Clinical Policy: Holter Monitors

Reference Number: CP.MP.113 [Coding Implications](#Coding_Implications)

Last Review Date: 06/19

[Revision Log](#Revision_Log)

**See** [Important Reminder](#Important_Reminder) **at the end of this policy for important regulatory and legal information.**

## Description

Ambulatory electrocardiogram (ECG) monitoring provides a view of cardiac activity over an extended period of time. Holter monitoring, or continuous ambulatory ECG monitoring, for 24 to 48 hours is most practical as the initial monitor for members with daily or near daily symptoms, as well as for assessing the efficacy of medication and other treatments for cardiac arrhythmias.

## Policy/Criteria

1. It is the policy of health plans affiliated with Centene Corporation® that Holter monitoring is **medically necessary** for adult members who require 24 to 48 hours of cardiac activity monitoring with any of the following symptoms or indications:
	1. Evaluation of any of these unexplained indications: syncope, near-syncope, episodic dizziness, recurrent palpitations, episodic shortness of breath or chest pain;
	2. Evaluation of neurological events when transient atrial fibrillation or flutter is suspected;
	3. Evaluation of syncope, near-syncope, episodic dizziness, or palpitation in whom a probable cause other than an arrhythmia has been identified but in whom symptoms persist despite treatment of this other cause;
	4. Evaluation of patients with cardiomyopathy, or a first-degree relative with arrhythmogenic right ventricular cardiomyopathy;
	5. Evaluation of possible or documented prolonged QT syndromes;
	6. To screen for asymptomatic arrhythmia in a patient with Brugada syndrome;
	7. Assessment of efficacy of medication for arrhythmia treatment when baseline arrhythmia frequency is reproducible and of sufficient frequency to permit analysis;
	8. Detection of proarrhythmic responses to antiarrhythmic therapy in patients at high risk;
	9. Assessment of the function of pacemakers or implantable cardioverter defibrillators (ICD) with frequent palpitations, syncope, or near-syncope, and to assist in programming of enhanced features;
	10. Evaluation of suspected pacemaker or ICD component failure or malfunction when device interrogation is inconclusive;
	11. Assessment of efficacy of adjunctive medications in patients receiving frequent ICD therapy;
	12. Assessment of suspected variant angina.
2. It is the policy of health plans affiliated with Centene Corporation® that Holter monitoring is **medically necessary** for pediatric members ≤ 18 years old who require 24 to 48 hours of cardiac activity monitoring with any of the following symptoms or indications:
	1. Evaluation of syncope, near-syncope, or dizziness in members with identified cardiac disease, previously documented arrhythmia, or pacemaker dependency;
	2. Evaluation of syncope or near-syncope associated with exertion when cause is not established;
	3. Evaluation of unexplained syncope, near-syncope, or sustained palpitation when there is no overt clinical evidence of heart disease;
	4. Assessment of efficacy of medications for arrhythmia following initiation of treatment or during rapid somatic growth;
	5. Evaluation of patients with cardiomyopathy, with or a first-degree relative with arrhythmogenic right ventricular cardiomyopathy;
	6. Evaluation of possible or documented prolonged QT syndromes;
	7. Evaluation of palpitation in a member with prior surgery for congenital heart disease and significant residual hemodynamic abnormalities;
	8. Evaluation of asymptomatic congenital complete atrioventricular (AV) block, non-paced;
	9. Evaluation of cardiac rhythm after transient AV block associated with heart surgery or catheter ablation;
	10. Evaluation of rate-responsive or physiological pacing function in symptomatic patients.
3. It is the policy of health plans affiliated with Centene Corporation® that Holter monitoring for any other indication not included in this policy is **not medically necessary** because efficacy has not been established.

## Background

The most common use of ambulatory ECG monitoring is the evaluation and diagnosis of cardiac arrhythmias or conduction abnormalities. The device continuously monitors the heart’s electrical activity for a period of 24 to 48 hours. The member has a self-activated event marker which identifies when they are experiencing symptoms such as palpitations, syncope/near-syncope, dizziness, shortness of breath, chest pain, or episodic fatigue. This is especially helpful in members who experience symptoms too infrequent to be caught on a standard ECG.

