Local Coverage Determination (LCD): Electrocardiographic (EKG or ECG) Monitoring (Holter or Real-Time Monitoring) (L29584)

Contractor Information

Contractor Name
Wisconsin Physicians Service Insurance Corporation

LCD Information

Document Information
LCD ID
L29584

LCD Title
Electrocardiographic (EKG or ECG) Monitoring (Holter or Real-Time Monitoring)

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Original Effective Date
For services performed on or after 10/16/2009

Revision Effective Date
For services performed on or after 04/01/2014

Revision Ending Date
N/A

Retirement Date
N/A

Notice Period Start Date
06/01/2012

Notice Period End Date
N/A
Jurisdiction "8" comprises the states of Indiana and Michigan. WPS is responsible for claims payment and Local Coverage Determination (LCD) development for this jurisdiction. This LCD was created as part of the legacy transition (7/16/2012 - 8/20/2012); and, is a consolidation of the previous legacy contractors’ policies. Coverage of each LCD begins when the state/contract number combination officially is integrated into the Jurisdiction. On the CMS MCD, this date is known as either the **Original Effective Date** or the **Revision Effective Date**. The following table details the official effective dates for each state/contract number combination.

<table>
<thead>
<tr>
<th>ST</th>
<th>Legacy A Contractor &amp; Contract Number</th>
<th>Legacy B Contractor &amp; Contract Number</th>
<th>J &quot;8&quot; MAC A Contractor &amp; Contract Number</th>
<th>J &quot;8&quot; MAC B Contractor &amp; Contract Number</th>
<th>J &quot;8&quot; Effective Date</th>
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<tbody>
<tr>
<td>IN</td>
<td>NGS: 00630</td>
<td></td>
<td>WPS: 08102</td>
<td></td>
<td>08/20/12</td>
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<tr>
<td>MI</td>
<td></td>
<td>WPS: 00953</td>
<td></td>
<td>WPS: 08202</td>
<td>07/16/12</td>
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<td>NGS: 00130</td>
<td></td>
<td>WPS: 08101</td>
<td></td>
<td>07/23/12</td>
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<tr>
<td>MI</td>
<td>NGS: 00452</td>
<td></td>
<td>WPS: 08201</td>
<td></td>
<td>07/23/12</td>
</tr>
</tbody>
</table>

Long-Term ECG Monitoring is defined as a diagnostic procedure, which can provide continuous recording capabilities of ECG activities of the patient's heart while the patient is engaged in daily activities. These can include continuous, patient-demand or *auto-detection devices. The purpose of these tests is to provide information about rhythm disturbances and waveform abnormalities and to note the frequency of their occurrence.

**Definitions:**

- **Cardiac Event Detection (CED)** is a 30-day service for the purpose of documentation and diagnosis of paroxysmal or suspected arrhythmias.
- **Holter Monitoring** (24-hour ECG monitoring) is a study used to evaluate the patient's ambient heart rhythm during a full day's (24 Hours) cycle. It is a wearable EKG monitor that records the overall rhythm and significant arrhythmias.

**A. Medical Necessity:**
The medical necessity indications listed in this policy must be present in order for these tests to be covered.

B. Indications for external 48-hour ECG recording (CPT/HCPCS codes 93224-93227) include one or more of the following

1. Symptoms:
   a. Arrhythmias
   b. Chest pain
   c. Syncope (lightheadedness) or near syncope
   d. Vertigo (dizziness)
   e. Palpitations
   f. Transient ischemic episodes
   g. Dyspnea (shortness of breath)

2. Evaluation of the response to antiarrhythmic drug therapy.

3. Evaluation of myocardial infarction (MI) survivors with an ejection fraction of 40% or less.

4. Assessment of patients with coronary artery disease with active symptoms, to correlate chest pain with ST-segment changes.

