Molina Clinical Policy
Mobile Cardiac Outpatient Telemetry
Policy No. 428

Last Approval: 10/14/2026
Next Review Due By: October 2027

DISCLAIMER

This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment. Providers are solely responsible for the diagnosis, treatment, and clinical recommendations for the member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular member. The member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their providers will need to consult the member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid members. CMS's Coverage Database can be found on the CMS website. References included were accurate at the time of policy approval and publication.

OVERVIEW

There are several ambulatory cardiac rhythm monitoring devices on the market. This policy is only applicable to mobile cardiac outpatient telemetry.

Cardiac Arrythmias cause significant morbidity and mortality. While many cardiac arrythmias can be captured on electrocardiograms (ECG), some can be missed on routine ECGs and short-term monitors, thus necessitating long-term telemetry to be captured, diagnosed, and treated.

There are a multitude of ambulatory cardiac monitoring methods, with the Holter monitor being the most common. Holter monitoring captures all ECG data for a 24-to-48-hour period and is not analyzed in real time. External event (loop) recorders can be worn up to a month and continuously record data but only save this data when activated (either automatically or patient activated) during a symptomatic event. This requires a patient interaction with the device, which may not be possible in cases of syncope. Alternately, loop recorders may be implanted subcutaneously. Implanted cardiac monitors, sometimes referred to as implantable loop recorders, are similar to the external devices in that they store data when an event is activated by the patient. Patch monitors, or other external long term continuous monitoring devices (e.g., Zio ECG monitors), are a small all in one adhesive patch that continuously record ECG data. These devices are typically worn for up to 14 days, with batch data processing instead of real time (Madias 2024).

Mobile Cardiac Outpatient Telemetry (MCOT) is used for evaluation of suspected non-life-threatening arrhythmias that have not been detected by office or hospital-based monitoring. A wearable mobile device provides real-time tracing of a patient's heart rhythm. When significant arrhythmias are detected, the monitor automatically transmits the patient's ECG data via a wireless network to the central monitoring station that are attended by trained technicians 24 hours per day. Reports of potentially life-threatening arrhythmias are sent for immediate evaluation by a healthcare provider. Daily reports are reviewed, which contain information such as heart rate and rhythm, any arrhythmias noted, ECG tracings for patient triggered events, technicians' notes, and reported symptoms. MCOT devices can be worn for up to 30 days (Madias 2024).

Regulatory Status

The U.S. Food and Drug Administration (FDA) has cleared several MCOT devices. MCOT devices can be found under product codes DSI, MHX, QYX (Arrhythmia detector and alarm [including ST-segment measurement and alarm]), DRG (Radiofrequency physiological signal transmitter and receiver), and DXH (Telephone electrocardiograph transmitter and receiver). The following list is not exhaustive, and the current status of the requested MCOT should be verified on the FDA website:

- CardioNet MCOT System (CardioNet)
- HEARTLink II System (Cardiac Telecom Corp.)
- TruVue Wireless Ambulatory Monitoring Systems (Biomedical Systems)
- VitalPatch VitalConnect Platform (Vital Connect Inc.)
- Zio AT Monitor (iRhythm)

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RELATED POLICIES

This policy does not apply to requests for services as part of a surveillance protocol for members engaging in a clinical trial. Refer to *Clinical Trials and Rare Disease: Policy No. 183.*

COVERAGE POLICY

Mobile cardiac outpatient telemetry (MCOT) may be **considered medically necessary** when prescribed by a qualified physician with clinical experience and training in cardiac telemetry and ALL the following criteria are met:

1. Member meets at least ONE of the following evaluation criteria:
   a. Non-diagnostic 48 Holter monitoring OR non-diagnostic external long term continuous monitoring of at least 14 days (e.g., Zio XT Patch)
   b. Member has documented unpredictable or infrequent clinically significant events which necessitate prolonged telemetry monitoring
   NOTE: Ordering Holter monitoring and MCOT simultaneously is not considered medically necessary

2. Member has not had previous outpatient cardiac telemetry completed in the last 3 months

3. Member meets ONE of the following clinical indications:
   a. Member requires monitoring for accurate information on arrhythmia burden for at least ONE of the following known non-life-threatening arrhythmias:
      i. Paroxysmal atrial fibrillation (particularly in the setting of cryptogenic stroke or transient cerebral ischemic events)
      ii. Paroxysmal supraventricular arrhythmias
      iii. Brady-arrhythmias
      iv. Intermittent bundle branch block
      v. Nocturnal arrhythmias (such as those associated with sleep apnea)
   b. Member is being monitored for arrhythmias following a cardiac surgery or procedure
   c. Member presents with at least ONE of the following *recurrent* clinically significant symptoms of a possible cardiac arrhythmia:
      i. Unexplained pre-syncope or syncope events
      ii. Infrequent (i.e., weekly or monthly) symptomatic palpitations or chest pain

