Medicare Medical Policy

Clinical Trials, Studies and Registries

MEDICARE MEDICAL POLICY NUMBER: 233

Effective Date: 8/1/2024

Last Review Date: 8/2024

Next Annual Review: 7/2025

INSTRUCTIONS FOR USE: Company Medicare Medical Policies serve as guidance for the administration of plan benefits and do not constitute medical advice nor a guarantee of coverage. Company Medicare Medical Policies are reviewed annually to guide the coverage or non-coverage decision-making process for services or procedures in accordance with member benefit contracts (otherwise known as Evidence of Coverage or EOCs) and Centers of Medicare and Medicaid Services (CMS) policies, manuals, and other CMS rules and regulations. In the absence of a CMS coverage determination or specific regulation for a requested service, item or procedure, Company policy criteria or applicable utilization management vendor criteria may be applied. These are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

The Company reserves the right to determine the application of Medicare Medical Policies and make revisions to these policies at any time. Any conflict or variance between the EOC and Company Medical Policy will be resolved in favor of the EOC.

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

PRODUCT AND BENEFIT APPLICATION

☒ Medicare Only

MEDICARE COVERAGE CRITERIA

IMPORTANT NOTE: More than one Centers for Medicare and Medicaid Services (CMS) reference may apply to the same health care service, such as when more than one coverage policy is available (e.g., both an NCD and LCD exist). All references listed should be considered for coverage decision-making. The Company uses the most current version of a Medicare reference available at the time of publication; however, these websites are not maintained by the Company, so Medicare references and their corresponding hyperlinks may change at any time. If there is a conflict between the Company Medicare Medical Policy and CMS guidance, the CMS guidance will govern.

Service	Medicare Guidelines
Investigational Device Exemption (IDE) Studies	I. An investigational device exemption (IDE) by the U.S. Food and Drug Administration (FDA) allows the device to be used in a clinical study in order to collect safety and effectiveness data. II. Medicare approved IDE studies are posted on the Medicare IDE webpage. The **only** IDE studies that may be considered for coverage are those which have received this Medicare approval. III. **For Category B IDE Studies** – The Company may consider *devices and services* related to Medicare-approved Category B IDE studies to be **medically necessary** (unless the device is paid for by the trial sponsor). IV. **For Category A IDE studies** – The Company may only consider the *routine care items and services* related to Medicare-approved Category A IDE studies to be **medically necessary**; however, the Category A *device* itself is not eligible for coverage or reimbursement. V. Category A and B investigational devices and related services not rendered in the context of an FDA-approved trial or study are considered **not medically necessary**. Notes and Supporting Medicare References/Resources: • Some services may be auto-denied as not medically necessary based on other Company policies, including but not limited to, the Medicare *New and Emerging Technologies and Other Non-*

	Covered Services (MP220) medical policy. Coverage may be reconsidered if documentation is submitted to support the services were provided in the context of a Medicare-approved IDE study based on guidelines above. • Medicare Benefit Policy Manual, Chapter 14 – Medical Devices, §20.1 – Medicare Requirements for Coverage of Items and Services in FDA-approved Category A and B IDE Studies • Medicare Benefit Policy Manual, Chapter 4 – Benefits and Beneficiary Protections, §10.7.2 – Payment for Investigational Device Exemption (IDE) Studies
Coverage with Evidence Development (CED) Studies and Registries	I. For national coverage determinations (NCDs) with CED criteria, the Company may consider items and services in CMS-approved CED studies to be **medically necessary** and eligible for reimbursement, *unless* Medicare determines the significant cost threshold is exceeded for that item or service (this significant cost threshold is identified in a Medicare article, MLN Newsletter, or Chapter 32, Section 66.2 of the Medicare Claims Processing Manual). II. All other medically reasonable and necessary criteria outlined in the NCD must also be met. III. For a list of CED-related procedures, see the Appendices section below. Notes and Supporting Medicare References/Resources: • Medicare approved CED studies can be found on the Medicare Coverage with Evidence Development webpage. • Some procedures and items subject to CED criteria are addressed in separate Medicare medical policies. • Medicare Benefit Policy Manual, Chapter 4 – Benefits and Beneficiary Protections, §10.7.3 – Payment for Clinical Studies Approved Under Coverage with Evidence Development (CED) • Medicare Claims Processing Manual, Chapter 32 – Billing Requirements for Special Services *(search document for the specific service)*
Other Clinical Trials (aka, Clinical Research Study)	• Coverage of routine costs for clinical trials is only available when the clinical trial or clinical research study is approved by Medicare. • If the study or trial is not related to an IDE or CED study addressed above, then the Company will not know in advance whether a trial or study is Medicare-approved or

