Sentara Health Plans

Medicaid

Implantable Hemodynamic Monitoring for Heart Failure, Medical 317

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Effective Date	12/1/2025
Next Review Date	8/2026
Coverage Policy	Medical 317
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All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Description & Definitions:

An FDA approved implantable hemodynamic monitoring device for heart failure is used to monitor heart rate and pulmonary artery pressure in patients with heart failure. Wireless technology is used to transmit information to the healthcare provider. These devices detect rising cardiac filling pressure before symptoms occur.

Criteria:

- Implantation of Pulmonary Artery Pressure Sensor for Heart Failure Management may be covered for **ALL** of the following:
  - Implantable pulmonary artery pressure sensor (IPAPS) furnished according to FDA market-authorized indication for heart failure (HF) management
  - Patient criteria met, as indicated by **ALL** of the following:
    - Diagnosis of chronic HF of at least 3 months' duration and in New York Heart Association functional Class II or III within past 30 days, prior to PAPS implantation, regardless of left ventricular ejection fraction
    - History of HF hospitalization or urgent HF visit (emergency room or other outpatient visit requiring IV diuretic therapy) within past 12 months, or elevated natriuretic peptides within past 30 days
    - On guideline-directed medical therapy (GDMT) for at least 3 months with goal of achieving optimal or maximally-tolerated GDMT prior to PAPS implantation
    - Evaluated for, and received if appropriate, ICD, cardiac resynchronization therapy (CRT)-pacemaker, or CRT-defibrillator at least 3 months prior to PAPS implantation[B]
    - No major cardiovascular event (eg, unstable angina, MI, PCI, open heart surgery, or stroke) within last 3 months prior to PAPS implantation
    - Has access to reliable connectivity to ensure daily collection and submission of IPAPS data

        - PAPS implantation **does not** occur during hospital admission for acute HF episode.
    - IPAPS item or service performed by appropriately trained provider, as indicated by **1 or more** of the following:
        - Physician referring and managing Medicare patient post implantation is cardiologist with training and experience in HF management.
        - Physician implanting IPAPS has training and experience in pulmonary arterial catheterization and intervention.
    - IPAPS item or service furnished in context of CMS-approved Coverage with Evidence Development (CED) study

Implantation of Hemodynamic Monitoring for Heart Failure Management is **NOT COVERED** for **ANY** of the following to include, but not limited to:

- Item or service furnished outside of CMS-approved Coverage with Evidence Development (CED) study

Document History:

Revised Dates:

- 2025: August - Implementation date of December 1, 2025. Criteria updated to incorporate language from NCD 20.36 Implantable Pulmonary Artery Pressure Sensors for Heart Failure Management.
- 2024: August – criteria updated references updated
- 2021: November
- 2020: January

Reviewed Dates:

- 2023: August
- 2022: August
- 2021: October
- 2020: October
- 2019: September

Origination Date: October 2017

Coding:

Medically necessary with criteria:

Coding	Description
33289	Transcatheter implantation of wireless pulmonary artery pressure sensor for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography, when performed

Considered Not Medically Necessary:

Coding	Description
	None

U.S. Food and Drug Administration (FDA) - approved only products only.

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) does not constitute or imply member coverage or provider reimbursement.

Special Notes: *

- Coverage: See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to products: Policy is applicable to Sentara Health Plan Medicaid products.
- Authorization requirements: Pre-certification by the Plan is required.
- Special Notes:
    - Medicaid
        - This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.
        - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.
        - The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services

(DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Keywords:

SHP Implantable Hemodynamic Monitoring for Heart Failure, SHP Medical 317, Cardiomems, New York Heart Association, NYHA, class 3, class III