4. Submission is accompanied by ALL the following clinical documentation supporting the medical necessity of telemetry:
   a. Progress note(s) from a cardiologist or electrophysiologist that prompted the request for MCOT
   b. Recent EKG (within 10 days), if available
   c. Most recent Holter, event monitor, or device interrogation report, if available

Limitations and Exclusions
The following are considered **experimental, investigational, and unproven** based on insufficient evidence:

1. Cases where a hospital setting may be more suitable or inpatient monitoring is required:
   a. Potentially life-threatening arrhythmias
   b. Patients deemed by the attending physician to require hospitalization
   c. High-risk of developing sustained ventricular tachycardia or ventricular fibrillation

2. Concurrent or prior use of other cardiac surveillance services or cardiac telemetry (e.g., ECG, Holter monitor, or other event recorder) has provided sufficient clinical data or information, and MCOT is not expected to provide the data/information required for the diagnosis and/or a change in the treatment of the member's condition/symptoms

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3. Prescribed primarily for the daily transmission of ECG rhythm strips or telemetry recordings in asymptomatic patients

Coverage Limitations

Real-time cardiac telemetry is a service that lasts **up to 30 days** and is used to diagnose or suspected and/or paroxysmal dysrhythmia. Generally, continuing testing for more than 30 days is not medically necessary. In most cases, failure to detect a dysrhythmia after a 30-day monitoring period does not necessitate further testing.

EXCEPTION: Monitoring for longer than 30 days is only medically necessary in exceptional circumstances and must be justified by the treating physician/provider with supporting documentation for review.

DOCUMENTATION REQUIREMENTS: Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

SUMMARY OF MEDICAL EVIDENCE

Randomized Controlled Trials

Rothman et al. (2007) conducted a multicenter RCT that compared mobile cardiac outpatient telemetry (MCOT) to the standard patient-activated external loop event monitoring to monitor patients who had palpitations, presyncope, syncope or a combination of these symptoms. All participants had a high clinical suspicion of malignant arrhythmia, symptoms of syncope, pre-syncope or severe palpitations occurring less frequently than once every 24 hours, and a nondiagnostic 24-hour Holter or telemetry monitor within 48 days prior to enrollment. All 266 participants (n=266) were randomly assigned to either MCOT or an external loop monitor for 30 days. The primary endpoint was either the confirmation or exclusion of an arrhythmic cause for the patient's symptoms. Arrhythmias were classified as either clinically significant or clinically insignificant. A diagnosis was made in 88% of the MCOT group and 75% of the loop event monitoring group. There was no significant difference between MCOT and external loop event monitoring in their ability to detect or exclude a cardiac arrhythmia occurring simultaneously with the symptoms (arrhythmia occurred simultaneously with symptoms in 40% and 47% in the two groups respectively in all patients with arrhythmia, and 42% and 40% respectively for patients with syncope/presyncope. The authors also noted that the MCOT system (CardioNet, USA) was compared to patient-activated external event recorders with looping and the study did not compare MCOT to implanted loop recorders, nor was it designed to compare it to auto-trigger loop recorders, which were used in only 16% of the external loop event monitoring group's patients. The authors concluded that outpatient telemetry system may detect more arrhythmias than external loop recorders in patients with syncope or presyncope.

Systematic Reviews and Meta-Analyses

Jiang et al. (2022) conducted a systematic retrospective review of all randomized controlled trials and prospective cohort studies investigating the use of extended ECG monitoring >24 hours for the detection of atrial fibrillation (AF) following cryptogenic stroke. Researchers reviewed a total of 3458 studies, with 47 studies selected for further analysis. These studies represented 6448 post-cryptogenic stroke patients who were evaluated for AF utilizing either implantable loop recorders or MCOT from January 2011 to November 2021. While historically implantable loop recorders were considered the gold standard of ECG monitoring, implantable loop recorders involve an invasive procedure requiring patient compliance for long-term follow-up and are more costly than MCOT. This meta-analysis found that systematic reviews of MCOT after cryptogenic stroke were limited and often did not provide comparison to implantable loop recorders. Another factor identified was the wide variety of MCOT device types including wireless recorders (52.9%), chest belts (29.4%), patches (17.6%), and handheld devices (17.6%). Researchers concluded that patient compliance is one of the main factors limiting the use of MCOTs due to the reliance on daily or more frequent application. Patient poststroke neurological disability also excluded some users from eligibility for MCOT devices due to insufficient cognitive and physical ability. Researchers concluded that appropriate device selection for ECG monitoring requires that the clinician consider patient clinical judgement and preference, duration of monitoring, and overall cost as components of treatment recommendations. Further research with specific criteria and comparison of device types is needed regarding the use of MCOT for detection of AF in patients with cryptogenic stroke.