5. Other acute and subacute forms of ischemic heart disease.

6. To detect arrhythmias post ablation procedures.

C. The use of 0295T, 0296T, 0297T and 0298T, external electrocardiographic recording for more than 48 hours up to 21 days by continuous rhythm recording and storage, may be considered medically necessary in patients treated for reasons listed in the ICD-9-CM list to monitor for asymptomatic episodes in order to evaluate treatment response, The use of external electrocardiographic event monitors for more than 48 hours up to 21 days that are either patient-activated or auto-activated may be considered medically necessary as a diagnostic alternative to Holter monitoring in patients who experience infrequent symptoms (less frequently than every 48 hours) suggestive of cardiac arrhythmias (i.e., palpitations, dizziness, presyncope, or syncope).

D. Long term 30-day monitoring; Telephonic Transmission of ECG (CPT codes 93228, 93229, and 93268-93272) involve 24 hour attended monitoring per 30 day period of time; no other EKG monitoring codes can be billed simultaneously with these codes. Indications for performing a Telephonic Transmission:

   a. Arrhythmias
   b. Chest pain
   c. Syncope (lightheadedness) or near syncope
   d. Vertigo (dizziness)
   e. Palpitations
f. Transient ischemic episodes
g. Dyspnea (shortness of breath)
h. To initiate, revise or discontinue arrhythmia drug therapy.
i. Evaluation of myocardial infarction (MI) survivors.
j. Evaluation of acute and subacute forms of ischemic heart disease.
k. Assessment of patients with coronary artery disease with active symptoms, to correlate chest pain with ST-segment changes.

**Coding Information**

**Bill Type Codes:**

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

013x Hospital Outpatient  
085x Critical Access Hospital

**Revenue Codes:**

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

Revenue codes only apply to providers who bill these services to the fiscal intermediary or Part A MAC. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or Part B MAC.

0489 Cardiology - Other Cardiology  
073X EKG/ECG (Electrocardiogram) - General Classification

**CPT/HCPCS Codes**

**Group 1 Paragraph:** Memory Loop Recordings

**Group 1 Codes:**

EXTERNAL PATIENT AND, WHEN PERFORMED, AUTO ACTIVATED  
93268 ELECTROCARDIOGRAPHIC RHYTHM DERIVED EVENT RECORDING WITH SYMPTOM-RELATED MEMORY LOOP WITH REMOTE DOWNLOAD
CAPABILITY UP TO 30 DAYS, 24-HOUR ATTENDED MONITORING; INCLUDES TRANSMISSION, REVIEW AND INTERPRETATION BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL
EXTERNAL PATIENT AND, WHEN PERFORMED, AUTO ACTIVATED ELECTROCARDIOGRAPHIC RHYTHM DERIVED EVENT RECORDING WITH SYMPTOM-RELATED MEMORY LOOP WITH REMOTE DOWNLOAD CAPABILITY UP TO 30 DAYS, 24-HOUR ATTENDED MONITORING; RECORDING (INCLUDES CONNECTION, RECORDING, AND DISCONNECTION)
EXTERNAL PATIENT AND, WHEN PERFORMED, AUTO ACTIVATED ELECTROCARDIOGRAPHIC RHYTHM DERIVED EVENT RECORDING WITH SYMPTOM-RELATED MEMORY LOOP WITH REMOTE DOWNLOAD CAPABILITY UP TO 30 DAYS, 24-HOUR ATTENDED MONITORING; REVIEW AND INTERPRETATION BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL

Group 2 Paragraph: Other up to 48-Hour Recordings

Group 2 Codes:

