External Ambulatory Electrocardiography

MEDICAL POLICY NUMBER: 188

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INSTRUCTIONS FOR USE: Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Company reserves the right to determine the application of medical policies and make revisions to medical policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

PLAN PRODUCT AND BENEFIT APPLICATION

☒ **Commercial (self-funded groups only)** ☐ **Medicaid/OHP*** ☐ **Medicare****

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

External Ambulatory Electrocardiography: Diagnostic Guideline Note D2

**Medicare Members

This *Company* policy may be applied to Medicare Plan members only when directed by a separate *Medicare* policy. Note that investigational services are considered **"not medically necessary"** for Medicare members.

COVERAGE CRITERIA

This policy and the criteria therein only apply to self-funded employer groups. For all other commercial groups, please refer to the Carelon Cardiovascular Guidelines.

NOTE: See Billing Guidelines for coding guidance. Incorrect billing may affect the review process and coverage determination.

Event Monitor/External Cardiac Loop Recorder (ELR) and External Cardiac Patch Recorder

I. A long-term (greater than 48 hours), external, ambulatory electrocardiographic (ECG) patch recorder (e.g., Zio AT from iRhythm, Cardea Solo and Carnation Ambulatory Monitor) (CPT 93241-8) or cardiac event monitor (also referred to as an external memory loop recorder [ELR]) (CPT 93268 and 93270-2) that is patient- or auto-triggered may be considered **medically necessary** when **both** of the following criteria are met (A. and B.):

   A. A cardiac arrhythmia is suspected (e.g., cryptogenic stroke, syncope, pre-syncope, palpitations); **and**
   B. When **either** of the following are met (1.-2.):
      1. A Holter monitor failed to establish a diagnosis; **or**
      2. The patient experiences symptoms so infrequently (less than every 48 hours) that Holter monitoring is unlikely to capture a diagnostic ECG.

II. Ambulatory ECG patch recorders and cardiac event monitors (aka, ELR) are considered **not medically necessary** when criterion I. above is not met.

Mobile Cardiac Outpatient Telemetry (MCOT)

III. A long-term (greater than 48 hours), external, ambulatory electrocardiographic (ECG) mobile cardiac outpatient telemetry (MCOT) device which includes data transmission to a central recording station (93228-93229) may be considered **medically necessary** when **all** of the following criteria are met (A.-C.):

   A. Patient is experiencing symptoms of a cardiac arrhythmia (e.g., cryptogenic stroke, syncope, pre-syncope, dizziness, and/or palpitations); **and**
   B. Patient has undergone ambulatory event monitoring (e.g., event monitor/loop recorder or patch recorder) for a minimum of 14 days which failed to establish a diagnosis; **and**
   C. The MCOT device must be prescribed by a cardiologist or electrophysiology cardiologist.

IV. Mobile cardiac outpatient telemetry is considered **not medically necessary** when criterion III. above is not met.

Link to Evidence Summary

POLICY CROSS REFERENCES

None

The full Company portfolio of current Medical Policies is available online and can be accessed here.

POLICY GUIDELINES

BACKGROUND

Cardiac Arrhythmia

A cardiac arrhythmia is an irregular heartbeat. Although arrhythmias are common, especially with increased age, some arrhythmias can be dangerous and require prompt diagnosis and management. Diagnosing arrhythmias can be difficult because some are asymptomatic or occur infrequently and unpredictably.[1] When a cardiac arrhythmia does cause symptoms, they typically include pre-syncope (feeling faint), syncope (fainting), palpitations, or dizziness. Due to these variations in the clinical presentation of cardiac arrhythmias, long-term ambulatory monitoring is sometimes necessary to obtain an accurate diagnosis.

