Priority Health	BILLING POLICY No. 189
ECG Interpretation	
Date of origin: 4/2026	**Review dates: None yet recorded**

Definition

An electrocardiogram (ECG) is a graphic representation of electrical activity within the heart. Electrodes placed on the body in predetermined locations sense this electrical activity, which is then recorded by various means for review and interpretation.

ECG interpretation isn't a mere review of the ECG, but rather a report on the patient and the comparative and relevant clinical data and findings revealed by the ECG. It may include measurement of all intervals and axis, rhythm and heart rate, interpretation of the tracing by the physician, summary of condition, etc. Interpretation of computer-generated reports.

To support that the physician has interpreted the computer-generated report findings as opposed to simply reviewing them, the documentation should include:

- Whether the physician agrees or disagrees with the computer-generated report findings
- Notation of what findings the physician disagrees with, if any
- Any additional or corrected information found from interpreting the findings

ECG interpretation billing

Payable:

Priority Health reimburses for ECG interpretations (CPT 93000, 93010 or G0403) by professional providers when the report includes these elements:

- Member demographics
- Complete, written report that is similar to one that is prepared by a specialist in the field. The content of the written report must address the relevant clinical issues, available comparative data, and test findings. The format of the report must be separately identifiable. It may be included under a separate heading within the clinical record or written on the ECG tracing itself, with a reference in the clinical record
- Indication that the reporting provider personally performed the interpretation
- Legible signature by provider of service
- Date of interpretation
- Legible patient medical record that clearly indicates the reasonableness and necessity of the service

The report does not have to be a separate document; it can be included in the medical record as a separate paragraph or section.

Not payable:

When claims include overly general language such as "ECG – normal", which is insufficient for interpretation and report purposes, we consider that the provider has simply reviewed the ECG results, and no reimbursement is due.

An ECG isn't payable when used for screening purposes or as part of a routine physical examination. Routine physical examinations (screening) are evaluation and management services supplied in the absence of associated signs, symptoms or complaints.

Priority Health will not pay twice for a service that is required only once to diagnose or treat an illness or injury. Typically, this A/B MAC will pay for only one PC of an ECG. This A/B MAC may pay for a second PC when the additional physician's expertise is necessary and reasonable to diagnose or treat the patient, such as to clarify a questionable finding. The physician performing the initial PC must have a valid reason to require another physician's expertise, such as, to interpret a confusing ECG. The second

physician's knowledge and expertise must be significantly greater than that of the first reader, and it must contribute substantially to the interpretation.

Multiple Interpretations of a Diagnostic Test in Institutional Settings: Medicare generally pays for only one reading of a diagnostic test.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

76- Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional
77- Repeat Procedure by Another Physician or Other Qualified Health Care Professional

Resources

- Billing and Coding: Electrocardiograms – A57326 (CMS)
- **The American College of Emergency Physicians** (ACEP) have outlined guidelines supporting this documentation requirement within their frequently asked questions**.**
- **The Centers for Medicare and Medicaid Services** have also addressed this in their Guidance Manual. Per CMS, a professional component billing based on a review of the findings of these procedures, without a complete, written report similar to that which would be prepared by a specialist in the field, does not meet the conditions for separate payment of services (Ch. 13, Section 100.1 – X-rays and EKGs furnished to Emergency Room Patients).
- **The Medicare Wisconsin Physicians Service (WPS) Insurance Corporation** has also addressed the documentation requirements to report an interpretation of an EKG computer-generated report.
- **The Coding Institute** also addresses this topic in their ED Coding Alert 2011, Volume 14, which is aligned with CMS and American College of Emergency Physicians guidelines for documentation of interpretation and reports.

Related policies

For more information, see ECG monitoring billing policy

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. 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 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 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
April 2026	New policy