EXTERNAL ELECTROCARDIOGRAPHIC RECORDING UP TO 48 HOURS BY CONTINUOUS RHYTHM RECORDING AND STORAGE; INCLUDES RECORDING, SCANNING ANALYSIS WITH REPORT, REVIEW AND INTERPRETATION BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL
EXTERNAL ELECTROCARDIOGRAPHIC RECORDING UP TO 48 HOURS BY CONTINUOUS RHYTHM RECORDING AND STORAGE; RECORDING (INCLUDES CONNECTION, RECORDING, AND DISCONNECTION)
EXTERNAL ELECTROCARDIOGRAPHIC RECORDING UP TO 48 HOURS BY CONTINUOUS RHYTHM RECORDING AND STORAGE; SCANNING ANALYSIS WITH REPORT
EXTERNAL MOBILE CARDIOVASCULAR TELEMETRY WITH ELECTROCARDIOGRAPHIC RECORDING, CONCURRENT COMPUTERIZED REAL TIME DATA ANALYSIS AND GREATER THAN 24 HOURS OF ACCESSIBLE ECG DATA STORAGE (RETRIEVABLE WITH QUERY) WITH ECG TRIGGERED AND PATIENT SELECTED EVENTS TRANSMITTED TO A REMOTE ATTENDED SURVEILLANCE CENTER FOR UP TO 30 DAYS; REVIEW AND
INTERPRETATION WITH REPORT BY A PHYSICIAN OR OTHER QUALIFIED
HEALTH CARE PROFESSIONAL
EXTERNAL MOBILE CARDIOVASCULAR TELEMETRY WITH
ELECTROCARDIOGRAPHIC RECORDING, CONCURRENT COMPUTERIZED
REAL TIME DATA ANALYSIS AND GREATER THAN 24 HOURS OF
ACCESSIBLE ECG DATA STORAGE (RETRIEVABLE WITH QUERY) WITH ECG
TRIGGERED AND PATIENT SELECTED EVENTS TRANSMITTED TO A REMOTE
ATTENDED SURVEILLANCE CENTER FOR UP TO 30 DAYS; TECHNICAL
SUPPORT FOR CONNECTION AND PATIENT INSTRUCTIONS FOR USE,
ATTENDED SURVEILLANCE, ANALYSIS AND TRANSMISSION OF DAILY AND
EMERGENT DATA REPORTS AS PRESCRIBED BY A PHYSICIAN OR OTHER
QUALIFIED HEALTH CARE PROFESSIONAL

Group 3 Paragraph: External electrocardiographic recording for more than 48 hours up to 21
days.

The CPT/HCPCS file states "Do not report 0295T-0298T in conjunction with 93224-93272 for
same monitoring period".

The use of auto-activated external electrocardiographic event recordings may be considered
medically necessary in the outpatient setting and are non-covered for inpatient or outpatient
observation care.
Documentation supporting medical necessity may be requested

Group 3 Codes:

0295T EXTERNAL ELECTROCARDIOGRAPHIC RECORDING FOR MORE THAN 48
HOURS UP TO 21 DAYS BY CONTINUOUS RHYTHM RECORDING AND
STORAGE; INCLUDES RECORDING, SCANNING ANALYSIS WITH REPORT,
REVIEW AND INTERPRETATION
0296T EXTERNAL ELECTROCARDIOGRAPHIC RECORDING FOR MORE THAN 48
HOURS UP TO 21 DAYS BY CONTINUOUS RHYTHM RECORDING AND
STORAGE; RECORDING (INCLUDES CONNECTION AND INITIAL RECORDING)
0297T EXTERNAL ELECTROCARDIOGRAPHIC RECORDING FOR MORE THAN 48
HOURS UP TO 21 DAYS BY CONTINUOUS RHYTHM RECORDING AND
STORAGE; SCANNING ANALYSIS WITH REPORT
0298T EXTERNAL ELECTROCARDIOGRAPHIC RECORDING FOR MORE THAN 48
HOURS UP TO 21 DAYS BY CONTINUOUS RHYTHM RECORDING AND
STORAGE; REVIEW AND INTERPRETATION

ICD-9 Codes that Support Medical Necessity

Group 1 Paragraph: Note: ICD-9 codes must be coded to the highest level of specificity.
Group 1 Codes:

