

# Medicare Medical Policy

## Clinical Trials, Studies and Registries

MEDICARE MEDICAL POLICY NUMBER: 233

<b>Effective Date:</b> 10/1/2023	MEDICARE COVERAGE CRITERIA.....	2
<b>Last Review Date:</b> 9/2023	POLICY CROSS REFERENCES.....	4
<b>Next Annual Review:</b> 7/2024	POLICY GUIDELINES.....	4
	REGULATORY STATUS.....	7
	BILLING GUIDELINES AND CODING .....	7
	REFERENCES.....	9
	POLICY REVISION HISTORY.....	11

**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
<i>Investigational Device Exemption (IDE) Studies</i>	<p>I. <b>Category B IDE Studies</b> – The Company may consider <u>devices and services</u> related to Medicare-approved Category B IDE studies to be <b>medically necessary</b> (unless the device is paid for by the trial sponsor).</p> <p>II. <b>Category A IDE studies</b> – The Company may consider routine <u>services</u> related to Medicare-approved Category A IDE studies to be <b>medically necessary</b>; however, the Category A <u>device</u> itself is not eligible for coverage or reimbursement.</p> <p>III. Category A and B investigational devices and related services not rendered in the context of an FDA-approved trial are considered <b>not medically necessary</b>.</p> <p>Notes and Supporting Medicare References/Resources:</p> <ul style="list-style-type: none"> <li>• Medicare approved IDE studies are posted on the <a href="#">Medicare IDE webpage</a>.</li> <li>• Some services may be auto-denied as not medically necessary based on other Company policies, including but not limited to, the <i>New and Emerging Technologies and Other Non-Covered Services (Medicare Only)</i> (MP220) 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.</li> </ul>

	<ul style="list-style-type: none"> <li>• Medicare Benefit Policy Manual, Chapter 14 – Medical Devices, <a href="#">§20.1 – Medicare Requirements for Coverage of Items and Services in FDA-approved Category A and B IDE Studies</a></li> <li>• Medicare Benefit Policy Manual, Chapter 4 – Benefits and Beneficiary Protections, <a href="#">§10.7.2 – Payment for Investigational Device Exemption (IDE) Studies</a></li> </ul>
<p><i>Coverage with Evidence Development (CED) Studies and Registries</i></p>	<p>I. For national coverage determinations (NCDs) with CED criteria, the Company may consider items and services in CMS-approved CED studies to be <b>medically necessary</b> and eligible for reimbursement, <i>unless</i> 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 of the Medicare Claims Processing Manual).</p> <p>Notes and Supporting Medicare References/Resources:</p> <ul style="list-style-type: none"> <li>• Medicare approved CED studies can be found on the <a href="#">Medicare Coverage with Evidence Development webpage</a>.</li> <li>• Some procedures and items subject to CED criteria are addressed in separate Medicare medical policies.</li> <li>• Medicare Benefit Policy Manual, Chapter 4 – Benefits and Beneficiary Protections, <a href="#">§10.7.3 – Payment for Clinical Studies Approved Under Coverage with Evidence Development (CED)</a></li> <li>• Medicare Claims Processing Manual, <a href="#">Chapter 32 – Billing Requirements for Special Services</a> (<i>search document for the specific service</i>)</li> </ul>
<p><i>Other Clinical Trials (aka, Clinical Research Study)</i></p>	<ul style="list-style-type: none"> <li>• Original Medicare or local Medicare Contractors (MACs) cover the routine costs of qualifying clinical trials on behalf of Medicare Advantage members and will waive the Part A and the Part B deductibles.</li> <li>• As the Medicare Advantage Organization (MAO), the Company is responsible for the remaining original Medicare coinsurance (minus plan’s normal copays). 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).</li> </ul> <p>Notes and Supporting Medicare References/Resources:</p> <ul style="list-style-type: none"> <li>• For coverage of costs associated with clinical trials, member benefit language requires the trial be approved by Medicare. The Company will be unable to give pre-service approval for trial participation. Instead, the Company will rely on the MEOB to</li> </ul>

confirm Medicare coverage was provided, as well as determine any remaining balance that is the responsibility of the MAO.

- If a clinical trial is not approved by Medicare, then it is not considered a “qualifying clinical trial.” This means the trial and its related services would **not** be covered by either Medicare or the Company (MAO).
- 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

<b>Category A Device:</b>	A device for which questions regarding safety and effectiveness remain because the “absolute risk” of the device type has not been established. <sup>1</sup>
<b>Category B Device:</b>	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. <sup>1</sup>
<b>CED:</b>	Coverage with Evidence Development
<b>IDE:</b>	Investigational Device Exemption
<b>MAC (aka, “A/B MACs”):</b>	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.
<b>MAO:</b>	Medicare Advantage Organization.
	Also referred to as Medicare Advantage (MA) Plans, Medicare+Choice Organizations, or Medicare Part C. <sup>2</sup>
<b>Medical Device:</b>	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: <ul style="list-style-type: none"> <li>• Recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them,</li> <li>• 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</li> <li>• 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”<sup>3,4</sup></li> </ul>
<b>MEOB</b>	Medicare Explanation of Benefits

## 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.

“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.<sup>5</sup>

“... 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*. Examples of services with significant cost threshold restrictions include pancreatic islet cell transplants. 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 medically reasonable and necessary per *Title XVIII of the Social Security Act §1862(a)(1)(A)*.