	not. Therefore, the Company is **not** able to make pre-service (prior authorization) coverage decisions for clinical trials. • If the member participates in a study that Medicare has **not** approved, the member is responsible for paying **all** costs for the study participation. Non-covered Medicare trials or studies are a direct benefit exclusion, as detailed in the member EOC. • Claims must be submitted to Original Medicare or the local Medicare Contractor (MAC) prior to being submitted to the Medicare Advantage plan. • Either Original Medicare or local MACs cover the majority of routine costs of qualifying clinical trials on behalf of Medicare Advantage members and will waive the Part A and the Part B deductibles. • As the Medicare Advantage Organization (MAO), the Company would then be responsible for the remaining Original Medicare coinsurance (minus plan's normal copays). • See Table 1 below for information regarding "routine costs." • Claims **must** be submitted to either Original Medicare or the MAC which processes fee-for-service claims for the provider first, and then submitted to the Company *with* the Medicare Explanation of Benefits (MEOB). Notes and Supporting Medicare References/Resources: • National Coverage Determination (NCD) for Routine Costs in Clinical Trials (310.1)

IMPORTANT NOTICE: While some services or items may appear medically indicated for an individual, they may also be a direct exclusion of Medicare or the member's benefit plan. Such excluded services or items by Medicare and member EOCs include, but are not limited to, services or procedures considered to be cosmetic, not medical in nature, or those considered not medically reasonable or necessary under *Title XVIII of the Social Security Act, §1862(a)(1)(A).* If there is uncertainty regarding coverage of a service or item, please review the member EOC or submit a pre-service organization determination request. Note that the Medicare Advance Beneficiary Notice of Noncoverage (ABN) form **cannot** be used for Medicare Advantage members. *(Medicare Advance Written Notices of Non-coverage. MLN006266 May 2021)*

POLICY CROSS REFERENCES

None

The full Company portfolio of Medicare Medical Policies is available online and can be accessed here.

POLICY GUIDELINES

DOCUMENTATION REQUIREMENTS

While the services in this policy are not subject to routine review, they are subject to audit and the following documentation will be beneficial in supporting Medicare coverage requirements are met:

- The name of the trial, registry, or study
- The clinical trial number, or NCT number
- The name of the device (if applicable)
- For an IDE study approved ***prior to*** January 1, 2015, IDE study approved documentation by the local MAC. A copy of the FDA-approval letter provided to the sponsor or manufacturer of the device is also beneficial and may aid with reviews or claim processing. The category assignment (Category A or Category B IDE) should be included on this FDA letter.