- **410.00 - 410.92** Acute Myocardial Infarction of Anterolateral Wall Episode of Care Unspecified - Acute Myocardial Infarction of Unspecified Site Subsequent Episode of Care
- **411.0 - 411.89** Postmyocardial Infarction Syndrome - Other Acute and Subacute Forms of Ischemic Heart Disease Other
- **412** Old Myocardial Infarction
- **413.0 - 413.9** Angina Decubitus - Other and Unspecified Angina Pectoris
- **426.0 - 426.9** Atrioventricular Block Complete - Conduction Disorder Unspecified
- **427.0 - 427.42** Paroxysmal Supraventricular Tachycardia - Ventricular Flutter
- **427.60 - 427.9** Premature Beats Unspecified - Cardiac Dysrhythmia Unspecified
- **780.02** Transient Alteration of Awareness
- **780.2** Syncope and Collapse
- **780.4** Dizziness and Giddiness
- **781.0** Abnormal Involuntary Movements
- **781.4** Transient Paralysis of Limb
- **785.1** Palpitations
- **786.00 - 786.09** Respiratory Abnormality Unspecified - Respiratory Abnormality Other
- **786.50** Unspecified Chest Pain
- **786.51** Precordial Pain
- **786.59** Other Chest Pain
- **V58.69** Long-Term (Current) Use of Other Medications

ICD-9 Codes that DO NOT Support Medical Necessity

**Paragraph:** Diagnoses not listed above

N/A

**General Information**

Associated Information

**Documentation Requirements**
Medicare Part B monitors for medical necessity, which can include frequency. Documentation would include a history and physical exam. The record should document the evaluation, which focuses on the cause(s) of the presenting symptoms and/or the need for this testing. Some examples are:
1. The patient record has an evaluation and management service that documents the symptoms experienced by the patient.

2. The patient has had a full workup in the past month with initial tests performed, and presents with continuing symptoms that indicate the need for up to 48 hour monitoring or long-term monitoring;

3. The patient requires a change in antiarrhythmic medication. In this case, an assessment of the patient's complaints, the name of the medication stopped and the name of the new medication should be indicated.

4. In the case of referred tests, documentation of medical necessity may be requested from the referring physician. These are considered purchased diagnostic tests.

5. Independent diagnostic testing facilities (IDTF) and suppliers must retain records that include:
   a. The referring physician's written orders; and
   b. The identity of the employee setting up the tracing.

Documentation should be submitted as indicated when requested or when unusual circumstances are present. The EMC narrative may be used.

Sources of Information and Basis for Decision
Pub 100-3, Ch 1- §20.15
Final Rule, Federal Register, Dec. 31, 2002

Other Medical Carriers

Other Comments
This LCD consolidates and replaces all previous policies and publications on this subject by the carrier and fiscal intermediary predecessors of Wisconsin Physicians Service. This coverage determination also applies within states outside the primary geographic jurisdiction that have nominated Wisconsin Physicians Service to process their claims.

Carrier Advisory Committee (CAC) Meeting
Any Carrier Advisory Committee (CAC) related information, including Start Date and End Date of Comment Period, reflects the last time this LCD passed through the Comment and Notice process. Formal comment is not required for LCD's being adopted as part of the MAC transition.

<table>
<thead>
<tr>
<th>Meeting Date</th>
<th></th>
</tr>
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<tbody>
<tr>
<td>Wisconsin</td>
<td>01/16/2009</td>
</tr>
<tr>
<td>Illinois</td>
<td>01/28/2009</td>
</tr>
<tr>
<td>Michigan</td>
<td>01/07/2009</td>
</tr>
<tr>
<td>Minnesota</td>
<td>01/22/2009</td>
</tr>
<tr>
<td>Iowa, Kansas, Missouri, Nebraska</td>
<td>02/12/2009</td>
</tr>
</tbody>
</table>
Revision History Information

Please note: Most Revision History entries effective on or before 01/24/2013 display with a Revision History Number of "R1" at the bottom of this table. However, there may be LCDs where these entries will display as a separate and distinct row.