Cryptogenic Stroke

A stroke is a “brain attack” and occurs when blood flow to the brain is cut off. Cryptogenic stroke is a stroke of unknown origin. Every year in the United States, about one third of all strokes are classified as cryptogenic. Atrial fibrillation (a type of cardiac arrhythmia that causes poor blood flow) is the leading

preventable cause of recurrent stroke; therefore, early detection and treatment of atrial fibrillation is critical.

Holter Monitor

Ambulatory Holter electrocardiography is considered the standard of care for diagnosing a suspected cardiac arrhythmia in patients who exhibit frequent symptoms.[2] The battery powered device is the size of a small camera and monitors heart rhythms through small electrodes attached to the chest. This noninvasive test provides continuous ECG data over a 24 to 48 hour time period. After the monitoring period, the device is returned to the physician's office where the ECG data is downloaded and reviewed. Due to the short monitoring period, Holter ECGs are not considered long-term cardiac monitors and can be ineffective for detecting infrequent or unpredictable arrhythmias.[1]

External Ambulatory Electrocardiography (ECG)

External ambulatory ECGs are diagnostic instruments capable of recording heart rhythms while a patient is engaged in daily activities. Typically, these devices record patient-activated or auto-detected ECG data for 21 to 30 days. A diagnostic ECG is considered the gold standard for diagnosing cardiac arrhythmias; however, due to the infrequent nature of some arrhythmias standard 48 hour tests might not provide a diagnosis.[3] Long-term ECG monitors can be more suitable for diagnosing an arrhythmia that is so infrequent it would not be diagnosed by a standard 12-lead EKG or Holter Monitor.[4] Although there are several technologies that provide long-term ECG monitoring, this policy will address external loop recorders, external patch recorders (e.g., ZioPatch®), and mobile cardiac outpatient telemetry (e.g., CardioNet® MCOT).

External Patch Recorders

External patch recorders (e.g., Zio XT monitor from iRhythm) are small, water-resistant, adhesive one lead ECGs that attach to the chest and provide ECG monitoring for up to 16 days. The device continuously records and stores rhythm data, though many models also allow the wearer to press a button or use a mobile device app when symptoms are detected to allow for symptom-rhythm correlation. At the end of the monitoring period the patch is mailed to a central location for analysis. A diagnostic report is then provided to the patient and physician. Some patches have more technological capabilities and are loop recorders, and patch devices may also have wireless transmission capabilities to even be considered MCOT.

Event Monitor / External Loop Recorder (ELR)

Event monitors were historically termed external loop recorders due to the continuously recording tape that could loop and record multiple events over a long period of time. Event monitors are generally small, portable devices clipped onto the patient's waistband, recording heart rhythms through two electrodes attached to the chest that provide up to 30 days of ECG data. However, there is also at least one patch version of this device class type that also includes the ability to wirelessly send event reports to a centralized monitoring location (Zio AT ECG Monitoring System from iRhythm). Event recorders can be patient activated when symptoms begin or auto-activated when the monitor detects an arrhythmia. Auto-activated event monitors are recommended for patients who experience incapacitating cardiac arrhythmia symptoms (e.g., syncope).[5]

Mobile Cardiac Outpatient Telemetry (MCOT)

Mobile Cardiac Outpatient Telemetry (MCOT) provides real-time, continuous heart rhythm monitoring through proprietary cardiac arrhythmia detection algorithms and wireless data transmission to a staffed central location (i.e., remote monitoring). CardioNet, Inc. first offered these devices in the early 2000's after obtaining FDA approval as an arrhythmia detector and alarm (including ST-segment measurement and alarm) (Product Code: DSI). Initially MCOT™ included a small sensor worn as a pendent or on a belt clip with 3 electrodes attached to the chest. Ten years after the initial MCOT™ launch, the company reincorporated and merged BioTel Heart technology into the new brand, BioTelemetry, Inc. An MCOT™ Patch is also FDA approved and marketed under this suite of brands, which emerged from their research branch, Braemar Manufacturing, Inc. Numerous other devices have joined this brand group due to acquisitions and mergers, including LifeWatch which offers the ECG Mini System Continuous ECG Monitor and Arrhythmia Detector (K151269). In 2021, BioTelemetry, Inc was acquired by Philips. Other companies offer combination patch and lead systems with various mobile device application options and central reporting methodologies.

