2025

WiSE® System Coding & Reimbursement Guide

MC-10022-A

Physician & Hospital Outpatient Facility CPT Coding

Physicians and outpatient facilities use Current Procedural Terminology (CPT®) codes to report procedures and services when performed. The American Medical Association has established the following Category III CPT codes for reporting the insertion, removal, replacement, revision, interrogation, and programming of the WiSE System for cardiac resynchronization therapy.

Insertion

PROCEDURE	CPT	DESCRIPTION
Complete system	0515T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; complete system (includes electrode and generator [transmitter and battery])
Electrode only	0516T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; electrode only
Battery & transmitter only	0517T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; both components of pulse generator (battery and transmitter) only

Removal

PROCEDURE	CPT	DESCRIPTION
Battery & transmitter	0861T	Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; both components (battery and transmitter)
Battery only	0518T	Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; battery component only

Removal & Replacement

PROCEDURE	CPT	DESCRIPTION
Battery & transmitter	0519T	Removal and replacement of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; both components (battery and transmitter)
Battery only	0520T	Removal and replacement of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only

Revision

PROCEDURE	CPT	DESCRIPTION
Battery only	0862T	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only
Transmitter only	0863T	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; transmitter component only

In-person Interrogation & Programming

PROCEDURE	CPT	DESCRIPTION
Device Interrogation	0521T	Interrogation device evaluation (in person) with analysis, review, and report, includes connection, recording, and disconnection per patient encounter, wireless cardiac stimulator for left ventricular pacing
Device Programming	0522T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, wireless cardiac stimulator for left ventricular pacing

Physician Category III CPT Code Reporting & Reimbursement

For Medicare claims, Category III CPT codes are Medicare Administrative Contractor (MAC) priced; therefore each MAC will assign payment rates for each procedure. MACs may establish a specific rate on their contractor physician fee schedule or on a per case basis.

When reporting Category III CPT codes, physicians should consider including a crosswalk to a Category I CPT code with established Relative Value Units (RVUs) to facilitate reimbursement. This crosswalk procedure should have similar time, physician work and complexity to the procedure described by the Category III CPT code.

When providing a CPT code crosswalk, submit the following with the claim:

- Clinic notes to support medical necessity
- Operative report detailing the procedure including the time, work, and resources involved
- A statement identifying the Category I CPT code including the Medicare RVUs, Medicare national payment and a brief description of how the two procedures compare as well as the anticipated payment
- Supporting documentation: which may include a copy of the FDA approval letter and published studies

For private payer claims, payment and Category III claims reporting requirements vary therefore it is recommended that providers understand individual payment policy and reporting requirements.

Hospital Outpatient Facility Reimbursement

Medicare reimburses Hospital Outpatient Departments (HOPDs) for services under the Ambulatory Payment Classification (APC) system. Each CPT code is assigned to an APC based on similar costs and clinical characteristics and that APC is assigned a payment and payment Status Indicator (SI) on the Medicare Outpatient Prospective Payment System (OPPS) fee schedule.

Private payers generally reimburse hospital outpatient departments at contracted rates and should be referenced for specific payment policy and reporting requirements.

Insertion

CPT	SHORT DESCRIPTION	CY 2025 MEDICARE NATIONAL[2]		
		STATUS INDICATOR	APC	PAYMENT
0515T	Insert Complete System	J1	5231	$22,446
0516T	Insert Electrode only	J1	5223	$10,465
0517T	Insert Battery & Transmitter only	J1	5223	$10,465

J1: Hospital Part B services paid through comprehensive APC- all covered Part B services on the claim are packaged with the primary "J1" service.

Removal

CPT	SHORT DESCRIPTION	CY 2025 MEDICARE NATIONAL[3]		
		STATUS INDICATOR	APC	PAYMENT
0861T	Remove Battery & Transmitter	Q2	5221	$3,639
0518T	Remove Battery only	Q2	5221	$3,639

Q2 T-Packaged Codes; packaged APC payment if billed on the same claim as a HCPCS code as-signed status indicator "T"; otherwise paid separately

Removal & Replacement

CPT	SHORT DESCRIPTION	CY 2025 MEDICARE NATIONAL[4]		
		STATUS INDICATOR	APC	PAYMENT
0519T	Remove and Replace Battery & Transmitter	J1	5223	$10,465
0520T	Remove and Replace Battery only	J1	5223	$10,465

J1: Hospital Part B services paid through comprehensive APC- all covered Part B services on the claim are packaged with the primary "J1" service.