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Noubiap et al. (2021) conducted a systematic review and meta-analysis of 47 studies for a pooled population of 8, 215 patients. The review analyzed different rhythm monitoring strategies to detect atrial fibrillation in patients with cryptogenic stroke or embolic stroke of undetermined source. The different rhythm methods analyzed were implantable cardiac monitors (ICM) such as the Reveal XT and Reveal LINQ, and MCOT. The analysis revealed various points surrounding different settings and types of ICMs. Additionally, the analysis revealed the pooled atrial fibrillation detection rate utilizing MCOT was MCOT was 9.5% (95% CI 5.6–13.4, I2 64%) at 3 weeks and 13.7% (95% CI 10.2–17.2, I2 64%) at 1-month. This detection rate was higher than the ICM detection rate of 4.1% at the 1-month time point. The authors did emphasize that this discrepancy is influenced by the fact that patients being chosen for an ICM tend to have extensive non-invasive monitoring prior to the ICM being placed; therefore, the two data points cannot be directly compared. However, this highlights the utility of month long non-invasive cardiac monitoring in post cryptogenic stroke patients.

Sposato et al. (2015) conducted a systematic review and meta-analysis of 50 studies (n = 11,658) to estimate the proportion of individuals with newly diagnosed AF following transient ischemic attack or stroke. The studies noted diagnostic methods including ECG, continuous inpatient ECG monitoring, Holter monitoring, continuous inpatient cardiac telemetry, outpatient MCOT, external loop recording and implantable loop recorders (ILR). Phase 1 was assessment in the emergency room with ECG. Phase 2 (inpatient stay) comprised serial ECG, continuous ECG, inpatient cardiac telemetry and inpatient Holter monitoring. In phase 3, the first ambulatory period, Holter monitoring was utilized. The fourth phase was the second ambulatory period, which consisted of MCOT, external loop recording (ELR) and ILR. Phase 4 revealed AF in 16.9% of patients. The overall AF detection yield after all phases of sequential cardiac monitoring was 23.7% (95% CI, 17.2% to 31.0%). In phase 4, there were no differences between the proportion of patients diagnosed with post-stroke AF by MCOT (15.3%), ELR (16.2%), or ILR (16.9%). In addition, only around 40% of patients persisted into phase 4 for further surveillance after phase 3. Age and risk variables for post-stroke AF differed throughout the 50 studies. This analysis suggests that extended outpatient MCOT detects post-stroke AF, however the proportion of patients diagnosed in phase 4 by implanted loop recording did not differ significantly from those diagnosed by mobile cardiac outpatient telemetry or external loop recording.

Non-Randomized Studies, Retrospective Reviews, and Other Evidence

Norlock et al. (2024) conducted a retrospective analysis utilizing Optum's de-identified database and applicable DRG codes. The authors compared outcomes in post-stroke patients with an ILR versus MCOT. The full balanced data set consisted of 2244 patients broken up into three cohorts: Without complications or comorbidity (WOCC), with complication of comorbidity (CC), major complication or comorbidity (MCC). Each of these three cohorts consisted of an equal number of ILR and MCOT patients. In the MCC cohort, MCOT patients had a significantly lower rate of all-cause readmissions (33.7% vs 46.7%; HR 1.59; 95% CI: 1.10–2.28; p = 0.012), all-cause emergency readmissions (HR 1.77; 95% CI: 1.14–2.76; p = 0.011), overall readmissions specific to cerebral infarction (HR 2.18; 95% CI: 1.10–4.30; p = 0.025), and emergency readmissions (HR 2.27; 95% CI: 1.04–4.98; p = 0.041 for MCC). These trends were also represented in the CC group. Across all groups, MCOT patients had lower emergency readmissions for cerebrovascular causes (HR 1.45; 95% CI: 1.07–1.98; p = 0.018), readmissions specific to cerebral infarction (HR 1.65; 95% CI: 1.26–2.16; p < 0.001), and fewer emergency readmissions (HR 1.60; 95% CI: 1.18–2.17; p = 0.002). In the WOCC subgroup, ILR patients had relatively fewer all cause readmissions than MCOT monitored patients across admission types; however, these differences did not reach statistical significance (HR 0.93; 95% CI: 0.63–1.38; p = 0.726 for all inpatient; HR 0.92; 95% CI: 0.60–1.42; p = 0.721 for non-elective; and HR 0.91; 95% CI: 0.58–1.42; p = 0.682 for emergency). With respect to healthcare cost, MCOT patients cost significantly less than the ILR patients. Across all groups, the adjusted average cost from the initial admission to the end of the 18-month follow-up period was $27,429 less for MCOT patients (95% CI: $22,353–$32,633; p < 0.001). MCOT patients also had a lower cost for follow up care (difference $9,825, CI; $4,512–$14,825; p < 0.001). Overall survival was relatively higher in the MCOT (91.1% vs 88.7%) group, but the difference did not reach statistical significance (HR 1.30; 95% CI: 1.00–1.69; p = 0.051). The authors concluded these results supported the place of MCOT in post-stroke follow up care.

