Local Coverage Determination (LCD): Electrocardiograms (L37283)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Noridian Healthcare Solutions, LLC	A and B MAC	02101 - MAC A	J - F	Alaska
Noridian Healthcare Solutions, LLC	A and B MAC	02102 - MAC B	J - F	Alaska
Noridian Healthcare Solutions, LLC	A and B MAC	02201 - MAC A	J - F	Idaho
Noridian Healthcare Solutions, LLC	A and B MAC	02202 - MAC B	J - F	Idaho
Noridian Healthcare Solutions, LLC	A and B MAC	02301 - MAC A	J - F	Oregon
Noridian Healthcare Solutions, LLC	A and B MAC	02302 - MAC B	J - F	Oregon
Noridian Healthcare Solutions, LLC	A and B MAC	02401 - MAC A	J - F	Washington
Noridian Healthcare Solutions, LLC	A and B MAC	02402 - MAC B	J - F	Washington
Noridian Healthcare Solutions, LLC	A and B MAC	03101 - MAC A	J - F	Arizona
Noridian Healthcare Solutions, LLC	A and B MAC	03102 - MAC B	J - F	Arizona
Noridian Healthcare Solutions, LLC	A and B MAC	03201 - MAC A	J - F	Montana
Noridian Healthcare Solutions, LLC	A and B MAC	03202 - MAC B	J - F	Montana
Noridian Healthcare Solutions, LLC	A and B MAC	03301 - MAC A	J - F	North Dakota
Noridian Healthcare Solutions, LLC	A and B MAC	03302 - MAC B	J - F	North Dakota
Noridian Healthcare Solutions, LLC	A and B MAC	03401 - MAC A	J - F	South Dakota
Noridian Healthcare Solutions, LLC	A and B MAC	03402 - MAC B	J - F	South Dakota
Noridian Healthcare Solutions, LLC	A and B MAC	03501 - MAC A	J - F	Utah
Noridian Healthcare Solutions, LLC	A and B MAC	03502 - MAC B	J - F	Utah
Noridian Healthcare Solutions, LLC	A and B MAC	03601 - MAC A	J - F	Wyoming
Noridian Healthcare Solutions, LLC	A and B MAC	03602 - MAC B	J - F	Wyoming

LCD Information

Document Information

LCD ID
L37283

Original Effective Date
For services performed on or after 03/26/2018

LCD Title

Revision Effective Date

Electrocardiograms

For services performed on or after 10/01/2019

Proposed LCD in Comment Period
N/A

Revision Ending Date
N/A

Source Proposed LCD
DL37283

Retirement Date
N/A

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Notice Period Start Date
02/07/2018

Notice Period End Date
03/25/2018

CMS National Coverage Policy

Title XVIII of the Social Security Act (SSA), §1862(a)(1)(A), states that no Medicare payment shall be made for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

Title XVIII of the Social Security Act, §1862(a)(7) and 42 Code of Federal Regulations, §411.15, exclude routine physical examinations.

Title XVIII of the Social Security Act, §1833(e), prohibits Medicare payment for any claim lacking the necessary documentation to process the claim.

Medicare's Carrier's Manual (MCM), §15047(D), explains coverage for preoperative diagnostic tests performed to determine a patient's perioperative risks and optimize perioperative care. (The reference will be crosswalked to the CMS Manual System, Publication 100-04, *Medicare Claims Processing Manual,* Chapter 12, §30.6.6.1 as soon as it become available.)

Medicare Carriers Manual, §15047(G), explains how to report preoperative tests. (The reference will be crosswalked to the CMS Manual System, Publication 100-04, *Medicare Claims Processing Manual,* Chapter 12, §30.6.6.1 as soon as it becomes available.)

CMS Manual System, Publication 100-04, *Medicare Claims Processing Manual,* Chapter 12, §20.3(E), describes bundling of payment for ECG services supplied concomitantly with other physician services.

CMS Manual System, Publication 100-04, *Medicare Claims Processing Manual,* Chapter 13, §100.1, states that in general only one payment is made for one interpretation of an EKG.

CMS Manual System, Publication 100-04, *Medicare Claims Processing Manual,* Chapter 23, §20.9.1. Correct Coding Initiative (CCI) describes correct usage of the 59 modifier for repeat procedural services performed on the same day.

CMS Manual System, Publication 100-03, *Medicare National Coverage Determinations Manual,* Chapter 1, §20.15, Electrocardiogram Service, "No payment is made for EKG interpretations by individuals other than physicians' and "A separate charge by an attending or consulting physician for EKG interpretation is allowed only when it is the normal practice to make such charge".

CMS Manual System, Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15, §§190 and 200, allow for services supplied by physician assistants and nurse practitioners.