Revision

CPT	SHORT DESCRIPTION	CY 2025 MEDICARE NATIONAL[5]		
		STATUS INDICATOR	APC	PAYMENT
0862T	Relocate Battery only	T	5054	$1,829
0863T	Relocate Transmitter only	T	5054	$1,829

T: Procedure or service subject to multiple procedure discounting

In-person Interrogation & Programming

CPT	SHORT DESCRIPTION	CY 2025 MEDICARE NATIONAL[6]		
		STATUS INDICATOR	APC	PAYMENT
0521T	Device Interrogation	Q1	5731	$24
0522T	Device Programming	Q1	5741	$37

Q1: STV Packaged Codes; Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "S," "T," or "V

HCPCS

Healthcare Common Procedure Coding System (HCPCS) Level II codes should be reported on all Medicare claims for device-intensive procedures performed in the outpatient setting. HCPCS codes are utilized by facilities to report costs associated with supplies and devices used in procedures. While HCPCS codes do not generally result in additional payment, it is important for facilities to report HCPCS codes for the supply of the device.

There is not a specific HCPCS code for the WiSE® CRT System. In addition to the CPT code for the implant or replacement procedure, facilities should report the following HCPCS indicating the supply of the WiSE® CRT System components:

- C1889 Implantable/insertable device, not otherwise classified

Private payer policies should be referenced for appropriate HCPCS selection and reporting requirements.

Hospital Inpatient Facility Coding Reimbursement

The International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) is the system of codes used by hospitals to report procedures and services provided in the inpatient setting. Currently, there are no unique ICD-10-PCS codes to describe the insertion of the WiSE® CRT System. However, the following ICD-10-PCS codes are available for complete system insertion:

PROCEDURE	ICD-10-PCS	DESCRIPTION
Electrode	02HL3DZ	Insertion of Intraluminal Device into Left Ventricle, Percutaneous Approach
Transmitter & Battery	0JH607Z	Insertion of Other Device into Chest Subcutaneous Tissue and Fascia, Open Approach

Medicare reimburses hospital inpatient stays under Medicare Severity-Diagnosis Related Groups (MS-DRGs) . Each stay is assigned to a single MS-DRG based on the procedures performed and patient diagnoses managed during the inpatient hospitalization.

The following are examples of possible MS-DRG assignments and associated payments:

MS-DRG	DESCRIPTION	FY 2025 MEDICARE NATIONAL PAYMENT[10]
228	Other Cardiothoracic Procedures with MCC	$35,563
229	Other Cardiothoracic Procedures without MCC	$22,168

Disclaimer:

The information contained in this document is for informational purposes only and is current as of April 2025. It is always the responsibility of the provider to determine if the services actually provided are accurately described by any specific code(s) and to report services consistent with specific payer requirements. This information is subject to change at any time, and ERB Systems, Inc. strongly recommends that you consult your payer organization with regard to its reimbursement policies. In all cases, services billed must be medically necessary, actually performed as reported and appropriately documented.

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1. *Current Procedural Terminology 2025, American Medical Association. Chicago, IL 2024. CPT is a registered trademark of the American Medical Association. Current Procedural Terminology (CPT®) is copyright 2024 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply*
2. *CMS-1809-FC, Addenda. Payments are effective January 1, 2025, through December 31, 2025.*
3. *CMS-1809-FC, Addenda. Payments are effective January 1, 2025, through December 31, 2025.*
4. *CMS-1809-FC, Addenda. Payments are effective January 1, 2025, through December 31, 2025.*
5. *CMS-1809-FC, Addenda. Payments are effective January 1, 2025, through December 31, 2025.*
6. *CMS-1809-FC, Addenda. Payments are effective January 1, 2025, through December 31, 2025.*
7. *HCPCS Level II, 2025 Expert. Copyright 2024 Optum 360, LLC*
8. *2025 International Classification of Diseases, 10th Revision, Procedure Coding System ICD-10-PCS https://www.cms.gov/medicare/coding-billing/icd-10-codes*
9. *ICD-10-CM/PCS MS-DRG v42.1 Definitions Manual: https://www.cms.gov/icd10m/fy2025-version42.1-fullcode-cms/fullcode_cms/P0001.html*
10. *CMS-1808-CN, CMS-I1808-IFC. Payments are effective October 1, 2024, through September 30, 2025.*