Clinical Policy: Holter Monitors

Reference Number: WNC.CP.134 Coding Implications
Last Review Date: 04/2026 Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Note: 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.

Description

This policy provides medical necessity guidelines for Holter monitoring up to 48 hours. For Holter monitoring beyond 48 hours, see clinical decision support criteria.

Ambulatory electrocardiogram (ECG) monitoring provides a view of cardiac activity over an extended period of time and can be performed using various techniques. The method selected to conduct ambulatory ECG monitoring depends on the desired outcome and the frequency and duration of symptoms. Continuous Holter monitoring for 24 to 48 hours is the most practical initial approach for those with daily or near daily unexplained symptoms, as well as for assessing the efficacy of medication and other treatments for cardiac arrhythmias.[1]

Policy/Criteria[1]

I. It is the policy of WellCare of North Carolina® that Holter monitoring with a Food and Drug Administration (FDA) approved device is medically necessary for members ≥ 18 years old who require 24 to 48 hours of cardiac activity monitoring with any of the following symptoms or indications:
- **A.** Evaluation of any of these unexplained indications: syncope, near-syncope, episodic dizziness, recurrent palpitations, episodic shortness of breath or chest pain;
- **B.** Evaluation of neurological events when transient atrial fibrillation or flutter is suspected;
- **C.** Evaluation of syncope, near-syncope, episodic dizziness, or palpitations in whom a probable cause other than an arrhythmia has been identified but in whom symptoms persist despite treatment of this other cause;
- **D.** Evaluation of members/enrollees with cardiomyopathy (e.g., arrhythmogenic right ventricular cardiomyopathy (ARVC), hypertrophic cardiomyopathy (HCM), dilated cardiomyopathy), or a first-degree relative with ARVC or HCM;
- **E.** Evaluation of possible or documented prolonged QT syndromes;
- **F.** To screen for asymptomatic arrhythmia in a members/enrollees with Brugada syndrome;
- **G.** Assessment of efficacy of medication for arrhythmia treatment when baseline arrhythmia frequency is reproducible and of sufficient frequency to permit analysis;
- **H.** Detection of proarrhythmic responses to antiarrhythmic therapy in members/enrollees at high risk;

I. 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;
J. Evaluation of suspected pacemaker or ICD component failure or malfunction when device interrogation is inconclusive;
K. Assessment of efficacy of adjunctive medications in members/enrollees receiving frequent ICD therapy;
L. Assessment of suspected variant angina;
M. Evaluation of recurrent chronic heart failure when arrhythmia is suspected;
N. Evaluation of possible arrhythmias post ablation procedures;
O. Baseline or periodic screening for those with adult congenital heart disease.

II. It is the policy of WellCare of North Carolina® that Holter monitoring with an FDA approved device is medically necessary for pediatric members/enrollees < 18 years old who require 24 to 48 hours of cardiac activity monitoring with any of the following symptoms or indications.
A. Evaluation of syncope, near-syncope, or dizziness in members/enrollees with identified cardiac disease, previously documented arrhythmia, or pacemaker dependency;
B. Evaluation of syncope or near-syncope associated with exertion when cause is not established;
C. Evaluation of unexplained syncope, near-syncope, or sustained palpitation when there is no overt clinical evidence of heart disease;
D. Assessment of efficacy of medications for arrhythmia following initiation of treatment or during rapid somatic growth;
E. Evaluation of patients with cardiomyopathy, or a first-degree relative with arrhythmogenic right ventricular cardiomyopathy;
F. Evaluation of possible or documented prolonged QT syndromes;
G. Evaluation of palpitation in a member/enrollee with prior surgery for congenital heart disease and significant residual hemodynamic abnormalities;
H. Evaluation of asymptomatic congenital complete atrioventricular (AV) block, non-paced;
I. Evaluation of cardiac rhythm after transient AV block associated with heart surgery or catheter ablation;
J. Evaluation of rate-responsive or physiological pacing function in symptomatic members/enrollees.