## **CLINICAL TRIALS AND CLINICAL RESEARCH STUDIES**

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. NCD 310.1 provides details regarding what services are considered “routine” costs, and what services are not considered routine costs.

Services which are not considered “routine” costs include, but are not limited to, the investigational item or service itself unless otherwise covered outside of the clinical trial, items and services provided solely to satisfy data collection and analysis needs but are not used in the direct clinical management of the patient, or items and services customarily provided by the research sponsors free-of-charge for an enrollee in the trial.

“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.

“...MA plans 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*)

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.

## 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:

- **IDEs:** 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)”<sup>6</sup> 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*		
<b>CPT</b>	None	
<b>HCPCS</b>	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 catheterization, 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

1. Medicare Benefit Policy Manual, Chapter 14 - Medical Devices, §20 – Food and Drug Administration (FDA)-Approved Investigational Device Exemption (IDE) Studies; Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c14.pdf>
2. Medicare National Coverage Determination (NCD) for *Routine Costs in Clinical Trials* ([310.1](#))
3. Medicare Benefit Policy Manual, Chapter 14 - Medical Devices, §10 - Coverage of Medical Devices; Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c14.pdf>

4. Food and Drug Administration (FDA) website:  
<https://www.fda.gov/AboutFDA/Transparency/Basics/ucm192695.htm>
5. Medicare webpage for Guidance for the Public, Industry, and CMS Staff: Coverage with Evidence Development; Available at: <https://www.cms.gov/medicare-coverage-database/view/medicare-coverage-document.aspx?MCDId=27>
6. CMS Manual System Change Request (CR) 5805, dated January 18, 2008; Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1418CP.pdf>
7. Medicare Claims Processing Manual, Chapter 32 – Billing Requirements for Special Services, §66 - National Coverage Determination (NCDs) services that are considered a significant cost for Medicare Advantage Plans. Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c32.pdf>.
8. Medicare webpage for Mandatory Reporting of National Clinical Trial (NCT) Identifier Numbers; Available at: <https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Downloads/Mandatory-Clinical-Trial-Identifier-Number-QsAs.pdf>
9. Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections, §10.7.3 – Payment for Clinical Studies Approved Under Coverage with Evidence Development (CED); Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf>
10. Medicare Claims Processing Manual, Chapter 32 - Billing Requirements for Special Services, §70.5 - Special Billing and Payment Requirements Medicare Advantage (MA) Beneficiaries; Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c32.pdf>
11. NCT number searches: <http://www.clinicaltrials.gov/>
12. Product Classification searches (Class I, Class II, or Class III):  
<http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPCD/classification.cfm>
13. Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections, §10.7.1 – Payment for Services; Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf>
14. Noridian webpage for Clinical Trials; Available at:  
<https://med.noridianmedicare.com/web/jfb/topics/clinical-trials> [Last Cited 07/01/2022]
15. Medicare webpage for Medicare Approved Facilities/Trials/Registries; Available at:  
<https://www.cms.gov/medicare/medicare-general-information/medicareapprovedfacilitie>
16. Medicare webpage for Medicare Clinical Trial Policies; Available at:  
<https://www.cms.gov/medicare/coverage/clinicaltrialpolicies?redirect=/clinicaltrialpolicies/>
17. Medicare Claims Processing Manual, Chapter 32 - Billing Requirements for Special Services, §68.1 – Billing Requirements for Providers Billing for Routine Care Items and Services in Category A IDE Studies; Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c32.pdf>
18. Medicare Claims Processing Manual, Chapter 32 - Billing Requirements for Special Services, §68.4 - Billing Requirements for Providers Billing Routine Costs of Clinical Trials Involving a Category B IDE; Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c32.pdf>
19. Medicare Claims Processing Manual, Chapter 32 - Billing Requirements for Special Services, §68.2 – Contractor Review of Category B IDEs; Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c32.pdf>

20. 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; Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c14.pdf>
21. Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections, §10.7.2 – Investigational Device Exemption (IDE); Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c04.pdf>
22. Medicare Managed Care Manual, Chapter 8 - Payments To Medicare Advantage Organizations, §40.4.3 - Special Rules for the September 2000 NCD on Clinical Trials; Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c08.pdf>
23. Medicare Managed Care Manual, Chapter 8 - Payments To Medicare Advantage Organizations, §40.4.4 - Category B Investigational Device Exemption (IDE) Trials; Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c08.pdf>
24. Medicare webpage for Medicare Coverage Related to Investigational Device Exemption (IDE) Studies; Available at: <https://www.cms.gov/medicare/coverage/ide>
25. NCT number searches: <http://www.clinicaltrials.gov/>
26. Product Classification searches (Class I, Class II, or Class III): <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPCD/classification.cfm>
27. Noridian Local Coverage Article (LCA) for *Investigational Device Exemptions (IDE) - IDE Documentation Requirements for Studies with an FDA Approval dated January 01, 2015 or later (A54917)*
28. Medicare webpage for Medicare Qualifying Clinical Trials Flowchart; Last Updated 08/2017; Available at: <https://www.unmc.edu/academicaffairs/documents/compliance/MedicareQualifyingClinicalTrialsFlowsheet1.pdf>

## 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