DEFINITIONS

Definitions and Acronyms

Case-control study	"A study that compares two groups of people: those with the disease or condition under study (cases) and a very similar group of people who do not have the disease or condition (controls). Researchers study the medical and lifestyle histories of the people in each group to learn what factors may be associated with the disease or condition. For example, one group may have been exposed to a particular substance that the other was not. Also called retrospective study."
Case report	"A detailed report of the diagnosis, treatment, and follow-up of an individual patient. Case reports also contain some demographic information about the patient (for example, age, gender, ethnic origin)."
Case series	"A group or series of case reports involving patients who were given similar treatment. Reports of case series usually contain detailed information about the individual patients. This includes demographic information (for example, age, gender, ethnic origin) and information on diagnosis, treatment, response to treatment, and follow-up after treatment."
Category A Device:	A device for which questions regarding safety and effectiveness remain because the "absolute risk" of the device type has not been established.[1]
Category B Device:	Also known as a "non-experimental/investigational" device, this is a device for which initial questions of safety and effectiveness of that device type have been resolved. This includes devices with known safety and efficacy because other manufacturers have obtained FDA premarket approval or clearance for that device type.[1]
CED:	Coverage with Evidence Development
Clinical trial	"Clinical trials are a type of research that studies new tests and treatments and evaluates their effects on human health outcomes.

	People volunteer to take part in clinical trials to test medical interventions including drugs, cells and other biological products, surgical procedures, radiological procedures, devices, behavioural treatments and preventive care."
Clinical trial sponsor	"A person, company, institution, group, or organization that oversees or pays for a clinical trial and collects and analyzes the data. Also called trial sponsor."
Cohort	"A group of individuals who share a common trait, such as birth year. In medicine, a cohort is a group that is part of a clinical trial or study and is observed over a period of time."
Cohort study	"A research study that compares a particular outcome (such as lung cancer) in groups of individuals who are alike in many ways but differ by a certain characteristic (for example, female nurses who smoke compared with those who do not smoke)."
IDE:	Investigational Device Exemption
MAC (aka, "A/B MACs"):	Medicare Administrative Contractor. Also known as a local contractor. Part A and Part B MACs process Medicare Part A and Medicare Part B claims for a defined geographic area or "jurisdiction," servicing institutional providers, physicians, practitioners, and suppliers.
MAO:	Medicare Advantage Organization. Also referred to as Medicare Advantage (MA) Plans, Medicare+Choice Organizations, or Medicare Part C.[2]
Medical Device:	Defined by the FDA as "an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part, or accessory which is: • Recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them, • Intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or • Intended to affect the structure or any function of the body of man or other animals, and which does not achieve any of its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of any of its primary intended purposes"[3,4]
MEOB	Medicare Explanation of Benefits
Meta-analysis	"A process that analyzes data from different studies done about the same subject. The results of a meta-analysis are usually stronger than the results of any study by itself."
NCT Number	National Clinical Trial number

Nonrandomized trial	"A clinical trial in which the participants are not assigned by chance to different treatment groups. Participants may choose which group they want to be in, or they may be assigned to the groups by the researchers."
Randomized trial	"A study in which the participants are divided by chance into separate groups that compare different treatments or other interventions. Using chance to divide people into groups means that the groups will be similar and that the effects of the treatments they receive can be compared more fairly. At the time of the trial, it is not known which treatment is best."

BACKGROUND

"Clinical trials are a type of research that studies new tests and treatments and evaluates their effects on human health outcomes." *(World Health Organization [WHO])* Individuals can volunteer to participate in clinical trials to evaluate the efficacy of medical interventions such as drugs, cells and other biological products, surgical procedures, radiological procedures, devices, behavioral treatments and preventive care.

Study Designs

In **nonrandomized** trials, participants are **not** assigned randomly to a treatment group. Instead, either the participant chooses which group they want to be in, or they may be assigned to a group by one of the researchers.

In contrast and as the name implies, **randomized** trials result in participants being divided randomly (by chance) into separate groups to compare different treatments or interventions. By using this method to divide participants into groups, it allows the groups to be similar, which in turn results in the treatment outcomes received being compared more fairly. In addition, because it is not known which treatment is best at the time of the trial, it reduces or eliminates bias for the researchers and/or placebo effects for the participants.

