Local Coverage Determination (LCD):
Cardiac Event Detection (L33952)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

Contractor Information

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LCD Information

Document Information

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<th>AMA CPT / ADA CDT / AHA NUBC Copyright Statement</th>
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<td>N/A</td>
<td>CPT codes, descriptions and other data only are copyright 2018 American Medical Association. All Rights Reserved. Applicable FARS/HHSARS apply.</td>
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**CMS National Coverage Policy**

Language quoted from Centers for Medicare and Medicaid Services (CMS), National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See §1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, *italicized* text represents quotation from one or more of the following CMS sources:

**Title XVIII of the Social Security Act (SSA):**

Section 1862(a)(1)(A) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Section 1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

**Code of Federal Regulations:**

42 CFR 410.32 indicates that diagnostic tests may only be ordered by the treating physician (or other treating practitioner acting within the scope of his or her license and Medicare requirements) who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary’s specific medical problem. Tests not ordered by the physician (or other qualified non-physician provider) who is treating the beneficiary are not reasonable and necessary (see Sec. 411.15(k)(1) of this chapter).

**CMS Publications:**

CMS Publication 100-02, *Medicare Benefit Policy*, Chapter 15:
Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Abstract:

Cardiac Event Detection (CED) involves the use of a long-term monitor by patients to document a suspected or paroxysmal dysrhythmia. Following the recording of events, the patient transmits data via telephone to a physician's office, hospital facility, IDTF, or other specified station that is equipped and staffed to assess electrocardiographic data and to initiate appropriate management action. The device must be patient or event activated.

The services included in this LCD require a 24-hour attended monitoring station to receive transmissions, and that the devices:

- are patient/event activated and intermittently record cardiac arrhythmic events;
- provide either presymptom memory loop or post-symptom recording; and
- are non-insertable (non-implanted).

A single service includes all recordings, transmissions and interpretations during a continuous 30-day period.

Ambulatory outpatient cardiac telemetry (outpatient cardiac monitoring) services are included among the cardiac event detection type of ambulatory EKG monitoring services (CMS Manual System, Pub 100-3, Chapter 1, Part 1, Section 20.15, subsection A "Descriptions of Ambulatory EKG Monitoring Technologies", bullet #2 and subsection D.)

Indications:

Cardiac event detection is covered for:

1. Detection, characterization, and documentation of symptomatic transient arrhythmias, when the frequency of the symptoms is limited and use of a 24-hour ambulatory EKG is unlikely to capture and document the arrhythmia;
2. Regulation of antiarrhythmic drug dosage, when needed to assess efficacy of treatment;
3. To monitor patients who have had surgical or ablative procedures for arrhythmias;
4. Although the service is a 30-day service, it is recognized that the event recorder may be discontinued once the symptom-producing arrhythmia has been documented and diagnosed or following multiple transmissions during symptoms, without arrhythmia. It is unlikely that the arrhythmias would always be diagnosed on the first day of recording, or that the service would always last only one day. The average duration of monitoring is anticipated to last 10-14 days, or more.

Limitations:

1. A CED service is medically unnecessary if it offers little or no potential for new clinical data beyond that which has been obtained from a previous test, (e.g., a standard electrocardiogram has already established a...
diagnosis), or if other tests are better suited to obtain the clinical data relevant to the patient’s condition. The CED should be coordinated with results from standard EKGs, Holter monitor tests, and stress tests.

2. The receiving station must be staffed on a 24-hour basis with personnel trained to read EKGs (e.g., critical care nurses or paramedics), who should be able to direct the patient for the management of all emergencies. An answering service/answering machine would not fulfill this requirement.

3. Systems utilizing computers to dial the physician’s office so the physician receives transmission by way of a relay are not covered since there is no 24-hour personnel attendance.

4. A test not ordered by a physician or qualified non-physician practitioner treating the beneficiary will be denied as not medically necessary.

5. The purpose of CED is the long term monitoring of patients to document a suspected or paroxysmal dysrhythmia. Therefore, it is considered medically unnecessary to utilize a CED service when only a standard EKG or EKG rhythm strip is required (even if it is used to transmit that EKG or rhythm strip to another location).

6. It is expected that CEDs would not be used for the routine daily transmission of EKG rhythm strips, or monitoring, in the absence of identified symptoms necessitating diagnosis as stated in this LCD.

7. Event recorders are covered only as diagnostic tests or for evaluating a patient being actively managed on arrhythmic medication.

8. Cardiac event detection is not covered for patients in hospitals, emergency rooms, skilled nursing facilities or other specialized facilities and will be denied as not medically necessary.

9. Cardiac event detection is not covered for either outpatient or facility-based cardiac monitoring.

10. Cardiac event detection is a 30-day service for the purpose of documentation and diagnosis of paroxysmal or suspected arrhythmias. The performance of this test is predicated by the pre-test incidence of symptoms related to arrhythmias and is considered not medically necessary for those patients who are not having significant recurrent arrhythmias which are anticipated to require treatment.

