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Reimbursement Guide: 12-lead Electrocardiogram

This guide explains Medicare coverage criteria for electrocardiographic (ECG) technologies used in the evaluation and management of suspected cardiac diseases or disorders. It outlines key considerations for appropriate diagnostic use when using the AliveCor Kardia 12L monitoring system for the following use cases: comprehensive cardiac or cardiomyopathy evaluation (e.g., evaluation of suspected symptoms, detection of myocardial injury, ischemia, or presence of prior infarction, metabolic disorders or electrolyte imbalances, congenital heart disease, trauma/emergency, monitoring pharmacotherapeutic effects or adverse effects of drug therapy, perioperative anesthesia monitoring, and athletic screening) and post-admission or post-surgical evaluation monitoring (e.g., monitoring post-cardiac surgery [TAVR, CABG], or post-ablation / post-cardioversion).

The Kardia 12L 12-lead ECG captures the heart's electrical activity from multiple perspectives using limb and chest electrodes, serving as the clinical gold standard for detecting arrhythmias, ischemia, and structural heart disease. The adoption of ECG technology has progressively expanded beyond acute and hospital settings into ambulatory and remote monitoring applications. Advances in device design, signal processing, and algorithmic analysis have enabled the development of compact, efficient, and user-friendly systems that preserve diagnostic accuracy while facilitating broader clinical utility. Clinical evidence demonstrates that reduced-lead ECG systems like Kardia 12L deliver reliable performance for routine cardiac screening and portable monitoring.[1, 2]

AliveCor's Kardia 12L cardiac monitoring system combines advanced signal processing, automated rhythm analysis, and cloud connectivity for accurate arrhythmia detection and timely clinical interpretation. These technologies increase accessibility, convenience, and patient empowerment, and support diverse care settings, including inpatient, outpatient, and where portability is essential. Implementation depends on technology features, clinical workflows, patient requirements, and provider preferences.

Physician Payment – Medicare

Physician claims must use the appropriate CPT/HCPCS code(s) to indicate the items and services that are furnished. Relevant ICD-10 codes can be found within CMS articles. Electrocardiograms are covered by CMS coding Article A57326, Local Coverage Determination LCD 34315, and National Coverage Determination NCD 20.15.

CPT/ HCPCS Code	Description	2026 Work RVUs	2026 Total Non- Facility RVUs	2026 Non-Facility Ntl Avg
	Electrocardiogram			
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	0.17	0.46	$15.36
93005	Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report	0.00	0.21	$7.01
93010	Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only	0.17	0.25	$8.35
	Reduced lead set ECG			
0903T	Electrocardiogram, algorithmically generated 12-lead ECG from a reduced-lead ECG; with interpretation and report	0.00	0.00	0.00
0904T	ECG ALG 12 algorithmically generated 12-lead ECG from a reduced-lead ECG; tracing only	0.00	0.00	0.00
0905T	Electrocardiogram, algorithmically generated 12-lead ECG from a reduced-lead ECG; interpretation and report only	0.00	0.00	0.00

Hospital Outpatient Payment – Medicare

Hospital outpatient claims must contain the appropriate CPT/HCPCS code(s) to indicate the items and services that are furnished. CMS has included reduced-lead ECG technology in the 2025 OPPS schedule under APC 5733. Access details by downloading the OPPS addendum file and search for 0904T at: https://www.cms.gov/license/ama?file=/files/zip/january-2025-opps-addendum-b.zip.

CPT/ HCPCS Code	Description	2026 APC	2026 Relative Weight	2026 Payment Rate
	Reduced lead set ECG			
0904T	Electrocardiogram, algorithmically generated 12-lead ECG from a reduced-lead ECG; tracing only	5733	0.664	$60.59

[1] Xue, J. (2024). Does a Reduced ECG Lead Set Contain the Full 12-Lead ECG Information for Interpretation. *Computing in Cardiology Conference (CinC)*.
[2] Gaddam, Meghna et al. Efficiency of an artificial intelligence-aided portable 12-lead electrocardiogram acquisition system Heart Rhythm O2, Vol 6, Issue 8, 1232 - 1233.

FAQs

1. **Do reduced-lead ECGs meet CPT 93000 CMS requirements?**
   CPT 93000 ("Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report") is associated with comprehensive 12-lead ECG studies, as specified in both industry coding resources and CMS guidance. The relevant CMS coding Article A57326, Local Coverage Determination LCD L37283 and National Coverage Determination NCD 20.15 for diagnostic electrocardiograms emphasize that coding selection is based on the generation of a 12-lead tracing interpreted by a provider, rather than the precise electrode configuration, provided clinical equivalence and reporting standards are met.

2. **How many times can CPT 93000 be billed per day?**
   CPT 93000 is typically reimbursed once per patient per day; repeat billing requires justification such as technical failure or clinical necessity.

3. **If ECG must be repeated on the same day for the same patient, what modifiers are applicable?**
   Modifiers may be used for special circumstances:
   - **Modifier 59** if two separate and distinct procedures were performed on the same day, on the same patient by the same provider, e.g., a 3-lead ECG and a 12-lead ECG. It unbundles the services that are typically considered part of the same procedure and ensures separate payments.
   - **Modifier 76** should be appended with CPT code 93000 if the same provider repeated the procedure on the same day. Reasons for a repeated procedure may be a technical failure on the first try or obtaining more readings for increased accuracy.
   - **Modifier 77** indicates that a different healthcare provider repeated the electrocardiography on the same patient on the same day. The reason could be that the first provider could not obtain accurate readings.