Medicare View of Study Design Quality

According to the 2003 national coverage analysis (NCA) for Implantable Cardioverter Defibrillators (ICDs) (CAG-00157R4), the following is a representative list of study designs (some of which may have alternative names) ranked from most to least methodologically rigorous in their potential ability to minimize systematic bias:

- Randomized controlled trials
- Non-randomized controlled trials
- Prospective cohort studies
- Retrospective case control studies
- Cross-sectional studies

- Surveillance studies (e. g., using registries or surveys)
- Consecutive case series
- Single case reports

According to the *Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections, 90.5 – Creating New Guidance*, in coverage situations where there is no NCD, LCD, or guidance on coverage in original Medicare manuals, a Medicare Advantage Organization (MAO), the MAO must make its own coverage determination and must provide an objective evidence-based rationale relying on authoritative evidence, such as studies from government agencies (e.g. the FDA) and well-designed controlled clinical studies that have appeared in peer review journals.

In addition, according to CMS Final Rule CMS-4201-F:

> "Clinical literature that CMS considers to be of high enough quality for the justification of internal coverage criteria **include large, randomized controlled trials or cohort studies or all-or-none studies with clear results, published in a peer-reviewed journal, and specifically designed to answer the relevant clinical question,** or **large systematic reviews or meta-analyses summarizing the literature of the specific clinical question published in a peer-reviewed journal with clear and consistent results.** Evidence that is unpublished, is a case series or report, or derived solely from internal analyses within the MA organization, or that does not comply with the standards, as previously described, would not represent proper justification for instituting internal coverage guidelines that would restrict access to care." *(**Bold** added for emphasis)*

INVESTIGATIONAL DEVICE EXEMPTION (IDE) STUDIES

Some devices provided in Food and Drug Administration (FDA)-approved Category A and Category B IDE studies may be eligible for Medicare coverage.

"An investigational device exemption (IDE) allows the investigational device to be used in a clinical study in order to collect safety and effectiveness data." While these studies are most often conducted to support post-market approval (PMA), they may also be performed to evaluate modifications or new intended uses of devices already on the market.[5]

> "MAOs are responsible for payment of claims related to enrollees' participation in both Category A and B IDE studies that are covered by the MAC with jurisdiction over the MA plan's service area. The MAO is responsible for payment of routine care items and services in CMS-approved Category A and Category B IDE studies. The MAO is also responsible for CMS-approved Category B devices. CMS will not approve Category A devices because they are statutorily excluded from coverage." *(Medicare Managed Care Manual, Chapter 4 – Benefits and Beneficiary Protections, §10.7.2 – Payment for Investigational Device Exemption (IDE) Studies)*

COVERAGE WITH EVIDENCE DEVELOPMENT (CED) REGISTRIES

Medicare uses an evidence-based medicine process for coverage determinations. Therefore, Medicare does not generally cover experimental or investigational items and services as reasonable and necessary under section 1862(a)(1)(A) of the Act. However, Medicare frequently receives requests for coverage of certain items and services when the expectations of interested parties are not supported by the existing evidence. The Coverage with Evidence Development (CED) provision is a mechanism implemented by Medicare to provide coverage of items and services only when furnished in the context of approved clinical studies or with the collection of additional clinical data.

Medicare believes they should support evidence development for certain innovative technologies that are likely to show benefit for the Medicare population, but where the available evidence base does not provide a sufficiently persuasive basis for coverage outside the context of a clinical study. By using the Medicare CED provision, Medicare members are provided an opportunity for coverage of innovative technology sooner, while ensuring systematic patient safeguards are in place to reduce the risks of new technologies, or to new applications of existing technologies.[6]

> "… MAOs are responsible for payment of items and services in CMS-approved CED studies unless CMS determines that the significant cost threshold is exceeded for that item or service..." *(Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections, §10.7.3 – Payment for Clinical Studies Approved Under Coverage with Evidence Development (CED))*

When Medicare determines that coverage of a CED service exceeds the significant cost threshold for MAOs, they generally publish this determination in an article, newsletter, or in the *Medicare Claims Processing Manual, Chapter 32, §66.2 – Services Identified as having Significant Cost for Medicare Advantage*. An example of services with significant cost threshold restrictions includes pancreatic islet cell transplants. Chimeric antigen receptor (CAR) T-cell therapy was also considered to exceed the significant cost threshold, but there was a term date on this decision, and as of January 1, 2021, MAOs became responsible for these CED services.