REGULATORY STATUS

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

Approval or clearance by the Food and Drug Administration (FDA) does not in itself establish medical necessity or serve as a basis for coverage. Therefore, this section is provided for informational purposes only.

Numerous examples of external ambulatory electrocardiography devices with United States FDA approval referred to in this policy are listed in Table 1. under Billing Guidelines, below.

CLINICAL EVIDENCE AND LITERATURE REVIEW

EVIDENCE REVIEW

A review of the ECRI, Hayes, Cochrane, and PubMed databases was conducted regarding the use of long-term ECG monitors for diagnosing cardiac arrhythmias. Below is a summary of the available evidence identified through September 2025.

Event Monitor/External Loop Recorder (ELR)

- A 2014 RCT by Gladstone and colleagues evaluated ambulatory ECG monitoring for the diagnosis and treatment of patients with unexplained stroke (EMBRACE trial).[4] In a randomized trial involving 572 patients aged ≥ 55 years who had a cryptogenic ischemic stroke or TIA within the prior six months and no known atrial fibrillation, investigators compared 30 day ambulatory ECG monitoring to a single additional 24 hour Holter monitor. They found that atrial fibrillation lasting at least 30 seconds was detected in 16.1% of the prolonged monitoring group versus

3.2% with standard monitoring (absolute difference 12.9 percentage points, P < 0.001), and episodes lasting ≥ 2.5 minutes were also more frequently identified. Initiation of anticoagulant therapy at 90 days was higher in the prolonged monitoring arm (18.6% vs. 11.1%, P = 0.01). A major strength of the trial is its randomized controlled design and substantial sample size, with clinically meaningful improvements in detection and treatment rates. Limitations include the patient age restriction (≥ 55 years), potentially limiting generalizability to younger stroke patients; the relatively short follow up duration (90 days) which does not address long term detection or clinical outcomes; and the inability to determine whether higher detection ultimately reduces stroke recurrence.

- A 2003, prospective, randomized study by Sivakumaran et al. evaluated the diagnostic yield of ELRs versus Holter monitors for identifying cardiac arrhythmias among 100 patients presenting with syncope or presyncope.[6] Participants were randomized to either a one-month ELR or a 48-hour Holter as their initial diagnostic tool. The study found that the ELR group had a significantly higher rate of symptom–rhythm correlation or arrhythmia detection (63%) compared to the Holter group (24%). Diagnostic success, defined as establishing or excluding an arrhythmic cause of symptoms, was also greater in the ELR group (56% vs. 22%). Despite this advantage, 23% of patients in the ELR group who had recurrent symptoms failed to activate the device properly, which limited its effectiveness. Strengths of the study include its randomized design and direct comparison of monitoring strategies in a clinically relevant population. Limitations include a modest sample size, the reliance on patient-triggered recording which led to missed data, and a study population that may not fully represent older or higher-risk patients.

External Patch Recorders

- In 2019 and updated in 2021, Hayes published updated health technology assessment of the Zio Patch from iRhythm Technologies, Inc. The review included 10 clinical studies that evaluated the efficacy of Zio Patch for diagnosing cardiac arrhythmias (1 poor-quality RCT with subsequent cohort study; 3 poor-quality cohort studies; 6 very poor-quality registry analyses).[7] The systematic review suggested that there is good correlation between Zio Patch and Holter monitoring for detection of clinically significant cardiac arrhythmias. The results also indicated that the longer monitoring time with Zio Patch can improve the detection of cardiac arrhythmias in some patients. Use of the Zio Patch was also shown to be advantageous for detection of asymptomatic cardiac events. The patch was well tolerated across study populations and had very few device-related adverse events. However, diagnostic and clinical limitations were seen in the devices ability to correlate patient symptoms with a corresponding cardiac arrhythmia; therefore limiting a symptom-rhythm correlation. Hayes gave an overall "C" rating for the use of Zio® Patch for long-term ambulatory electrocardiography in adults with known or suspected arrhythmias (potential but unproven benefit). Hayes gave "D2" ratings (insufficient evidence) for use of the Zio Patch in children and asymptomatic adults who are at-risk of developing an arrhythmia. Hayes concluded that "there is insufficient evidence to draw conclusions regarding the clinical validity or utility of the Zio Patch."