CMS Manual System, Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 15, §250, states that payment may be made under Part B for the medical and other health services enumerated in paragraph C, but only where no payment can be made for such services under Part A.

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

The electrocardiogram (ECG, EKG) and ECG rhythm strip records the electrical activity of the heart throughout the cardiac cycle of contraction (depolarization) and relaxation (repolarization). The changes in electrical potential during the cardiac cycle are detected at the body surface and recorded on graph paper. The recording is reviewed by a physician who provides an interpretation and written report. An ECG may be reported as the technical aspect only, the interpretation and written report only, or both aspects together as one service.

The electrical activity of the heart can be viewed along various electrical axes (viewpoints). Each viewpoint is described as a "lead”. A typical ECG views the heart from 12 axes and, therefore, has 12 leads. A rhythm strip typically includes one to three leads. Typically, a 12-lead ECG is a separate document from the medical progress notes, while a printed rhythm strip may be pasted into the progress notes.

An ECG is indicated to diagnose or treat a patient for symptoms, signs, or a history of heart disease; or systemic conditions that affect the heart, including:

- Chest pain or angina pectoris,
- Myocardial ischemia or infarction,
- Arteriovascular disease including coronary, central, and peripheral disease,
- Hypertension,
- Conduction abnormalities,
- Cardiac rhythm disturbances,
- Cardiac hypertrophy,
- Heart failure,
- Pericarditis,
- Structural cardiac conditions,
- Endocrine abnormalities,
- Neurological disorders affecting the heart,
- Syncope,
- Paroxysmal weakness,
- Palpitations,
- Sudden lightheadedness,
- Electrolyte imbalance,
- Acid-base disorders,
- Temperature disorders,
- Pulmonary disorders, and
- Drug cardiotoxicity.

An ECG may help identify cardiac disorders as part of a preoperative clinical evaluation. A preoperative ECG may be reasonable and necessary under one of the following conditions:

- In the presence of pre-existing heart disease such as congestive heart failure, prior myocardial infarction (MI), angina, coronary artery disease, or dysrhythmias;
- In the presence of known comorbid conditions that may affect the heart, such as chronic pulmonary disease, peripheral vascular disease, diabetes, or renal impairment; or
- When the pending surgery requires a general or regional anesthetic.

The results of the ECG must be relevant to the management of the patient.

When an ECG is performed on the same day as a cardiac stress test, but is not part of that stress test, it is separately payable. The ECG must add additional information to the stress test. For example, an ECG may be reasonable and necessary to rule out an acute MI prior to a same day stress ECG performed to evaluate possible accelerating angina. Typically, when the ECG stress test is scheduled in advance, a separate ECG on the same day is not reasonable and necessary.

An ECG is not a covered benefit when used for screening purposes or as part of a routine physical examination. Routine physical examinations (screening) are evaluation and management services supplied in the absence of associated signs, symptoms or complaints. These services are denied as not a benefit of the Medicare program. Patients may choose to pay privately for these services.

A second ECG performed to replace a technically inadequate ECG may not be reported as an additional service.

Rhythm ECGs are used to evaluate signs and symptoms that may reflect a cardiac rhythm disorder.

A rhythm ECG interpretation and report only (93042) is included in a 12-lead ECG interpretation and report (93000 or 93010).

A rhythm ECG tracing (93040 or 93041) is included in a 12-lead ECG tracing (93000 or 93005).

When several ECG rhythm (or monitor) strips from a single date of service are reviewed at a single setting, report only one unit of service, regardless of the number of strips reviewed.

If one physician bills a rhythm strip interpretation, and another physician bills an ECG interpretation for the same patient on the same date of service, then both services must be reasonable and necessary. Typically, the patient will receive and require **prolonged** rhythm monitoring in addition to a 12-lead ECG.

An ECG furnished on an **emergency** basis by a laboratory or a portable X-ray supplier requires that a physician be in attendance at the time the service was performed or immediately thereafter.

Payments for a home-based ECG above the ECG base amount (i.e., for transportation costs) requires a medical need for performing the service in the patient's home, in addition to the need for the ECG itself. Typically, qualifying patients will be homebound or bed-confined.

Payment for the technical component of an ECG will be denied when the facility is paid for the technical component through the fiscal intermediary (i.e., during a Part A covered nursing home stay). In these cases, the ECG supplier is paid by the facility under a contract arrangement.

Payment for more than one Professional Component (PC) of a single ECG:

Medicare will not pay twice for a service that is required only once to diagnose or treat an illness or injury. Typically, this A/B MAC will pay for only one PC of an ECG. This A/B MAC may pay for a second PC when the additional physician expertise is necessary and reasonable to diagnose or treat the patient, such as to clarify a questionable finding. The physician performing the initial PC must have a valid reason to require another physician’s expertise, such as, to interpret a confusing ECG. The second physician's knowledge and expertise must be significantly greater than that of the first reader, and it must contribute substantially to the interpretation.