Some procedures and items subject to CED criteria may be addressed in separate Medicare medical policies, while others are not. Examples of CED topics include, but are not limited to: Vagus nerve stimulation, transcatheter aortic valve replacement (TAVR), CPAPs, artificial hearts, transcatheter mitral valve replacement (TMVR), leadless pacemakers, and PILD (i.e., MILD®, ADUHELM™). While medical necessity reviews may not be routinely performed for all services, providers are expected to submit claims only for services that are considered medically reasonable and necessary per *Title XVIII of the Social Security Act §1862(a)(1)(A)* and when the relevant NCD coverage criteria are met.

CLINICAL TRIALS AND CLINICAL RESEARCH STUDIES

For trials and research studies which are not IDE or CED studies/registries, then coverage and the primary payor changes. "For clinical trials covered under the Clinical Trials National Coverage Determination (NCD) (NCD manual, Pub. 100-3, Part 4, Section 310), Medicare covers the routine costs of qualifying clinical trials for all Medicare enrollees, including those enrolled in MA plans, as well as reasonable and necessary items and services used to diagnose and treat complications arising from participating in qualifying clinical trials. All other Medicare rules apply.

"…MAOs pay the enrollee the difference between original Medicare cost-sharing incurred for qualified clinical trial items and services and the MA plan's in-network cost-sharing for the same category of items and services…" *(Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections, §10.7 – Clinical Trials, §10.7.1 – Payment for Services)*

This means claims are submitted to Original Medicare or the local Medicare contractor (MAC) **before** ever being sent to the MAO plan.

When a claim is submitted to the MAO for services that are part of a qualifying clinical trial, the claim should be accompanied with the Medicare Explanation of Benefits (MEOB). The MAO will then process the claim as the secondary carrier according to Medicare guidelines described above. Claims submitted without the MEOB will be denied. Coverage of any charges related to a clinical trial or clinical research study is reliant on Original Medicare coverage. Participation in a clinical trial or research study that Medicare has **not** approved is a direct benefit exclusion and the member will be responsible for all charges related to the non-covered trial/study, as explicitly stated in the member EOC handbook.

ROUTINE COSTS

Unless the service or device is statutorily excluded by Medicare or non-covered under a national coverage decision, routine costs of clinical trials may be covered by Medicare. Table 1 below and NCD 310.1 provides details regarding what services are considered "routine" costs, and what services are not considered routine costs.

Table 1: Routine Costs

Include	Exclude
• Routine costs **include:** ○ **Items and services otherwise available to Medicare members* (i.e., there is a benefit category, it is not statutorily excluded, there is not a national non-coverage decision, etc.) when provided in either the experimental or the control arms of a clinical trial;** ○ **Items or services typically provided absent a clinical trial (e.g., conventional care);** ○ **Items or services required solely for the provision of the investigational item or service (e.g., administration of a noncovered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and**	• Routine costs do **not** include: ○ The item or service itself that is under investigation unless otherwise covered outside of the clinical trial; ○ Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan); and ○ Items and services customarily provided by the research sponsors free-of-charge for any enrollee in the trial.

○ Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service in particular, for the diagnosis or treatment of complications.	

*Items or services which are either not a covered benefit or are statutorily excluded would not be eligible as a routine cost of a clinical trial or study. For example, hearing aids and dentures are not covered Medicare benefits, so a clinical trial which investigates a novel hearing aid or new type of denture would not be eligible for coverage as a "routine cost" of the clinical trial.