Background[1]

The most common use of ambulatory electrocardiogram (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/enrollee 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/enrollees who experience symptoms too infrequent to be caught on a standard ECG.[1]

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.[1]

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 implantable cardioverter defibrillators (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/enrollees receiving frequent ICD therapy.[1,2]

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/enrollee. Furthermore, ambulatory ECG can be beneficial in members/enrollees 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.[1,3]

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.[3,4] Likewise, this monitoring is beneficial in pediatric members/enrollees with hypertrophic or dilated cardiomyopathies or known or suspected prolonged QT syndromes.[5] Ambulatory ECG can also be used to evaluate asymptomatic pediatric members/enrollees with congenital complete atrioventricular (AV) block in order to identify those at increased risk for sudden arrhythmic events who may benefit from prophylactic pacemaker implantation. [1,3,4]

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 2026, 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 CODE	Description
G45.9	Transient cerebral ischemic attack, unspecified
G71.00 through G71.09	Muscular dystrophy
G99.0	Autonomic neuropathy in diseases classified elsewhere
I20.0 through I20.9	Angina pectoris
I24.0 through I24.9	Other acute ischemic heart diseases
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris
I25.112	Atherosclerotic heart disease of native coronary artery with refractory angina pectoris
I25.702	Atherosclerosis of coronary artery bypass graft(s), unspecified, with refractory angina pectoris
I25.712	Atherosclerosis of autologous vein coronary artery bypass graft(s) with refractory angina pectoris
I25.722	Atherosclerosis of autologous artery coronary artery bypass graft(s) with refractory angina pectoris

ICD-10-CM CODE	Description
I25.732	Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with refractory angina pectoris
I25.752	Atherosclerosis of native coronary artery of transplanted heart with refractory angina pectoris
I25.762	Atherosclerosis of bypass graft of coronary artery of transplanted heart with refractory angina pectoris
I25.792	Atherosclerosis of other coronary artery bypass graft(s) with refractory angina pectoris
I34.0 through I34.9	Nonrheumatic mitral valve disorders
I35.0 through I35.9	Nonrheumatic aortic valve disorders
I36.0 through I36.9	Nonrheumatic tricuspid valve disorders
I37.0 through I37.9	Nonrheumatic pulmonary valve disorders
I42.0 through I42.9	Cardiomyopathy
I44.0 through I44.7	Atrioventricular and left bundle-branch block
I45.0 through I45.9	Other conduction disorders
I46.2 through I46.9	Cardiac arrest
I47.0 through I47.9	Paroxysmal tachycardia
I48.0 through I48.92	Atrial fibrillation and flutter
I49.01 through I49.9	Other cardiac arrhythmias
I50.1 through I50.9	Heart failure
I51.7	Cardiomegaly
I63.00 through I63.9	Cerebral infarction
I67.841 through I67.848	Cerebral vasospasm and vasoconstriction
Q20.0 through Q20.9	Congenital malformations of cardiac chambers and connections
Q21.0 through Q21.9	Congenital malformations of cardiac septa
Q22.0 through Q22.9	Congenital malformations of pulmonary and tricuspid valves
Q23.0 through Q23.9	Congenital malformations of aortic and mitral valves
Q24.0 through Q24.9	Other congenital malformations of heart
Q25.0 through Q25.9	Congenital malformations of great arteries
R00.0 through R00.9	Abnormalities of heart beat
R06.00 through R06.09	Dyspnea
R07.2	Precordial pain
R07.89	Other chest pain
R07.9	Chest pain, unspecified
R42	Dizziness and giddiness
R53.81 through R53.83	Other malaise and fatigue
R55	Syncope and collapse
R94.31	Abnormal electrocardiogram [ECG] [EKG]
Z48.812	Encounter for surgical aftercare following surgery on the circulatory system

ICD-10-CM CODE	Description
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 Approval	Reviewed Date	Approval Date
Policy developed.	04/26	04/26

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North Carolina Guidance

Eligibility Requirements

1. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
2. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
3. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

- 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure:

I. that is unsafe, ineffective, or experimental or investigational.
II. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

- If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
- **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:

NCTracks Provider Claims and Billing Assistance Guide:
https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

i. meet Medicaid qualifications for participation;
ii. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
iii. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance
Provider(s) shall comply with the following in effect at the time the service is rendered:

A. All applicable agreements, federal, state, and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
B. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

- Claim Type - as applicable to the service provided:
  Professional (CMS-1500/837P transaction)
  Institutional (UB-04/837I transaction)
  Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
- International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
- Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
  Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service

- Modifiers - Providers shall follow applicable modifier guidelines.
- Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
- Co-payments -
  For Medicaid refer to Medicaid State Plan:
  https://medicaid.ncdhhs.gov/meetingsnotices/medicaid-state-plan-public-notices

- Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

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/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees 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/enrollees, 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/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.