89, I46.2, I46.9****, I47.1,*** *I47.2,* ***I47.9, I48.11, I48.19, I48.3, I48.4, I48.91, I48.92,*** *I49.01, I49.02, I49.3,* ***I49.5,*** *I49.9,* ***Q24.6,*** *T82.110A, T82.111A, T82.118A, T82.119A, T82.120A, T82.121A, T82.128A, T82.129A, T82.190A, T82.191A, T82.198A, T82.199A, T82.7XXA, Z00.6, Z45.02, and Z86.74*

Note: Codes ***BOLDED*** *indicate pacemaker diagnosis codes.*

C. *Effective for outpatient institutional claims with dates of service on or after February 15, 2018, that contain a procedure/HCPCS code from Group 1; contractors shall accept one (1) of the following three (3)*

conditions for diagnosis codes for ICD services:

Group 1- ICD-10 Diagnosis Codes

1) *One of the following ICD-10 diagnosis codes: I42.1, I42.2, I45.6, I45.81, I45.89, I46.2, I46.9, I47.2, I49.01, I49.02, I49.3, I49.9, T82.110A, T82.111A, T82.118A, T82.119A, T82.120A, T82.121A, T82.128A, T82.129A, T82.190A, T82.191A, T82.198A, T82.199A, T82.7XXA, Z45.02, Z86.74, (Z00.6 ONLY in the context of a Category B IDE trial denoted by the presence of an IDE number)*

OR

2) *One of the following ICD-10 diagnosis codes: I25.2, I25.5, I42.0, I42.6, I42.7, I42.8; paired with one of the following ICD-10 diagnosis codes: I50.21, I50.22, I50.23, I50.41, I50.42, I50.43*

OR

3) *The following ICD-10 diagnosis codes: Z76.82; paired with the following ICD-10 diagnosis codes: I50.84*

Effective for outpatient institutional claims with dates of service on or after February 15, 2018, that contain a procedure/HCPCS code from Group 2; contractors shall accept one (1) of the following three (3) conditions for diagnosis codes for ICD services:

Group 2 - ICD-10 Diagnosis Codes

One of the following ICD-10 diagnosis codes: ***G90.01,*** *I42.1, I42.2****, I44.0, I44.1, I44.2, I44.30, I44.7, I45.10, I45.19, I45.2, I45.3,*** *I45.6, I45.81, I45.89, I46.2, I46.9,* ***I47.1,*** *I47.2,* ***I47.9, I48.11, I48.19, I48.3, I48.4, I48.91, I48.92,*** *I49.01, I49.02, I49.3,* ***I49.5,*** *I49.9,* ***Q24.6,*** *T82.110A, T82.111A, T82.118A, T82.119A, T82.120A, T82.121A, T82.128A, T82.129A, T82.190A, T82.191A, T82.198A, T82.199A, T82.7XXA, Z45.02, Z86.74, (Z00.6 ONLY in the context of a Category B IDE trial denoted by the presence of an IDE number)*

OR

1) *One of the following ICD-10 diagnosis codes: I25.2, I25.5, I42.0, I42.6, I42.7, I42.8; paired with one of the following ICD-10 diagnosis codes: I50.21, I50.22, I50.23, I50.41, I50.42, I50.43*

OR

2) *The following ICD-10 diagnosis Code: Z76.82; paired with the following ICD-10 diagnosis code: I50.84*

Note: Codes ***BOLDED*** *indicate pacemaker diagnosis codes*

270.2 - *Special Editing for Inpatient Claims (Rev.10635, Issued: 03-23-2021, Effective: 02-15-2018, Implementation: 07-6-2021)*

Effective for Inpatient institutional claims with dates of service on or after February 15, 2018, contractors shall edit inpatient claims to meet one (1) of the following criteria:

One of the following ICD-10 PCS codes:

0JH608Z, 0JH609Z, 0JH638Z, 0JH639Z, 0JH808Z, 0JH809Z, 0JH838Z, 0JH839Z, 02H43KZ, 02H60KZ, 02H63KZ, 02H64KZ, 02H70KZ, 02H73KZ, 02H74KZ, 02HK0KZ, 02HK3KZ, 02HK4KZ, 02HL0KZ, 02HL3KZ, 02HL4KZ, 0JH60FZ, 0JH63FZ;

Additionally, one of the following ICD-10 diagnosis codes:

1) *I42.1, I42.2, I45.6, I45.81, I45.89, I47.2, I49.3, I49.01, I49.02, I46.2, I46.9, I49.9, Z45.02, Z86.74*

   OR

2) *One of the following ICD-10 diagnosis codes: I25.2 or I25.5; paired with one of the following ICD-10 diagnosis codes: I50.21, I50.22, I50.23, I50.41, I50.42, I50.43*

   OR

3) *One of the following ICD-10 diagnosis codes: I42.0, I42.6, I42.7, I42.8; paired with one of the following ICD-10 diagnosis codes: I50.21, I50.22, I50.23, I50.41, I50.42, I50.43*

OR

4) *The following ICD-10 diagnosis code: Z76.82 paired with the following ICD-10 diagnosis code: I50.84*

OR

5) *The following ICD-10 diagnosis code Z00.6 ONLY in the context of a Category B IDE trial denoted by the presence of an IDE number.*

270.3 - Denial Messaging
(Rev.10635, Issued: 03-23-2021, Effective: 02-15-2018, Implementation: 07-6-2021)

Contractors shall deny claims for ICD services when the service is not rendered to an inpatient or outpatient of a hospital, including critical access hospitals, hospital-based outpatient clinics, Ambulatory Surgery Center (ASC), or Military facilities as indicated by institutional claims
Type of Bills (TOB's) 011x, 012x, 013x, and 85x and professional claim Place of Service (POS) codes 19, 21, 22, and 26 using the following codes:
Claim Adjustment Reason Code (CARC) 171 – Payment is denied when performed/billed by this type of provider in this type of facility.
NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
Remittance Advice Remark Code (RARC) N428 – Not covered when performed in this place of service.
Group Code CO (Contractual Obligation) or PR (Patient Responsibility) dependent on liability.
Medicare Summary Notice (MSN) 16.2 - This service cannot be paid when provided in this location/facility."

Contractors shall deny claims for ICD services that do not contain an appropriate diagnosis code using the following messages:
CARC 11 - The diagnosis is inconsistent with the procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
RARC N386 - This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.
Group Code CO (Contractual Obligations) or PR (Patient Responsibility) dependent on liability
Medicare Summary Notice (MSN) 15.19: "We used a Local Coverage Determination (LCD) to decide coverage for your claim. To appeal, get a copy of the LCD at www.cms.gov/medicare-coverage-database (use the MSN Billing Code for the CPT/HCPCS Code) and send with information from your doctor."
Spanish Version - Usamos una Determinación de Cobertura Local (LCD) para decidir la cobertura de su reclamo. Para apelar, obtenga una copia del LCD en www.cms.gov/medicare-coverage-database (use el código de facturación de MSN para el código "CPT/HCPCS") y envíela con la información de su médico.
MSN 15.20 - "The following polices were used when we made this decision: NCD 20.4."
Spanish Version – "Las siguientes políticas fueron utilizadas cuando se tomó esta decisión: NCD 20.4."
NOTE: Due to system requirement, the Fiscal Intermediary Shared System (FISS) has combined messages 15.19 and 15.20 so that, when used for the same line item, both messages will appear on the same MSN.
In addition to the codes listed above, contractors shall afford appeal rights to all denied parties.