<table>
<thead>
<tr>
<th>Revision History Date</th>
<th>Revision History Number</th>
<th>Revision History Explanation Reason(s) for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/01/2014</td>
<td>R4</td>
<td>03/10/2014: Annual review completed, ICD-9 codes moved from the body of this LCD, diagnosis codes remain within the tables of the LCD. No change in coverage. The WPS Carrier Contract Numbers 00951(WI), 00952(IL), and 00954(MN) were removed from this LCD. Effective date 04/01/2014.</td>
</tr>
<tr>
<td>09/07/2013</td>
<td>R3</td>
<td>09/07/2013, the Jurisdiction 6 Part B MAC contractor for Illinois, Wisconsin, and Minnesota is National Government Services (NGS).</td>
</tr>
<tr>
<td>06/01/2013</td>
<td>R2</td>
<td>06/01/2013: Annual review with formatting changes. No changes to coverage (five). 01/01/2013: CPT 2013 revisions; Description changes for CPT codes 93224, 93227, 93228, 93229, 93268 and 93272, effective 01/01/2013 (four).</td>
</tr>
<tr>
<td>01/01/2013</td>
<td>R1</td>
<td>10/22/2012: In accordance with Section 911 of the Medicare Modernization Act of 2003 and CMS Change Request 8059, contractor numbers in this LCD policy were updated due to the transition from WPS Fiscal Intermediary Contract Number 52280 to WPS Part A MAC Contractor Number 05901. No other changes were made to this LCD policy.</td>
</tr>
</tbody>
</table>
08/20/2012: This LCD was revised to add the Jurisdiction 8 (J-8) Indiana Part B MAC Contract Number 08102. The CMS Statement of Work for the J8 Medicare Administrative Contract (MAC) requires that the contractor retain the most clinically appropriate LCD within the jurisdiction. This WPS policy is being promulgated to the J8 MAC as the most clinically appropriate LCD within this jurisdiction. No coverage changes were made to this LCD for this revision.

07/23/2012: This LCD was revised to add the Jurisdiction 8 (J-8) Indiana and Michigan Part A MAC Contract Numbers 08101 and 08201. The CMS Statement of Work for the J8 Medicare Administrative Contract (MAC) requires that the contractor retain the most clinically appropriate LCD within the jurisdiction. This WPS policy is being promulgated to the J8 MAC as the most clinically appropriate LCD within this jurisdiction. No coverage changes were made to this LCD for this revision.

07/16/2012: This LCD was revised to add the Jurisdiction 8 (J-8) Michigan Part B MAC Contract Number 08202 and remove the legacy Michigan Part B Carrier Contract Number 00953. The CMS Statement of Work for the J8 Medicare Administrative Contract (MAC) requires that the contractor retain the most clinically appropriate LCD within the jurisdiction. This WPS policy is being promulgated to the J8 MAC as the most clinically appropriate LCD within this jurisdiction. No coverage changes were made to this LCD for this revision.

05/01/2012: Addition of CPT codes 0295T, 0296T, 0297T and 0298T, effective 01/01/2012. Inclusion of Category III codes as payable when medically necessary and conditions of coverage have been met.
expands coverage. Thus no notice period applies. (three)

04/01/2011: Annual review. Reformatted. No coverage changes (two).

*01/01/2011, CPT 2011 revisions; Discontinued CPT codes 93012, 93014, 93230, 93231, 93232, 93233, 93235, 93236, and 93237. CPT long description changes CPT codes 93224, 93225, 93226, 93227, 93228, 93229, 93268, 93270, 93271, and 93272. Deleted under Indications and Limitations paragraph C. Effective 01/01/2011 (one).

09/02/2009 No change to coverage.