Multiple Interpretations of a Diagnostic Test in Institutional Settings:

Medicare generally pays for only one reading of a diagnostic test. Medicare’s rules are clearly explained in the Internet-Only Manual, Pub. 100-04, Medicare Claims Processing Manual, Chapter 13, Section 100.1 which made clear with public notice and comment that CMS policy would not pay for routine second readings). While Chapter 13 is titled, “Radiology Services”, Section 100.1 is titled “X-rays and EKGs furnished to Emergency Room Patients.” The principles apply to double-readings of diagnostic tests in general. The following paragraphs quote extensively from Section 100.1. [*Emphasis added by this A/B MAC*]

> **Generally, A/B MACs (B) must pay for only one interpretation of an EKG** *or x-ray procedure furnished to an emergency room patient. They pay for a second interpretation (which may be identified through the use of modifier "-77")* **only under unusual circumstances** *(for which documentation is provided) such as a questionable finding for which the physician performing the initial interpretation believes another physician’s expertise is needed or a changed diagnosis resulting from a second interpretation of the results of the procedure. When A/B MACs (B) receive only one claim for an interpretation, they must presume that the one service billed was a service to the individual beneficiary rather than a quality control measure and pay the claim*

if it otherwise meets any applicable reasonable and necessary test.

When A/B MACs (B) receive multiple claims for the same interpretation*, they must generally pay for the first bill received. A/B MACs (B) must pay for the interpretation and report that directly contributed to the diagnosis and treatment of the individual patient. Consideration is not given to physician specialty as the primary factor in deciding which interpretation and report to pay regardless of when the service is performed. Consideration is not given to designation as the hospital's "official interpretation" as a factor in determining which claim to pay. A/B MACs (B) pay for the interpretation billed by the cardiologist or radiologist if the interpretation of the procedure is performed at the same time as the diagnosis and treatment of the beneficiary. (This interpretation may be an oral report to the treating physician that will be written at a later time.) [End quotations]*

Section 100.1 provides one example of a medically appropriate "double payment" for a second interpretation, an example where an ER physician diagnoses pneumonia but a radiologist provides a requested second reading for possible tumor. For double reading of an EKG, a similar circumstance must apply, an unusual reason why a second interpretation (for example, a reading by a cardiologist) was specifically medically necessary. Otherwise, the second interpretation must be denied per the manual as a "quality control service."

Alternatively, if the first physician defers diagnosis with a telegraphic note and passes the test to the second physician for his/her diagnostic interpretation, only the second physician should bill. Chapter 13, Section 100.1 states that a telegraphic note in an E/M record is considered part of the E/M service and not a separate report. For example, a treating physician may see an x-ray with a radiologist's report of a fractured tibia, and he may note "x-ray, fx tibia" in his E/M summary, but he may not charge an additional "radiologic interpretation" fee. The CMS manual states as follows:

A/B MACs (B) generally distinguish between an "interpretation and report" of an x-ray or an EKG procedure and a "review" of the procedure. A professional component billing based on a review of the findings of these procedures, without a complete, written report similar to that which would be prepared by a specialist in the field, does not meet the conditions for separate payment of the service. This is because the review is already included in the emergency department evaluation and management (E/M) payment. For example, a notation in the medical records saying "fx-tibia" or EKG-normal would not suffice as a separately payable interpretation and report of the procedure and should be considered a review of the findings payable through the E/M code. An "interpretation and report" should address the findings, relevant clinical issues, and comparative data (when available). [end quotation.]

Each payable interpretation must include a complete, written report similar to one that is prepared by a specialist in the field. The content of the written report must address the relevant clinical issues, available comparative data, and test findings. The format of the report must be separately identifiable. It may be included under a separate heading within the clinical record or written on the ECG tracing itself, with a reference in the clinical record.

Summary of Evidence

NA

Analysis of Evidence
(Rationale for Determination)

NA

General Information

Associated Information

Supportive documentation evidencing the condition and treatment is expected to be documented in the medical record and be available upon request.

An interpretation and report must address the findings and comparative data, if available (i.e., a prior ECG).

The patient's medical record must be legible and clearly indicate the reasonableness and necessity of the service.

The documentation must show that the service was reasonable and necessary for at least one of the covered conditions in this policy.

A laboratory or a portable X-ray supplier that supplies an ECG must maintain in its records the referring physician's written order and the identity of the employee taking the tracing.

