

## **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.

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### **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/ordering 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).

CPT code 93229 is the technical component of this service and includes all of the following within a course of treatment that includes up to 30 consecutive days of cardiac monitoring:

- a. Patient hook-up and patient-specific instruction and education
- b. Transmission and receipt of ECG
- c. Analysis of ECG by nonphysician personnel
- d. Medical chart documentation including daily report, patient and/or physician interaction and response, and summary report at the end of the monitoring episode
- e. Equipment maintenance.
- f. All supplies necessary for completion of the monitoring

CPT code 93228 is the professional component of this service and includes review and interpretation of each 24-hour cardiac surveillance as well as 24-hour availability and response to monitoring events within a course of treatment that includes up to 30 consecutive days of cardiac monitoring.

The following documentation requirements apply to all claims reporting CPT code 93228 and/or 93229:

- a. The date of service must be reported as the date the patient was initially placed on the monitor.
- b. A monitoring episode (one to 30 consecutive days) is reported as a unit of one.
- c. Any additional claims reporting procedure code 93228 or 93229 for ECG arrhythmia detection and alarm system within an episode of care (one to 30 days after an initial service) will be denied.

### **GY and GZ Modifiers**

When billing for services, requested by the beneficiary for denial, that are statutorily excluded by Medicare (i.e. screening), report a screening ICD-9 code and the GY modifier (items or services statutorily excluded or does not meet the definition of any Medicare benefit)

When billing for services, requested by the beneficiary for denial, that would be considered **not** reasonable and necessary, report an ICD-9 code that best describes the patients condition and the GA modifier if an ABN signed by the beneficiary is on file or the GZ modifier (items or services expected to be denied as not reasonable) when there is no ABN for the service on file.

### **B. Types of monitoring and coverage:**

1. CPT Codes 93224-93227  
Continuous up to 48-hour Monitoring (CPT codes 93224-93227), includes a coverage period of up to 48-hours for one unit of service. No other EKG monitoring codes can be billed simultaneously with these codes.
2. CPT Codes 0295T-0298T  
External electrocardiographic recording for more than 48 hours up to 21 days (CPT codes 0295T, 0296T, 0297T and 0298T) includes a coverage period greater than 48 hours up to 21 days. No other EKG monitoring codes can be billed simultaneously with these codes and services represented by these codes are non- covered for inpatient or outpatient observation care.
3. CPT codes 93268-93272

*Cardiac event monitor technology varies among different devices. For patient-activated event monitors, the patient initiates recording when symptoms appear or when instructed to do so by a physician (e.g., following exercise). For self-sensing automatically triggered monitors, an EKG is automatically recorded when the device detects an arrhythmia, without patient intervention. Some devices permit a patient to transmit EKG data trans-telephonically (i.e., via telephone) to a receiving center where the data is reviewed. A technician may be available at these centers to review transmitted data 24-hours per day. In some instances, when the EKG is determined to be outside certain pre-set criteria by a technician or other non-physician, a physician is available 24 hours per day to review the transmitted data and make clinical decisions regarding the patient. These services are known as 24 hour "attended monitoring". In other instances, transmitted EKG data is reviewed at a later time and are, therefore, considered "non-attended."*

- a. The person receiving the transmission must be a technician, nurse, or a physician trained in interpreting ECG's and abnormal rhythms.
- b. A physician must be available 24 hours a day for immediate consultation to review the transmission in case of significant symptoms or ECG abnormalities

4. CPT codes 93224-93227

See Section A above for information related to external mobile cardiac telemetry monitors

5. *Additionally, the transmitting devices must meet at least the following criteria;*

- a. *They must be capable transmitting EKG Leads I, II or III; and*
- b. *The tracing must be sufficiently comparable to a conventional EKG.*

*24-hour attended coverage used as early post-hospital monitoring of patients discharged after MI is only covered if provision is made for such 24-hour attended coverage in the manner described below.*

*24-hour attended coverage means there must be, at a monitoring site or central data center, an EKG technician or other non-physician, receiving calls and/or EKG data. Tape recording devices do not meet this requirement. Further, such technicians should have immediate 24-hour access to a physician to review transmitted data and make clinical decisions regarding the patient. The technician should also be instructed as to when how to contact available facilities to assist the patient in case of emergencies.*

6. Nationally Non-covered Indications

*The following indications are non-covered nationally unless otherwise specified below:*

- a. *The time-sampling mode of operation of ambulatory EKG cardiac event monitoring recording.*
- b. *Separate physician services other than those rendered by an IDTF unless rendered by the patient's attending or consulting physician.*
- c. *Home EKG services without documentation of medical necessity.*
- d. *Emergency EKG services by a portable x-ray supplier without a physician in attendance at the time of the service or immediately thereafter.*
- e. *24-hour attended coverage used as early post-hospital monitoring of patients discharged after MI unless provision is made for such 24-hour attended coverage in the manner described in section 4 above.*

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**Revision History Explanation**

06/01/2012: This document was revised to add the Jurisdiction 8 (J-8) MAC contractor numbers. 08101, 08102, 08201, 08202 and removed Michigan Carrier contract number 00953.

This Billing and Coding document is effective for J-8 providers in Michigan MAC B 07/16/12, Michigan MAC A 07/23/12, Indiana MAC A 07/23/12 and Indiana MAC B 08/20/12

05/01/2012: Addition of CPT codes 0295T, 0296T, 0297T and 0298T, effective 01/01/2012.

04/01/2011: Clarified instructions for CPT codes 93224-93227 found in Coding Guidelines Section, paragraph one (1). Changed the term wearable mobile cardiovascular telemetry services, per the 2011 CPT coding update, to external mobile cardiovascular telemetry services; (two).

01/01/2011, Billing and Coding document revised to reflect the 2011 CPT Coding revisions. Revisions include the following; Deleted under Coding Guidelines section, sentence six, CPT codes 93012 and 93014. Changed under Coding Guidelines section, sentence seven to state up to 48-hours. Revised under section B; Types of monitoring and coverage sentence one to state up to 48-hours and deleted CPT codes 93230-93233 and 93235-93237. Deleted under section B; Types of monitoring and coverage, sentence two. Under section B; Types changed sentence three to sentence two and deleted CPT codes 93012 and 93014 (one).