06/30/2009 The contractor number 05392 will no longer be valid as of 8/1/2009 as it will be joining with the W MO number.

Revision to draft 6/30/2009

04/19/2010—In accordance with Section 911 of the Medicare Modernization Act of 2003, the states of American Somoa, California, Guam, Hawai i, Nevada and Northern Mariana Islands were removed from this LCD because claims processing for those states are transitioning from FI Contractor Wisconsin Physician Services (WPS - 52280) to MAC Part A Contractor Palmetto.

8/1/2010 - The description for Bill Type Code 13 was changed
8/1/2010 - The description for Bill Type Code 85 was changed

8/1/2010 - The description for Revenue code 0489 was changed
8/1/2010 - The description for Revenue code 0730 was changed
8/1/2010 - The description for Revenue
code 0731 was changed
8/1/2010 - The description for Revenue code 0732 was changed
8/1/2010 - The description for Revenue code 0739 was changed

10/18/2010 - In accordance with Section 911 of the Medicare Modernization Act of 2003, the states of Colorado, New Mexico, Oklahoma and Texas were removed from this LCD because claims processing for those states are transitioning from FI Wisconsin Physicians Service (52280) to MAC Part A Trailblazer (04901).

11/21/2010 - For the following CPT/HCPCS codes either the short description and/or the long description was changed. Depending on which description is used in this LCD, there may not be any change in how the code displays in the document:
93268 descriptor was changed in Group 2
93270 descriptor was changed in Group 2
93271 descriptor was changed in Group 2
93272 descriptor was changed in Group 2
93224 descriptor was changed in Group 3
93225 descriptor was changed in Group 3
93226 descriptor was changed in Group 3
93227 descriptor was changed in Group 3
93228 descriptor was changed in Group 3
93229 descriptor was changed in Group 3

11/21/2010 - The following CPT/HCPCS codes were deleted:
93012 was deleted from Group 1
93014 was deleted from Group 1
93230 was deleted from Group 3
93231 was deleted from Group 3
93232 was deleted from Group 3
93233 was deleted from Group 3
93235 was deleted from Group 3
93236 was deleted from Group 3
93237 was deleted from Group 3

02/21/2011 — In accordance with Section
911 of the Medicare Modernization Act of 2003, the states of Delaware, District of Columbia, Maryland, New Jersey and Pennsylvania were removed from this LCD because claims processing for these states are transitioning from FI Wisconsin Physician Service (WPS 52280) to MAC Part A contractor Highmark (12901).

11/21/2011 - For the following CPT/HCPCS codes either the short description and/or the long description was changed. Depending on which description is used in this LCD, there may not be any change in how the code displays in the document:
93271 descriptor was changed in Group 1

11/25/2012 - For the following CPT/HCPCS codes either the short description and/or the long description was changed. Depending on which description is used in this LCD, there may not be any change in how the code displays in the document:
93268 descriptor was changed in Group 1
93272 descriptor was changed in Group 1
93224 descriptor was changed in Group 2
93227 descriptor was changed in Group 2
93228 descriptor was changed in Group 2
93229 descriptor was changed in Group 2

**Associated Documents**

Attachments
Billing & Coding Guidelines 6/1/12 opens in new window (PDF - 27 KB )

Related Local Coverage Documents
N/A

Related National Coverage Documents
N/A

Public Version(s)
Updated on 04/14/2014 with effective dates 04/01/2014 - N/A
Updated on 08/26/2013 with effective dates 09/07/2013 - 03/31/2014
Updated on 05/21/2013 with effective dates 06/01/2013 - 09/06/2013
Updated on 12/18/2012 with effective dates 01/01/2013 - 05/31/2013
Billing and Coding Guidelines
Contractor Name
Wisconsin Physicians Service Insurance Corporation
Title
Billing and Coding Guidelines for CV-016; Electrocardiographic (EKG or ECG) Monitoring (Holter or Real-Time Monitoring
)
Document Effective Date
10/16/2009
Revision Effective Date:
*07/16/2012
Text:
This document contains the coding and billing guidelines and reasons for denial for LCD CV-016. This article is intended for use with LCD Electrocardiographic (EKG or ECG) Monitoring (Holter or Real-Time Monitoring).