Patients presenting with an acute ischemic episode may require several ECGs on one or more days to delineate the severity and progression of that episode when needed to properly treat the patient.

Unstable patients (e.g., electrolyte imbalance, recurrent rhythm disturbances, recurrent chest pain) may require more than one ECG annually to diagnose the condition or assess response to treatment.

Typically, patients with chronic stable heart disease, or other diseases potentially affecting the heart do not require an ECG more frequently than annually.

No comments were received for this draft LCD for comment period ending 08/14/2017.

01/17/18-At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This update is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.

LCD updated to update the language referenced from the IOM 100-4 Chapter 13 Section 100.1 from carriers to A/B MACs (B) and add the following ICD-10 codes new for 2018 because they are within the coverage indications of this LCD:

E85.81-E85.82, E85.89, I21.9, I21.A1, I21.A9, I27.20-I27.24, I27.29, I27.83, I50.810-I50.814, I50.82-I50.84, I50.89 and R06.03

Sources of Information

1. Other contractor's local medical review policies
2. Contractor Medical Director
3. New England and Los Angeles LMRPs

Bibliography

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
10/01/2019	R5	The LCD is revised to remove CPT/HCPCS codes in the Keyword Section of the LCD. At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.	• Other (The LCD is revised to remove CPT/HCPCS codes in the Keyword Section of the LCD.)
10/01/2019	R4	As required by CR 10901, all billing and coding information has been moved to the companion article, this article is linked to the LCD. 10/01/2019: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.	• Revisions Due To Code Removal
10/01/2019	R3	Effective 10/01/2019, the following codes were added, deleted and revised per the 2019/2020 annual ICD-10 updates. Added to Group 1: • I26.93 - Single subsegmental pulmonary embolism without acute cor pulmonale • I26.94 - Multiple subsegmental pulmonary emboli without acute cor pulmonale • I48.11 - Longstanding persistent atrial fibrillation • I48.19 - Other persistent atrial fibrillation • I48.20 - Chronic atrial fibrillation, unspecified • I48.21 - Permanent atrial fibrillation • T6701XA - Heatstroke and sunstroke, initial	• Creation of Uniform LCDs Within a MAC Jurisdiction • Revisions Due To ICD-10-CM Code Changes

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		encounter • T6701XD - Heatstroke and sunstroke, subsequent encounter • T6701XS - Heatstroke and sunstroke, sequela • T6702XA - Exertional heatstroke, initial encounter • T6702XD - Exertional heatstroke, subsequent encounter • T6702XS - Exertional heatstroke, sequela • T6709XA - Other heatstroke and sunstroke, initial encounter • T6709XD -Other heatstroke and sunstroke, subsequent encounter • T6709XS - Other heatstroke and sunstroke, sequela Deleted from Group 1: • I48.1 - Persistent atrial fibrillation • I48.2 - Chronic atrial fibrillation • T67.0XXA - Heatstroke and sunstroke, initial encounter • T67.0XXD - Heatstroke and sunstroke, subsequent encounter • T67.0XXS - Heatstroke and sunstroke, sequela Description Changes from Group1 • Revised from J44.0 – Chronic obstructive pulmonary disease with acute lower respiratory infection to J44.0 - Chronic obstructive pulmonary disease with (acute) lower respiratory infection 09/16/2019 - At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.	
10/01/2018	R2	09/06/2018 - At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and,	• Revisions Due To ICD-10-CM Code Changes

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		therefore not all the fields included on the LCD are applicable as noted in this policy. The following ICD-110 codes were added, deleted and revised per the Annual ICD-10 Updates. **Added:** E78.41, E78.49, I63.81, I63.89, I67.850, I67.858, K82.A2, K83.01, T43.641A, T43.641D, T43.641S, T43.642A, T43.642D, T43.642S, T43.643A, T43.643D, T43.643S, T43.644A, T43.644D and T43.644S. **Deleted:** E78.4 and I63.8. **Revised:** I63.333 and T81.11XA, T81.11XD and T81.11XS.	
03/26/2018	R1	05/08/2018 -At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This update is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy. LCD revised to add ICD-10-CM Z51.81 and Z79.899 effective 03/26/2018. There is no change in the LCD coverage.	• Reconsideration Request

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Article(s)
A57327 - Billing and Coding: Electrocardiograms
LCD(s)
DL37283
- (MCD Archive Site)

Related National Coverage Documents

N/A

Public Version(s)

Updated on 01/29/2020 with effective dates 10/01/2019 - N/A
Updated on 10/03/2019 with effective dates 10/01/2019 - N/A
Updated on 09/06/2018 with effective dates 10/01/2018 - 09/30/2019
Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.

Keywords

- Electrocardiograms
- ECG
- EKG