



February 7, 2020

Seema Verma  
Administrator  
U.S. Department of Health and Human Services  
Centers for Medicare and Medicaid Services  
200 Independence Avenue SW  
Washington, DC 20201  
Attn: [MedicarePhysicianFeeSchedule@cms.hhs.gov](mailto:MedicarePhysicianFeeSchedule@cms.hhs.gov)

**Re: Medicare Physician Fee Schedule;  
Potentially Misvalued Codes; Holter monitoring services  
(CPT Code 93226)**

Dear Administrator Verma:

We write in response to CMS' request for stakeholder input on potentially misvalued codes, as set forth in the preamble to the 2020 Medicare physician fee schedule. The Remote Cardiac Services Provider Group believes that CPT Code 93226, which describes external electrocardiographic recording of up to 48 hours (*i.e.*, Holter monitoring) is no longer appropriately valued for the reasons set forth below. We ask that it be reviewed as part of the 2021 rulemaking cycle.

The RCSPG, founded in 2004 and incorporated in 2007, is a nonprofit coalition whose members include independent diagnostic testing facilities (IDTFs) that furnish over half of the remote cardiac diagnostic monitoring services in this country including Holter monitoring, cardiac event monitoring, outpatient mobile cardiac telemetry (MCT) and monitoring of implantable devices such as implantable loop recorders (ILRs) and intracardiac monitors (ICMs). IDTFs account for approximately 89 percent of Holter services billed to Medicare under CPT Code 93226. That code describes:

*External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; scanning analysis with report*

CPT Code 93226 was revised by the CPT Editorial Panel, effective 2011, to describe monitoring of "up to 48 hours."<sup>1</sup> Before this revision, the code described monitoring of up to 24 hours. Because of the change in the code descriptor, physicians have, since 2011, been ordering an increasing number of 48-hour monitoring services. When an IDTF receives an order for a 48-

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<sup>1</sup> The code change was considered editorial and was not reviewed by the AMA's RUC.

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hour Holter monitoring service, the patient wears the monitor for 48 hours which means that the monitor cannot be used by another patient thereby increasing IDTF costs.<sup>2</sup>

The Holter monitoring family of codes (CPT Codes 93224-93227) were reviewed by the RUC at its January 2020 meeting in connection with the RUC's review of several new CPT codes describing longer EKG monitoring with new technology.<sup>3</sup> At the meeting, the relevant specialty societies, the American College of Cardiology (ACC) and the Heart Rhythm Society (HRS), recommended to the RUC that the number of minutes of equipment time for the Holter monitor (EQ127) be increased from 24 hours to 36 hours to account for the fact that many more physicians are now ordering 48-hour monitoring. The recommendation of 36 hours was based on data the RCSPG provided to ACC and HRS from RCSPG member companies. The data indicated that the 24-hour and 48-hour test were each performed approximately 50% of the time. The specialties recommended that the minutes of use (*i.e.*, the number of minutes the monitor is worn by the patient) for the Holter monitor (EQ 127) be increased from 1440 minutes (24 hours) to 2160 minutes (36 hours) to reflect the average length of service.

The RUC did not accept this recommendation because it concluded that there was insufficient evidence to warrant a change from the current 24 hours of equipment time. Specifically, the RUC took the position that use of average time was inappropriate and that equipment time must be based on the "typical" rather than the average service which the RUC defined as the most frequently performed monitoring period, *i.e.*, 24 or 48 hours. Since there was insufficient evidence to demonstrate that 48-hour monitoring was performed more than 50 percent of the time, the RUC decided the requested increase was unwarranted.<sup>4</sup> We believe the focus on a hypothetical "typical" service rather than numerical average results in inaccurate direct cost inputs that will inevitably result in substantial underpayment for some services.

The concept of the "typical" was first used in the determination of physician work RVUs. Since the time and intensity of physician work varies within a service, it was important to establish work RVUs that reflected a hypothetical "typical" service – not the longest or most complex nor the shortest or least complicated. In other words, Medicare should pay for the average or typical service. This concept has also been applied to the development of practice expense RVUs.<sup>5</sup> Clinical staff time, like physician time, is based on the average or typical service. The same concept applies to equipment time and supplies.

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<sup>2</sup> IDTFs perform these services based on a physician order and have no control over the length of the service to be provided.

<sup>3</sup> The new codes, 93XX0 to 93XX3, describe external electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage. New codes 93XX4-93XX7 describe the same service for more than 7 days up to 15 days.

<sup>4</sup> The RUC did recommend an increase in equipment time for 93226 of 34 minutes which was reallocated from CPT Code 93225.

<sup>5</sup> See 80 Fed. Reg. 70891 (Nov. 16, 2015).

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For example, when CPT Code 93229, which describes up to 30 days of outpatient mobile cardiac telemetry, was valued in 2009, IDTFs that were the principal providers of the service submitted data showing that the average number of days of monitoring was 14 days. Consequently, direct practice expense inputs, including equipment use time, were based on 14 days and not 30 days. The 14 days was based on the average length of service rather than a hypothetical “typical” service.

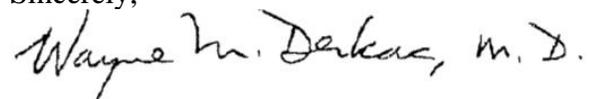
Similarly, for CPT Code 93271, which describes up to 30 days of cardiac event monitoring, the number of minutes of use for the CEM System (EQ 297) is 83 minutes which is based, in part, on the average number of transmissions of EKG data by the patient to the IDTF during the 30-day period. In of the above examples, average time is used to establish direct cost inputs.

Consistency requires that the same methodology be used for determining equipment time for the up to 48-hour Holter service. Because some services last 24 hours and others 48 hours, the most accurate number of equipment minutes of use would be the average time. If Medicare payment is based on a Holter monitor being in use for 24 hours (*i.e.*, the “typical” service) this underpays approximately half of the tests – those that are ordered for 48 hours. Likewise, it would not seem fair to base payment on 48 hours of use if only half of the services were performed for 48 hours. Therefore, we urge CMS, in the proposed rule, to calculate equipment time for the Holter monitor (EQ 127) based on 36 hours of use when proposing RVUs for CPT Code 93226.

At the very least, we ask that CMS, in the proposed rule, solicit data on length of monitoring from all providers of Holter services including ordering physicians. Although we believe our data set indicates that 24- and 48-hour monitoring were each ordered approximately 50 percent of the time, we are open to CMS seeking data from multiple stakeholders.

We appreciate your attention to this issue.

Sincerely,



Wayne M. Derkac, MD, FACC

President

Remote Cardiac Services Provider Group