The recorded data are analyzed with the event markers to determine if the symptoms are related to an arrhythmia. There are four outcomes this analysis could provide. Useful findings include the simultaneous documentation of a cardiac arrhythmia capable of producing the noted symptoms, which can lead to directed therapy for the arrhythmia; and symptoms that occur without arrhythmia, demonstrating symptoms are not related to an arrhythmia. Of equivocal value, the findings may show that a cardiac arrhythmia is present but no symptoms were present during the recording, indicating the arrhythmia may or may not be related to the symptoms. Lastly, if there were no symptoms during the recording and there were no arrhythmias identified, the recording is not useful.

Ambulatory ECG is also helpful in assessing the efficacy of antiarrhythmic therapy. It is noninvasive, provides quantitative data, and permits correlation of symptoms with ECG phenomena. It does have some limitations in regard to its use as a therapeutic guide, which should be taken into consideration. Additionally, ambulatory ECG monitoring is useful in assessing pacemakers and ICDs, as it can evaluate symptoms of palpitations, syncope, or near-syncope to assess device function; assist in the programing of enhanced features; evaluate suspected component failure or a malfunctioning device; and assess concomitant pharmacological therapy for members receiving frequent ICD therapy.

Due to the advancement of technological capabilities in ambulatory ECG assessment, it can provide accurate and clinically meaningful information about myocardial ischemia in patients with coronary disease. The most commonly encountered ambulatory ECG sign of ischemia is ST-segment depression and, while this is an important finding, it is important to note that ST-segment changes and other repolarization abnormalities can occur for reasons other than ischemia. These conditions must be considered when evaluating the predictive value of ST-segment changes in each specific member. Furthermore, ambulatory ECG can be beneficial in members suspected of having variant angina. Periods of ST-segment elevation indicative of transmural ischemia can be identified in those with variant angina or high-grade proximal stenosis.

In the pediatric population, ambulatory ECG can be used for the same indications as for adults, in addition to a number of pediatric-specific concerns. Monitoring in children with heart disease, with or without symptoms, is used to observe the evolution of disease processes, identify medication dose changes required due to growth, and identify the progressive onset of late arrhythmias after surgery for congenital heart defects. Likewise, this monitoring is beneficial in pediatric members with hypertrophic or dilated cardiomyopathies or known or suspected prolonged QT syndromes. Ambulatory ECG can also be used to evaluate asymptomatic pediatric members with congenital complete AV block in order to identify those at increased risk for sudden arrhythmic events who may benefit from prophylactic pacemaker implantation.

**Coding Implications**

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

| **CPT® Codes**  | **Description** |
| --- | --- |
| 93224 | External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional |
| 93225 | External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; recording (includes connection, recording, and disconnection) |
| 93226 | External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; scanning analysis with report |
| 93227 | External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; review and interpretation by a physician or other qualified health care professional |

**ICD-10-CM Diagnosis Codes that Support Coverage Criteria**

| **ICD-10-CM Code** | **Description** |
| --- | --- |
| G45.9 | Transient cerebral ischemic attack, unspecified |
| G71.00 - G71.09 | Muscular dystrophy |
| G99.0 | Autonomic neuropathy in diseases classified elsewhere |
| I20.0-I20.9 | Angina pectoris |
| I24.0-I24.9 | Other acute ischemic heart diseases |
| I25.10 | Atherosclerotic heart disease of native coronary artery without angina pectoris |
| I34.0-I34.9 | Nonrheumatic mitral valve disorders |
| I35.0-I35.9 | Nonrheumatic aortic valve disorders |
| I36.0-I36.9 | Nonrheumatic tricuspid valve disorders |
| I37.0-I37.9 | Nonrheumatic pulmonary valve disorders |
| I42.0 | Dilated cardiomyopathy |
| I42.1 | Obstructive hypertrophic cardiomyopathy |
| I42.2 | Other hypertrophic cardiomyopathy |
| I42.8 | Other cardiomyopathies |
| I42.9 | Cardiomyopathy, unspecified |
| I44.0-I44.7 | Atrioventricular and left bundle-branch block |
| I45.0-I45.9 | Other conduction disorders |
| I46.2-I46.9 | Cardiac arrest |
| I47.0-I47.9 | Paroxysmal tachycardia |
| I48.0-I48.92 | Atrial fibrillation and flutter |
| I49.01-I49.9 | Other cardiac arrhythmias |
| I50.1-I50.9 | Heart failure |
| I51.7 | Cardiomegaly |
| I63.00-I63.9 | Cerebral infarction |
| I67.841-I67.848 | Cerebral vasospasm and vasoconstriction |
| Q20.0-Q20.9 | Congenital malformations of cardiac chambers and connections |
| Q21.0-Q21.9 | Congenital malformations of cardiac septa |
| Q22.0-Q22.9 | Congenital malformations of pulmonary and tricuspid valves |
| Q23.0-Q23.9 | Congenital malformations of aortic and mitral valves |
| Q24.0-Q24.9 | Other congenital malformations of heart |
| Q25.0-Q25.9 | Congenital malformations of great arteries |
| R00.0-R00.9 | Abnormalities of heart beat |
| R06.00-R06.09 | Shortness of breath |
| R07.2 | Precordial pain |
| R07.89 | Other chest pain |
| R07.9 | Chest pain, unspecified |
| R42 | Dizziness and giddiness |
| R53.81-R53.83 | Malaise and fatigue |
| R55 | Syncope and collapse |
| R94.31 | Abnormal electrocardiogram |
| Z48.812 | Encounter for surgical aftercare following surgery on the circulatory system |
| Z82.41 | Family history of sudden cardiac death |
| Z87.74 | Personal history of (corrected) congenital malformations of heart and circulatory systems |
| Z94.1 | Heart transplant status |
| Z95.0 | Presence of cardiac pacemaker |
| Z95.810  | Presence of automatic (implantable) cardiac defibrillator |