Medicare Advantage Member EOCs

Plan Medicare Advantage EOC documents read (in part) as follows:

> **Section 5.1 What is a "clinical research study"?**
>
> A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.
>
> Once Medicare approves the study, and you express interest, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.
>
> If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.
>
> If you want to participate in any Medicare-approved clinical research study, you do not need to tell us or to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.
>
> Although you do not need to get our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study.*

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

SUMMARY FOR CLINICAL TRIALS, STUDIES AND REGISTRIES

Table 2: Summary of Clinical Trials, Studies and Registries

Trial, Registry, or Study Type	Who Responsible for Approval?	Primary Payor	What's Covered vs. Not Covered?	Is a Prior Authorization Possible?
IDE Studies (Category A or B)	**Effective 1/1/2015:** Original Medicare (CMS). A directory of approved IDE studies can be found on the CMS website (see link in the criteria table). **Prior to 1/1/2015:** Local MACs	Medicare Advantage Organization (MAO) plan	CMS-approved **Category A and B IDE** Studies: Routine care items and services in are covered. For Category A IDE studies, the device is excluded from coverage (it is considered investigational). For Category B IDE studies, the device under investigation may also be covered.	Yes While Medicare is responsible for approval of IDEs, MAOs are the primary payor and therefore can make pre-service coverage determinations.
Coverage with Evidence Development (CED) Studies and Registries	Medicare. Approved CED studies and registries are found on the CMS CED web site (link is above).	The MAO plan is primary *unless* Medicare has determined the significant threshold is exceeded and has accepted financial responsibility. *(This does not happen often and is usually temporary)*	Routine services and the device under investigation if both are rendered within a CMS-approved CED study. Note: If the item in question is not FDA-approved at all for any indication, further research may be required because the item would not be expected to be covered under Medicare and may not meet NCD criteria.	Yes While Medicare is responsible for approval of CED studies, MAOs are the primary payor and therefore can make pre-service coverage determinations. Exceptions may occur on a service-by-service basis if the service exceeds the significant threshold. As of the most recent policy review, no services covered under the CED provision qualify as this exception.

Clinical trials not otherwise specified	Medicare. The health plan does not have access to any list of approvals of these trials, and coverage by the MAO is dependent on Original Medicare coverage. No coverage can be allowed by PHP if the claim is not submitted to Medicare first. Coverage will also be denied by PHP if the claim is submitted to Medicare, but denied by Medicare.	Primary Payor: Original Medicare or Local MAC. Secondary Payor: MAO (claim must be submitted to the MAO with Medicare Explanation of Benefits (MEOB)	Original Medicare or local MAC covers routine costs of qualifying (approved) clinical trials on behalf of MA members. The deductibles are waived for these. MAOs are responsible for any remaining original Medicare coinsurance (minus copays). An MAO would not be able to make payments or coverage determinations without an MEOB being submitted.	No Medicare is not only responsible for the approval of trials that fall under this category, but they are also the primary payor for these services, as well as the routine costs associated with a clinical trial. The Plan cannot make payment if Medicare denies a claim for a clinical trial because **these are direct member benefit exclusions**. Even a list of Medicare-approved clinical trials was available, the MA plan does not determine whether or not Medicare will make payment for an individual member. Therefore, we cannot determine in advance if coverage is available.

REGULATORY STATUS

U.S. FOOD & DRUG ADMINISTRATION (FDA)

While clearance by the Food and Drug Administration (FDA) is a prerequisite for Medicare coverage, the 510(k) premarket clearance process does not in itself establish medical necessity. Medicare payment policy is determined by the interaction of numerous requirements, including but not limited to, the availability of a Medicare benefit category and other statutory requirements, coding and pricing guidelines, as well as national and local coverage determinations and clinical evidence.

BILLING GUIDELINES AND CODING

GENERAL

The codes listed in this policy are **not** all-inclusive of codes that may be used for services rendered in the context of a clinical trial, study or registry. Any service rendered in the context of a research trial may be subject to the guidelines in this medical policy.