- In 2018 and updated in 2022, ECRI completed an evidence review evaluating the efficacy of the Carnation Ambulatory Monitor (CAM) for diagnosing cardiac arrhythmias.[8] Having searched the literature through May 2018, ECRI identified and reviewed 2 comparative studies (n=80) and 4 conference abstracts. Studies reported evidence of some clinical utility as a primary diagnostic

tool for cardiac arrhythmias. Nonetheless, investigators concluded that the limited quantity and quality of data (e.g. small sample sizes, lack of randomization, and lack of blinding) limited studies' validity.

Mobile Cardiac Outpatient Telemetry (MCOT)

- In 2019 and updated in 2022, ECRI conducted an evidence review of outpatient cardiac telemetry monitors for diagnosing and managing cardiac arrhythmias.[9] Searching the literature through February 2019, investigators reviewed the full text of three studies and abstracts of three studies reporting data on 90,590 patients. One systematic review assessing 50 studies (n = 11,658) compared the CardioNet MCOT monitor with external and implanted event recorders and reported on AF diagnostic yields after stroke or transient ischemic attack. One patient registry study (n = 78,490) compared CardioNET MCOT with the auto-trigger looping event recorder (AT-LER) and reported on diagnostic yield and time to diagnosis in patients with suspected arrhythmias. A case series (n = 100) reported on diagnostic yield with the SEEQ telemetry monitor in patients with suspected arrhythmia and negative 24-hour Holter monitoring. One diagnostic cohort study (n = 36) reported on diagnostic accuracy for automated long QT syndrome detection with the BodyGuard telemetry monitor compared with manual ECG recording review. One study (n = 152) reported on the BioMonitor implanted telemetry system's sensitivity compared with that of 48-hour Holter monitoring. Limitations included studies' small sample sizes, inadequate follow-up and a lack of prospective studies. Evidence to date has also yet to assess clinical utility, only indirect evidence pertaining to diagnostic yield. Investigators concluded that evidence on the whole was "inconclusive."

- In 2022, ECRI conducted a clinical evidence assessment of the BioTel Mobile Outpatient Cardiac Telemetry (MCOT) system for diagnosing and managing cardiac arrhythmias.[10] Investigators reviewed the full text of five studies and abstracts of two additional studies, collectively reporting on over 82,000 patients. One systematic review (n = 11,658) found no significant difference in post-stroke atrial fibrillation (AF) detection between MCOT and external or implanted loop recorders. A randomized controlled trial (n = 266) reported that MCOT had a significantly higher diagnostic yield than loop recorders (41% vs. 15%, P < 0.001) in patients with suspected arrhythmias. A large retrospective registry study (n = 78,490) found MCOT had superior diagnostic yields for AF (128% higher), ventricular tachycardia (222%), and other arrhythmias compared to auto-triggered loop event recorders, and reduced time to diagnosis by 7.5 days. A retrospective Medicare claims analysis (n = 4,164) showed MCOT use after transcatheter aortic valve replacement was associated with higher pacemaker detection (6.6% vs. 2.1%, P = 0.007) and no added cost. Case series reported MCOT identified arrhythmias not detected by Holter monitors, influencing treatment decisions in some patients. A cost-benefit analysis projected that using MCOT prior to ILR placement in cryptogenic stroke patients would lower cost per AF case detected from $228,507 to $29,598. Evidence limitations included small sample sizes, retrospective design, lack of comparator arms, and insufficient data on arrhythmia-related outcomes (e.g., morbidity, mortality). No serious adverse events were reported; minor skin irritation was the only noted complication. Investigators concluded that although MCOT improves diagnostic yield compared to other outpatient monitors, evidence remains inconclusive regarding its clinical utility and impact on patient outcome.