Derkac et al. (2017) conducted a retrospective review of the BioTelemetry database over an 8-month period (January 2016 – September 2016) to compare diagnostic yield of MCOT vs external autotrigger looping event recorders (AT-LER). The authors reviewed the diagnostic yield, mean time to first diagnosis, patient age and patient gender and patient diagnostic codes were determined for the diagnoses of asymptomatic (device triggered) atrial fibrillation, bradycardia, ventricular pause, supraventricular tachycardia, and ventricular tachycardia. A total of 69,977 patients were prescribed MCOT vs 8,513 patients prescribed AT-LER. The average length of use was 19.9 days for MCOT and 27.4 days for AT-LER. Comparatively, MCOT had a 128% higher diagnostic yield for atrial fibrillation, a 17% higher

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diagnostic yield for ventricular pause, an 80% higher diagnostic yield for supraventricular tachycardia, and a 222.2% higher diagnostic yield for ventricular tachycardia than the AT-LER cohort despite having a shorter duration of monitoring. The authors discussed that lack of patient compliance with sending AT-LER data could contribute to lower diagnostic yield, as the device's data would either erase or stop recording when it was full. In contrast, MCOT sends arrythmia reports in real time and continuously records data, making it easier to diagnose arrhythmias.

National and Specialty Organizations

The **American Heart Association (AHA) / American Stroke Association (ASA)** *2021 AHA/ASA Guidelines for Prevention of Stroke in Patients with Ischemic Stroke or TIA* recommend the following for detection of occult AF (Kleindorfer et al. 2021): "In patients with cryptogenic stroke who do not have a contraindication to anticoagulation, long-term rhythm monitoring with mobile cardiac outpatient telemetry, implantable loop recorder, or other approach is reasonable to detect intermittent AF (Class 2a, Level of Evidence B-R)."

The **American College of Cardiology (ACC) / American Heart Association (AHA) / Heart Rhythm Society (HRS)** published the *Guideline for the Evaluation and Management of Patients with Syncope* (Shen et al. 2017) that addresses several ambulatory ECG monitoring options. The guidelines recommend that the duration and type of monitoring system be determined by the frequency and nature of syncope events. The following external cardiac monitoring approaches can be useful in evaluating selected ambulatory patients with syncope of suspected arrhythmic etiology: Holter monitor, transtelephonic monitor, external loop recorder, patch recorder, and mobile cardiac outpatient telemetry

(Class 2a, Level B-NR [Class 2a: It is reasonable to perform procedure. Level of Evidence B-NR: Based on moderate-quality evidence from one or more well-designed, well-executed nonrandomized, observational or registry studies]).

The **National Institute for Health and Care Excellence (NICE)**, published the *Atrial Fibrillation: Diagnosis and Management* guideline [NG196] in the 2021, which recommends for patients with suspected paroxysmal atrial fibrillation that is not detected with a 12-lead electrocardiogram:

- Use a 24-hour ambulatory ECG monitor if asymptomatic episodes are suspected or symptomatic episodes are less than 24 hours apart
- Use an ambulatory ECG monitor, event recorder or other ECG technology for a period appropriate to detect atrial fibrillation if symptomatic episodes are more than 24 hours apart

CODING & BILLING INFORMATION

CPT (Current Procedural Terminology)

Code	Description
93228	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional **Note: CPT codes (93228 and 93229) can only be reported once per 30 days of service.
93229	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional **Note: CPT codes (93228 and 93229) can only be reported once per 30 days of service.

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informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

APPROVAL HISTORY

10/14/2026	Policy reviewed. No changes to coverage criteria.
10/08/2025	Policy revised. Added requirement of non-diagnostic Holter or long-term continuous monitoring prior to MCOT. IRO peer review on September 26, 2025 by a physician board-certified in Cardio-Vascular Disease.
10/09/2024	Policy reviewed. No changes to coverage criteria. IRO Peer Review on September 6, 2024, by a practicing physician board-certified in Internal Medicine; Cardiovascular Disease; Interventional Cardiology.
12/13/2023	Policy reviewed. No changes to coverage criteria.
12/14/2022	New policy.

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