<u>**Billing and Coding Guidelines**</u>

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:
*01/01/2011

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
CPT codes, descriptions and other data only are copyright 2009 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply. Current Dental Terminology, (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. © 2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply

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. List the appropriate procedure code.
   a. If billing for 48 hours for codes 93224-93227, indicate this by placing <u>each date of service</u> on a separate line with a 1 in the unit's box (e.g., 010).
   b. The documentation in the progress notes must reflect medical necessity for the service.

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 laboratory 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 laboratory for the professional codes to the billing laboratory. If a letter is not on file, professional services billed by the IDTF laboratories 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. Wearable Mobile Cardiovascular

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

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. 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 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

3. *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.

4. *<u>24-hour attended coverage</u> 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. <u>Nationally Non-covered Indications</u>

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.

Published: 09/01/2009

Revision History, Number/Explanation

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).