CLINICAL PRACTICE GUIDELINES

American College of Cardiology

In 2024, the American College of Cardiology published guidelines outlining the expert consensus decision pathway on practical approaches for arrhythmia monitoring after stroke.[11] On the basis of "expert consensus," authors wrote that a "monitoring period of 2 to 4 weeks (14 to 28 days) is reasonable" for event monitors or patch recorders to detect heart issues.

U.S. Preventive Services Task Force (USPSTF)

In 2018, USPSTF commissioned a systematic review[12] to evaluate the evidence on the benefits and harms of screening for atrial fibrillation with ECG in older adults, and the effectiveness of screening with ECG for detecting previously undiagnosed atrial fibrillation compared with usual care.[13] The USPSTF concluded that evidence was insufficient to assess the risks and benefits of screening for atrial fibrillation with ECG.

American College of Cardiology/American Heart Association/Heart Rhythm Society (ACC/AHA/HRS)

The 2017 evidence-based ACC/AHA/HRS guidelines for managing patients with syncope stated, "the selection and usefulness of cardiac monitors is highly dependent on patient characteristics with regard to the frequency of syncope and the likelihood of an arrhythmic cause of syncope".[5]

The guidelines suggested the following external cardiac monitors to evaluate ambulatory patients with syncope of suspected arrhythmic etiology:

1. Holter monitor
2. Transtelephonic monitor
3. External Loop Recorder
4. Patch recorder
5. Mobile cardiac outpatient telemetry

EVIDENCE SUMMARY

Evidence is sufficient to show that mobile cardiac outpatient telemetry (MCOT), cardiac event monitors (also known as external memory loop recorders) and patch recorders may improve overall health outcomes for those with a suspected cardiac arrhythmia when shorter term monitoring (e.g., Holter monitor) has failed to lead to a diagnosis. Clinical practice guidelines based on research recommend these types of monitors over 24-hour monitoring in select patient populations. Therefore, cardiac event monitors (also known as external memory loop recorders) and patch recorders may be medically necessary when policy criteria are met. MCOT, cardiac event monitors (external memory loop recorders) and patch recorders are considered not medically necessary when policy criteria are not met.Ann

HEALTH EQUITY CONSIDERATIONS

The Centers for Disease Control and Prevention (CDC) defines health equity as the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving health equity requires addressing health disparities and social determinants of health. A health disparity is the occurrence of diseases at greater levels among certain population groups more than among others. Health disparities are linked to social determinants of health which are non-medical factors that influence health outcomes such as the conditions in which people are born, grow, work, live, age, and the wider set of forces and systems shaping the conditions of daily life. Social determinants of health include unequal access to health care, lack of education, poverty, stigma, and racism.

The U.S. Department of Health and Human Services Office of Minority Health calls out unique areas where health disparities are noted based on race and ethnicity. Providence Health Plan (PHP) regularly reviews these areas of opportunity to see if any changes can be made to our medical or pharmacy policies to support our members obtaining their highest level of health. Upon review, PHP creates a Coverage Recommendation (CORE) form detailing which groups are impacted by the disparity, the research surrounding the disparity, and recommendations from professional organizations. PHP Health Equity COREs are updated regularly and can be found online here.

BILLING GUIDELINES AND CODING

BILLING GUIDELINES

Codes specific to the ambulatory cardiac rhythm monitor device class are noted in both the Policy Criteria and CPT Codes sections of this policy. Incorrect coding, which may include billing with codes not specific to the cardiac monitor device class requested, may result in a denial of payment. The following (Table 1.) is a non-exhaustive list of classes and examples of marketed devices relevant to this policy with the proper code.