CMS National Coverage Policy
Title XVIII of the Social Security Act section 1862 (a) (1) (A). This section allows coverage and payment of those services that are considered to be medically reasonable and necessary.
Title XVIII of the Social Security Act section 1862 (a) (7). This section excludes routine physical examinations and services.
Title XVIII of the Social Security Act section 1833 (e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.
*An asterisk indicates a revision to that section of the companion document
*Italicized font - represents CMS national policy language/wording copied directly from CMS Manuals or CMS transmittals.
AMA CPT/ ADA CDT Copyright Statement
A. Coding Guidelines
The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This information does not take precedence over CCI edits. Please refer to CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare.

1. *CPT codes for holter monitoring services (CPT codes 93224-93227) are intended for up to 48 hours of continuous recording. For 48 hour monitoring codes (CPT 93224-93227):
   a. The documentation in the progress notes must reflect medical necessity for the service.
   b. These services may be reported globally with CPT codes 93224. Use the date of physician review as the date of service (DOS).
   c. When submitting claims for the recording only (CPT code 93225) or for the analysis with report only (CPT code 93226) use the date the service was performed as the DOS.
   d. When submitting claims for physician review and interpretation (CPT code 93227) use the date the service was performed as the DOS.
   e. For less than 12 hours continuous recording, modifier -52 (reduced services) should be appended. (2011 Insider’s View p. 181)

2. List the ICD-9 code(s) indicating the reason for the test.

3. The name and NPI number of the referring/der physician or qualified non-physician practitioner must be reported in boxes 17 and 17a of CMS-1500 form or in the EAO record fields 20.0 (for NPI number) and 22.0 (name) when submitting electronically.
4. The physician interpreting the test must be identified on the claim form with his/her sequence number in Box 24K. For EMC, use NSF format field FA0 - 23, or ANSI - 837 or NM1 - 09 (loop 2310).

5. The codes describing technical work may be billed by an independent diagnostic testing facility (IDTF) if they meet all requirements listed in the code descriptions and coverage requirements. They may bill the total component only if the physician interpreting the test is employed or contracted by the IDTF and is not billing for the interpretation separately. The physician's name and address must be on record with our WPS Provider Enrollment Department. A letter should be sent by the physician assigning all monies collected by the IDTF for the professional codes to the billing IDTF. If a letter is not on file, professional services billed by the IDTF will be denied.

6. Do not use the "TC" or "26" modifier with the codes 93224-93229, 93268, 93270, 93271, or 93272, listed in the CPT/HCPCS section of the LCD.

7. For the same dates of service, either the wearable patient monitor or the up to 48-hour monitor will be covered (not both).

8. External Mobile Cardiac Telemetry Monitors
As of 01/01/2009, CPT codes 93228 and 93229 describe wearable mobile cardiovascular telemetry services. Because of this, wearable mobile cardiovascular telemetry services should no longer be reported using 93799 Providers are instructed to bill one (1) unit of procedure code 93228 and/or 93229 per a course of treatment that includes up to 30 consecutive days of cardiac monitoring.

*As of 01/01/2011, the term wearable mobile cardiovascular telemetry services, is changed to external mobile cardiovascular telemetry services.

*As of 01/01/2011, do not report CPT code
93228 with CPT codes 93224 and 93227.
*As of 01/01/2011, do not report CPT code 93229 with CPT codes 93224 and 93226.
For dates of service prior to 01/01/2009, claims for outpatient mobile cardiovascular telemetry should be submitted using CPT code 93799 (unlisted cardiovascular service procedure).