Priority Health	BILLING POLICY No. 080
ELECTROCARDIOGRAPHIC (EKG OR ECG) MONITORING (HOLTER OR REAL-TIME MONITORING)	
Date of origin: Mar. 18, 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

DEFINITION

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's a wearable EKG monitor that records the overall rhythm and significant arrhythmias.

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

We won't reimburse both a wearable patient monitor and a 48-hour monitor for the same dates of service.

A technician, nurse or physician trained to interpret ECGs and abnormal rhythms can receive transmissions associated with the services below. Physicians must be available for immediate consultation to review or discuss the transmission of ECGs with abnormalities or significant symptoms.

Coding specifics

CPT Codes for holter monitor services, up to 48 hours of continuous monitoring

- **93224**: 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
- **93225**: External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; recording (includes connection, recording, and disconnection)
- **93226**: external electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; scanning analysis with report
- **93227**: External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; review and interpretation by a physician or other qualified health care professional

CPT codes for external mobile cardiac telemetry monitors, up to 30 days of consecutive monitoring

- **93228**: 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 (professional component)

- **93229**: 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 (technical component)

CPT codes for long-term continuous recorders, greater than 48 hours and up to 7 days or for greater than 7 days up to 15 days

- **93241**: External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation
- **93242**: External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; recording (includes connection and initial recording)
- **93243**: External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; scanning analysis with report
- **93244**: External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; review and interpretation
- **93245**: External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation
- **93246**: External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; recording (includes connection and initial recording)
- **93247**: External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; scanning analysis with report
- **93248**: External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; review and interpretation

Place of service

Independent Diagnostic Testing Facility (use the POS code for the setting in which the patient received the test)

Coverage will be considered for services furnished in the appropriate setting to the patient’s medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Documentation requirements

List the diagnosis code(s) indicating the reason for the test

A history and physical exam documenting the evaluation, which focuses on the cause(s) of the presenting symptoms and/or the need for this testing. This includes:

- An evaluation and management service that documents the symptoms experienced by the patient.
- 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.
- A required 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.
- If testing is referred, documentation of medical necessity may be requested from the referring physician.
- Independent diagnostic testing facilities (IDTF) and suppliers must retain records that include:
    - The referring physician's written orders; and

    - The identity of the employee setting up the tracing.

CPT codes 93224-93227 describe services intended for up to 48 hours of continuous recording:

- Documentation must detail the medical necessity for service and diagnoses indicating reason for test
- The physician review date should be utilized for date of service when code 93224 is reported for global services
- The date service was performed should be utilized for date of service when reporting CPT 93225 (recording only) or 93226 (analysis with report)
- For continuous recording that is less than 12 hours, modifier 52 must be appended
- Modifiers 26 and TC are not appropriate for these services
- Only one unit of service should be reported for codes in the range 93224-93227 as these represent up to 48-hours.
- No additional EKG monitoring codes can be billed in conjunction with these services
- Services should not be split and billed individually when performed by the same diagnostic testing facility. The physician performing interpretation services should be reported in the notes section of the claim.

CPT code 93228 and/or 93229:

- The date of service must be reported as the date the patient was initially placed on the monitor.
- A monitoring episode (one to 30 consecutive days) is reported as a unit of one.

Modifiers

- For less than 12 hours continuous recording, modifier -52 (reduced services) should be appended.
- Don't use the TC or 26 modifier with the codes 93224-93229, 93268, 93270, 93271 or 93272

Incorrect application of modifiers will result in denials. Get more information on modifier use in our Provider Manual.

Resources

- LCD: Electrocardiographic (EKG or ECG) Monitoring (Holter or Real-Time Monitoring) (CMS)
- Article: Billing and Coding: Electrocardiographic (EKG or ECG) Monitoring (Holter or Real-Time Monitoring) (CMS)
- Ambulatory Electrocardiographic (AECG) Monitoring (United Healthcare)

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and

abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made