Table 1. Long-term External Ambulatory Electrocardiography Device Classes, Coding and Examples (Non-exhaustive)

Device Class	Device Description	Coding Guideline	Example Devices
External Cardiac Patch Recorder	Adhesive patch that does not require any separate leads, attachments or batteries. Worn on the chest for more than 48 hours up to 14 or 16 days. The patch device both records and stores continuous rhythms. A report is provided after sending the device in for data retrieval and reading at a centralized location. On some patch recording devices, the	93241, 93242, 93243, 93244, 93245, 93246, 93247, 93248	• Carnation Ambulatory Monitor (CAM) (K210036)[14] from BardyDx • Zio XT monitor (K202359)[15] with myZio app for symptom logging

	patient may press a button or use a mobile application to log experiences of symptoms in order to generate event matching from the device recordings. Note that the FDA classifies these devices as loop recorders (Product Code: DSH, Medical magnetic tape recorder), and some patches maybe classified as MCOT depending on their capabilities (see below).		• Cardea SOLO from Cardiac Insight, Inc. (K162503)[16]
Event Monitor/ External Cardiac Loop Recorder	Event monitors were historically referred to as loop monitors due to the ability to continuously loop the recording tape. They are patient- or auto-activated when symptoms are present (event recording), depending upon the device. Generally, the small monitor (about the size of a pager) is clipped onto the patient's waistband and records heart rhythms through two electrodes attached to the chest.	93268, 93270, 93271, 93272	• M5 Recorder (K202456)[17] from Global Instrumentation, LLC • Nuubo System (K173461)[18] • BodyGuardian MINI/ BodyGuardian MINI Plus (K182030)[19] from Preventice Solutions, Inc.
Mobile Cardiac Outpatient Telemetry	Mobile cardiac outpatient telemetry traditionally included three leads, but is now also offered as a patch. These devices perform continuous monitoring and wireless transmission to a centralized reporting location for up to 30 days. Symptomatic events may be triggered by the patient or automatically by the device and wirelessly transmitted for physician review and interpretation. Product Code: DSI.	93228, 93229	• Zio AT ECG Monitoring System[20] • MCOT Patch, aka Braemar Telemetry Patch System, Model BTPS1000 (K153473)[21] • ECG Mini System Continuous ECG Monitor and Arrhythmia Detector (K151269)[22] • BodyGuardian Heart (K151188)[23] from Preventice Solutions, Inc.

CODES*		
Mobile Cardiac Outpatient Telemetry (MCOT)		
CPT	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
	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
External Cardiac Patch Recorder		
	0902T	QTc interval derived by augmentative algorithmic analysis of input from an external, patient-activated mobile ECG device
	0937T	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; including recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional
	0938T	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; recording (including connection and initial recording)
	0939T	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; scanning analysis with report
	0940T	External electrocardiographic recording for greater than 15 days up to 30 days by continuous rhythm recording and storage; review and interpretation by a physician or other qualified health care professional
	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
Event Monitor/External Cardiac Loop Recorder (ELR) with Attended Monitoring		
	93268	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; includes transmission, review and interpretation by a physician or other qualified health care professional
	93270	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)
	93271	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; transmission and analysis
	93272	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
Unlisted Codes		
	93799	Unlisted cardiovascular service or procedure

***Coding Notes:**

- The above code list is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit.
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

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POLICY REVISION HISTORY

DATE	REVISION SUMMARY
2/2023	Converted to new policy template.
9/2023	Annual review. No changes to coding or criteria.
9/2024	Annual review. No changes to coding or criteria.
1/2025	Q1 code set update.
4/2025	Interim update. Updated III.B.
10/2025	Annual Review. Updated III.A.