For additional Medicare billing guidance, see the following resources:

- Items or services covered under the **Investigational Device Exemption (IDE)** provision: See the Medicare Claims Processing Manual, Chapter 32 – Billing Requirements for Special Services, §68 – Investigational Device Exemption (IDE) Studies.
- Items or services covered under the **coverage with evidence development (CED)** provision: See the Medicare Claims Processing Manual, Chapter 32 – Billing Requirements for Special Services. For these topics, there will likely be a specific section dedicated to addressing how to report for the given service or item.
- **Medicare-approved (qualifying) clinical trials:** See the Medicare Claims Processing Manual, Chapter 32 – Billing Requirements for Special Services, §69 - Qualifying Clinical Trials.
- **Costs of healthy volunteers in a qualified clinical trial**: See the MLN Matters® Number: MM6776.

MODIFIER USE

Effective January 1, 2008, Medicare requires that all claims submitted for patient care in clinical research "studies that are certified under the Medicare Clinical Research Policy, Investigational Device Exemption (IDE) trials, and studies required under a coverage with evidence development (CED) national coverage determination (NCD)"[7] use the –Q0 or –Q1 modifiers for routine and investigational clinical services.

• Q0 - Investigational clinical service provided in a clinical research study that is in an approved clinical research study.
• Q1 - Routine clinical service provided in a clinical research study that is in an approved clinical research study.

In addition to the above modifiers, claims also need to include the ICD-10 code Z00.6 (or ICD9 code V70.7 if the services were rendered prior to October 1, 2015).

Some of these services are covered by Original Medicare or local MACs as the primary carrier, while services would be processed by the MAO.

CODES*		
CPT	None	
HCPCS	C9758	Blinded procedure for NYHA class III/IV heart failure; transcatheter implantation of interatrial shunt or placebo control, including right heart catheterization, trans-esophageal echocardiography (TEE)/intracardiac echocardiography (ICE), and all imaging with or without guidance (for example, ultrasound, fluoroscopy), performed in an approved investigational device exemption (IDE) study
	C9760	Non-randomized, non-blinded procedure for NYHA Class II, III, IV heart failure; transcatheter implantation of interatrial shunt or placebo control, including right and left heart catheterization, transeptal puncture, trans-esophageal echocardiography (TEE)/intracardiac echocardiography (ICE), and all imaging with or without guidance (e.g., ultrasound, fluoroscopy), performed in an approved investigational device exemption (IDE) study
	C9782	Blinded procedure for New York Heart Association (NYHA) Class II or III heart failure, or Canadian Cardiovascular Society (CCS) Class III or IV chronic refractory angina; transcatheter intramyocardial transplantation of autologous bone marrow cells (e.g., mononuclear) or placebo control, autologous bone marrow harvesting and preparation for transplantation, left heart catheterization including ventriculography, all laboratory services, and all imaging with or without guidance (e.g., transthoracic echocardiography, ultrasound, fluoroscopy), performed in an approved investigational device exemption (IDE) study
	C9783	Blinded procedure for transcatheter implantation of coronary sinus reduction device or placebo control, including vascular access and closure, right heart catherization, venous and coronary sinus angiography, imaging guidance and supervision and interpretation when performed in an approved investigational device exemption (IDE) study
	C9792	Blinded or nonblinded procedure for symptomatic New York Heart Association (NYHA) class II, III, IVA heart failure; transcatheter implantation of left atrial to coronary sinus shunt using jugular vein access, including all imaging necessary to intra procedurally map the coronary sinus for optimal shunt placement (e.g., tee or ice ultrasound, fluoroscopy), performed under general anesthesia in an approved investigational device exemption (IDE) study

***Coding Notes:**

- The code list above is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit. According to Medicare, "presence of a payment amount in the MPFS and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare." The issuance of a CPT or HCPCS code or the provision of a payment or fee amount by Medicare does **not** make a procedure medically reasonable or necessary or a covered benefit by Medicare. *(Medicare Claims Processing Manual, Chapter 23 - Fee Schedule*

Administration and Coding Requirements, §30 - Services Paid Under the Medicare Physician's Fee Schedule, A. Physician's Services)

- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

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POLICY REVISION HISTORY

DATE	REVISION SUMMARY
4/2023	Interim update. Converted to new policy template.
8/2023	Annual review; no changes
10/2023	Q4 2023 code updates
11/2023	Interim update. No change to references or resources, but add notes to clarify what is covered and who the primary payor is for different types of trials, studies or registries; add appendices for CED topics
8/2024	Annual review; informational and clarifying updates only

APPENDICES

Appendix I: CED topics **with** a Medicare medical policy.

