Cardiology Services

Reimbursement Policy ID: RPC.0107.SCM1

Recent review date: 03/2025

Next review date: 01/2026

First Choice VIP Care Plus reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. First Choice VIP Care Plus may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT®); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

Policy Overview

This policy addresses reimbursement of a range of cardiovascular testing and monitoring for the diagnosis and treatment of coronary disorders.

Exceptions

N/A

Reimbursement Guidelines

Electrocardiograms (ECG's)

Electrocardiograms (ECGs) are performed to diagnose and evaluate a variety of heart conditions.

A routine ECG (93000) will not be reimbursed when billed in an office setting for a patient 18 years of age or greater if the only diagnosis on the claim is a screening diagnosis code and 93005 (ECG tracing) is not also billed. Payment for CPT code 93010 (interpretation and report of EKG) will be denied when billed with an E/M service in the office setting if 93005 (ECG tracing) is not also billed.

Routine ECGs are reimbursable in an office setting when performed other than for screening and when CPT code 93005 is also billed. Interpretation and report of ECG (93010) is not reimbursed when billed with an office service E/M code if the ECG tracing is not also billed.

Evaluation and Management Services (E/M)

The interpretation of an ECG, 99042 (Interpretation and report of ECG with 1-3 leads), is not separately reimbursed with an E/M code in a hospital setting.

Based on the NCCI edits, E/M services will not be reimbursed when billed on the same date of service as the following cardiovascular services

CPT Code	Description
93260	Program device interpretation (in person), implantable subcutaneous lead defibrillator system
93261	Interrogation device analysis (in person), implantable subcutaneous lead defibrillator System
93282	Programming device evaluation (in person) with iterative adjustment of single lead transvenous implantable defibrillator system
93283	Programming device evaluation (in person) with iterative adjustment of dual lead transvenous implantable defibrillator system
93284	Programming device evaluation (in person) with iterative adjustment of multiple lead transvenous implantable defibrillator system
93287	Peri-procedure device evaluation (in person) of single, dual, multiple lead implantable defibrillator system
93289	Interrogation device analysis (in person) of single, dual, multiple lead transvenous implantable defibrillator system including analysis of heart rhythm derived data elements
93292	Interrogation device analysis (in person) of wearable defibrillator system

Reimbursement for evaluation and management services require that modifier -25 be appended when billed the same date of service as cardiac device monitoring services, cardiac device evaluation services, or noninvasive physiologic studies.

Multiple procedures

If more than one myocardial perfusion or cardiac blood pool imaging study (78451-78454, 78466-78469 or 78472, 78473, 78483, 78494) is billed for the same date of service, the procedure with the lowest allowed amount will not be reimbursed. External mobile cardiovascular telemetry devices and external patient activated ECG event recording will not be reimbursed more than once in 6 months when billed by any provider.

Bioimpedance-derived physiologic cardiovascular analysis (93701) will not be reimbursed when billed the same date of service as cardiac bypass surgery (33510-33536).

Device Limits

External mobile cardiovascular telemetry devices and external patient activated ECG event recording are not reimbursable more than once in 6 months when billed by any provider.

A left ventricular assist device (LVAD) is used as a mechanical pump that is surgically implanted in the heart to help treat advanced heart failure. LVADs are used in two main ways. It may take over the heart's pumping function while the patient waits for a transplant or used as a long-term treatment for patients who aren't eligible for a transplant. An LVAD battery assist device is worn on the onside of the body for the ventricular assist devices. Replacement batteries may not be billed more than once within 6-month period. The VAD accessories will not be reimbursed if billed more than one unit per year unless billed with the appropriate modifier.

Other Requirements

A claim with a diagnosis of syncope and collapse will not be reimbursed if an external electrocardiographic monitoring (93000-93010, G0403-G0405) has not been billed in the previous 90 days by any provider. E/M services are not reimbursed when billed the same date of service as evaluation of cardiovascular function with tilt table.

A transcatheter aortic valve replacement [TAVR] or implantation [TAVI] (33361-33366) is an advanced, minimally invasive surgical procedure for patients with severe aortic stenosis. The following information is required for reimbursement:

- modifier Q0 (Investigational clinical service provided in an approved clinical research study).
- modifier 62 (Two surgeons working together as primary surgeons).
- a secondary diagnosis indicating the patient is participating in an approved clinical trial
- place of service is 21 (Inpatient hospital)

Definitions

N/A

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI).
VI. Medicare Fee Schedule(s).

Attachments

N/A

Associated Policies

N/A

Policy History

03/2025	Reimbursement Policy Committee Approval
04/2024	Revised preamble
08/2023	Removal of policy implemented by First Choice VIP Care Plus from Policy History section
01/2023	Template Revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section