| **Reviews, Revisions, and Approvals** | **Date** | **Approval Date** |
| --- | --- | --- |
| Policy developed and specialist reviewed | 08/16 | 08/16 |
| ICD-10-CM code table updated | 11/16 |  |
| Added “Evaluation of patients with cardiomyopathy, or a first-degree relative with arrhythmogenic right ventricular cardiomyopathy” as an indication to the adult criteria, and expanded pediatric criteria for cardiomyopathy- “evaluation of patients with hypertrophic or dilated cardiomyopathy” to the same as the adult cardiomyopathy criteria. Added “Evaluation of possible or documented prolonged QT syndromes” and “To screen for asymptomatic arrhythmia in a patient with Brugada syndrome;” to adult criteria. Added ICD-10-CM Codes I42.8 and Z82.41 | 08/17 | 08/17 |
| References reviewed and updated. | 06/18 | 06/18 |
| References reviewed and updated. Specialist review. | 05/19 | 06/19 |

### References

1. Crawford MH, Bernstein SJ, Deedwania PC, DiMarco JP, Ferrick KJ, Garson A Jr, Green LA, Greene HL, Silka MJ, Stone PH, Tracy CM. ACC/AHA guidelines for ambulatory electrocardiography: executive summary and recommendations: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to Revise the Guidelines for Ambulatory Electrocardiography). Circulation. 1999;100:886-893
2. Gersh BJ, Maron BJ, Bonow RO, et al. 2011 ACCF/AHA guideline for the diagnosis and treatment of hypertrophic cardiomyopathy: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. Circulation. 2011;124(24):e783.
3. Gray B, Kirby A, Kabunga P, et al. Twelve-lead ambulatory electrocardiographic monitoring in Brugada syndrome: Potential diagnostic and prognostic implications. Heart Rhythm. 2017 Jun;14(6):866-874. doi: 10.1016/j.hrthm.2017.02.026.
4. [Groeneweg JA, Bhonsale A, James CA, et al. Clinical Presentation, Long-Term Follow-Up, and Outcomes of 1001 Arrhythmogenic Right Ventricular Dysplasia/Cardiomyopathy Patients and Family Members. Circ Cardiovasc Genet 2015; 8:437.](https://www.uptodate.com/contents/arrhythmogenic-right-ventricular-cardiomyopathy-diagnostic-evaluation-and-diagnosis/abstract/9)
5. Madias C. Ambulatory ECG monitoring. In: UpToDate, Zimetbaum PJ (Ed), UpToDate, Waltham, MA. Accessed 05/28/19.
6. [Sen-Chowdhry S, Lowe MD, Sporton SC, McKenna WJ. Arrhythmogenic right ventricular cardiomyopathy: clinical presentation, diagnosis, and management. Am J Med 2004; 117:685.](https://www.uptodate.com/contents/arrhythmogenic-right-ventricular-cardiomyopathy-diagnostic-evaluation-and-diagnosis/abstract/3)

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

©2016 Centene Corporation. All rights reserved.  All materials are exclusively owned by Centene Corporation and are protected by United States copyright law and international copyright law.  No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Centene Corporation. You may not alter or remove any trademark, copyright or other notice contained herein. Centene® and Centene Corporation® are registered trademarks exclusively owned by Centene Corporation.