CED-COVERED PROCEDURE & NCD	RELEVANT PLAN MEDICARE MEDICAL POLICY
Allogeneic Hematopoietic Stem Cell Transplant for MDS, Multiple Myeloma, Myelofibrosis, or Sickle Cell Disease (NCD 110.23)	Stem Cell Transplantation, MP283
Autologous Platelet-rich Plasma (270.3)	Platelet-Rich Plasma (PRP) for Orthopedic Indications, Wound Care and Other Miscellaneous Conditions, MP224
CPAP For Obstructive Sleep Apnea (NCD 240.4)	Sleep Disorder Treatment: Positive Airway Pressure, MP53
Cochlear Implantation (NCD 50.3)	Cochlear Implants and Auditory Brainstem Implants, MP189
Extracorporeal Photopheresis for Bronchiolitis Obliterans Syndrome Following Lung Transplant (NCD 110.4)	Apheresis (Therapeutic Pheresis), MP310
Home Oxygen for COPD (NCD 240.2.1)	Home Oxygen Equipment and Supplies, MP292
Percutaneous Image-guided Lumbar Decompression for Lumbar Spinal Stenosis (150.13)	Back: Fusion and Decompression Procedures, MP358
Percutaneous Left Atrial Appendage Closure (LAAC) (NCD 20.34)	Cardiac: Left Atrial Appendage Devices Closure, MP74
Pharmacogenomic Testing for Warfarin Response (NCD 90.1)	Genetic and Molecular Testing, MP317
TENS for chronic low back pain (NCD 160.27)	Electrical Stimulation and Electromagnetic Therapies, MP333
Transcatheter Aortic Valve Replacement (NCD 20.32)	Cardiac: Transcatheter Aortic Valve Replacement (TAVR), MP221
Vagus Nerve Stimulation (VNS) for Treatment Resistant Depression (TRD) (NCD 160.18)	Electrical Stimulation and Electromagnetic Therapies, MP333

Appendix II: CED topics **without** a Medicare medical policy.

NOTE: In the absence of a formal Medicare medical policy, providers are still expected to adhere to Medicare's medical necessity requirements and only provide services when coverage criteria are met.

CED-COVERED PROCEDURE & NCD	ADDITIONAL NOTES

Leadless Pacemakers (NCD 20.8.4)	
Transcatheter Edge-to-Edge Repair (TEER) (NCD 20.33)	In 2021, CMS replaced the term transcatheter mitral valve repair (TMVR) with mitral valve transcatheter edge-to-edge repair (TEER).
For the following topics, no Medicare *medical* policy exists, but a separate *Pharmacy* policy may apply.	
Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease (AD) (NCD 200.3)	
Off-label use of Colorectal Cancer Drugs (110.17)	NCD title is *Anti-Cancer Chemotherapy for Colorectal Cancer*
For the following topics, Carelon Insights (formerly AIM Specialty Health) administers the plan's *High Tech Diagnostic Imaging: MRI, MRA, SPECT, CT, CTA, PET, Nuclear Cardiology* program	
Amyloid PET (NCD 220.6.20)	
FDG PET and Other Neuroimaging Devices for Dementia (NCD 220.6.13)	
NaF-18 PET for Bone Metastasis (NCD 220.6.19) *(Between February 26, 2010 and December 15, 2021 only)*	Effective 12/15/2021, this NCD was changed to a non-coverage determination instead of a CED policy.