4. **Why are there two code set options?**
   Given advancements in technology, some payers have begun incorporating specific Category III (T) codes (e.g., 0903T-0905T) for algorithmically generated 12-lead ECGs, such as those generated by the Kardia 12L. Utilization of these codes may be appropriate in certain payer environments, especially as payer policy adapts to emerging digital health solutions. While these do not have payment amounts for physicians today, the T codes may be cross walked to existing codes to support billing and payment.

5. **What criteria must be met to show medical necessity for CPT 93000, 93005, 93010 ECG codes?**
   To show medical necessity for CPT codes 93000, 93005, and 93010 (all representing standard 12-lead ECG services), documentation must clearly support that the test was ordered in response to a patient's symptoms, abnormal findings, or specific clinical concerns—not as part of routine screening or a general exam without relevant indications.
   - **Documented Symptoms or Clinical Indication:** The record must state a reason for the ECG, such as chest pain, palpitations, syncope, shortness of breath, new arrhythmias, suspected heart disease, or pre-procedure evaluations based on risk factors. Routine screening without symptoms is generally not covered.
   - **Relevant Diagnosis or ICD-10 Code:** Claims must match the ECG order to an appropriate diagnosis code, such as those indicating cardiac symptoms, suspected myocardial infarction, arrhythmias, or monitoring for medication effects.
   - **Physician Order and Interpretation:** There must be a written physician order for the ECG (for CPT 93000 and 93005), and a formal interpretation and report by a qualified provider (required for CPT 93000 and 93010).
   - **Full Report and Documentation:** Documentation must include a complete ECG report, the interpretation, and evidence that the test directly addressed the described clinical issue.
   - **Compliance with Coverage Policies:** Tests must comply with payer-specific guidelines, including local (LCDs) or national coverage determinations (NCDs).

6. **How should denied or reduced payments for ECGs be appealed?**
   Addressing claims payment issues can be complicated. The American Medical Association (AMA) offers resources to help physicians secure correct claims payment from health plans and learn insurance refund recoupment laws by state, navigate the overpayment recovery process, and appeal incorrect payments. AMA Tools. For "T" code denials, you may contact reimbursement@alivecor.com.

7. **When will CAT III CPT Codes (0903T, 0904T, 0905T) be converted to CAT I and how does that impact reimbursement?**
   Until a national fee is set, payment for Cat III codes is determined on a local, case-by-case basis, and most codes remain carrier priced or unpaid for several years. To help accelerate progress, AliveCor is actively working to generate and submit supporting clinical evidence and demonstrate widespread use and clinical benefit, moving the Cat III codes toward national coverage as quickly as possible. Meanwhile, we are committed to partnering directly with you—helping support your claim submissions to MACs and commercial insurers. While payment decisions remain at the discretion of each individual payer, we are here to assist you throughout this process and advocate for broader coverage.

   At this time, there is no scheduled date when a national non-facility fee will be established for Medicare Category III T codes. These codes are designed for new or emerging services, and CMS does not immediately assign them a standard fee schedule. Instead, they are typically listed as "carrier priced," which means each local Medicare Administrative Contractor (MAC) makes its own decisions about reimbursement, or may choose not to reimburse at all. Usually, a national payment rate is considered only after a Cat III code has been in use for several years and significant supporting clinical evidence, billing data, and positive outcomes have been submitted and reviewed. This process is not tied to a specific annual timeline.

References

1. CMS Physician Fee Schedule, https://www.cms.gov/medicare/payment/fee-schedules/physician.
2. CMS Modifiers, https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00003604.
3. Electrocardiograms are covered under LCD L37283, LCD 314315 and Article A57476.
4. Electrocardiographic services are covered under NCD 20.15.
5. Cardiac Event Monitoring is covered under LCD L34573.
6. AMA Payment Processing Tools, https://www.ama-assn.org/practice-management/claims-processing/tools-proper-payment-appea
7. AliveCor Instructions For Use, https://alivecor.zendesk.com/hc/en-us/articles/1500000462022-User-Manuals.

Disclaimers

This document provides general reimbursement information only and does not constitute legal, billing, or coding advice. Providers are solely responsible for their coding, billing, and compliance with all payer requirements—policies and rates may change and should always be verified with current, authoritative sources.

Consult your own legal, regulatory, or reimbursement expert before billing for any service. AliveCor is not responsible for any payer's position regarding coding or reimbursement.

Codes included here are commonly used examples—not a complete list. Providers must select codes and modifiers that best describe the actual services rendered. 2026 Medicare national average rates are provided for reference only; actual payment varies by location and facility. Consult CMS articles and Local Coverage Determinations (LCDs) for official Medicare coverage, coding, and billing guidance. For the latest Medicare rates, use the **Medicare Fee Schedule Lookup Tool**. For official coverage and coding policy, visit the **Medicare Coverage Database**.

AliveCor products must be used only consistent with FDA-cleared labeling and regulations. Providers are responsible for medical necessity, accurate service description, and proper site of care.