11. Testing for more than 30 consecutive days is only rarely medically necessary, and the need for the continued testing must be justified by the treating physician. Failure to document an arrhythmia during a 30-day test period is not sufficient justification to reimburse a second or subsequent test. It is unlikely to be medically necessary to repeat a second test within a year in the absence of new or recurrent undiagnosed symptoms.

12. Event recorders may be patient activated, and may not use time-sampling technology. Accordingly, this test will be considered medically unnecessary for any patient who is unresponsive, comatose, severely confused or otherwise unable to recognize symptoms, or activate the recorder (patient activated devices) or unable to participate in the use of the device.

13. Event recorders are not covered for outpatient monitoring of recently discharged post-infarct patients, and will be denied as not medically necessary.

14. "Routine" continued monitoring in the absence of treatable symptoms is considered screening and is not medically necessary.

15. Because the cardiac event detection service requires the diagnosis and evaluation of intermittent arrhythmias, and patients must be continuously attached to pre-symptom loop recorders or be able to be attached at the start of symptoms to post-symptom loop recorders, each patient is required to have a recorder for his/her own exclusive use throughout the duration of the monitoring period. Recorders may not be "shared" amongst two or more patients, regardless of the environment or site of the service. Claims for CED will be denied as not medically necessary when patients do not have exclusive use of a recorder for the entire service period (30 days).

16. Cardiac event detection is a 30-day packaged service. Tests may not be billed within 30 days of each other, even if the earlier of the tests was discontinued when arrhythmias were documented and the patient is now reconnected for follow-up of therapy or intervention.

Other Comments:

For claims submitted to the Part A MAC: this coverage determination also applies within states outside the primary geographic jurisdiction with facilities that have nominated CGS to process their claims.
Bill type codes only apply to providers who bill these services to the Part A MAC. Bill type codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or Part B MAC.

Limitation of liability and refund requirements apply when denials are likely, whether based on medical necessity or other coverage reasons. The provider/supplier must notify the beneficiary in writing, prior to rendering the service, if the provider/supplier is aware that the test, item or procedure may not be covered by Medicare. The limitation of liability and refund requirements do not apply when the test, item or procedure is statutorily excluded, has no Medicare benefit category or is rendered for screening purposes.

Summary of Evidence

N/A

Analysis of Evidence
(Rationale for Determination)

N/A

Coding Information

**Bill Type Codes:**

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

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**Revenue Codes:**

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

N/A

**CPT/HCPCS Codes**
Additional ICD-10 Information
N/A

General Information

Associated Information

1. The patient's medical record must contain documentation that fully supports the medical necessity for services included within this LCD. (See "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

2. Records must include EKG rhythm strips with interpretation for each transmission. The date and time of each transmission, when the symptoms occurred and what the symptoms were must be documented for each transmission. The medical record should also include when the reviewing physician and the ordering physician were notified of the transmission and its results.

3. The interpretation must be a de novo interpretation by the physician billing the interpretation, in addition to any
4. The CED provider's records must include the referring physician's request for the test and the indications for the test. This information should be incorporated into a formal report (interpretation) of the test.

5. Documentation of the necessity should include the referring physician's diagnostic impression, and an indication of relevant signs and symptoms.

6. The provider performing the technical component of the service must retain a written copy of the physician/NPP order for the test which should include the indication(s) for the test. This provider must also maintain copies of all transmissions, documentation of actions taken and physicians contacted or instructions given to the beneficiary.

7. Documentation must be available to Medicare upon request.

**Sources of Information**

This bibliography presents those sources that were obtained during the development of this policy. CGS is not responsible for the continuing viability of Web site addresses listed below.


**Bibliography**

N/A

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**Revision History Information**

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10/01/2015  R3
Revision Effective: N/A
Revision Explanation: Annual review no changes made.
Other - Annual Review

10/01/2015  R2
Revision Effective: 10/01/2015
Revision Explanation: Annual review no changes made.

10/01/2015  R1
Revision Effective: 10/01/2015
Revision Explanation: Added ICD-10 codes R06.00-R06.01, R06.09, R06.1, R06.2, and R06.4

**Reason(s) for Change**
- Other (Annual Review)
- Other (Annual Review)
- Reconsideration Request

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**Associated Documents**

**Attachments**
N/A

**Related Local Coverage Documents**

Article(s)
A56452 - Billing and Coding for Cardiac Event Detection

**Related National Coverage Documents**
N/A

**Public Version(s)**
Updated on 03/29/2019 with effective dates 04/04/2019 - N/A
Updated on 10/30/2018 with effective dates 10/01/2018 - 04/03/2019
Updated on 09/19/2018 with effective dates 10/01/2018 - N/A
Updated on 10/30/2017 with effective dates 10/01/2015 - 09/30/2018
Updated on 10/31/2016 with effective dates 10/01/2015 - N/A
Updated on 10/23/2015 with effective dates 10/01/2015 - N/A
Updated on 10/15/2015 with effective dates 10/01/2015 - N/A
Updated on 03/13/2014 with effective dates 10/01/2015 - N/A

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**Keywords**
N/A