Medical Necessity Guidelines:
Mobile Cardiac Outpatient Telemetry (MOCT)

Effective: January 1, 2023

<table>
<thead>
<tr>
<th>Prior Authorization Required</th>
<th>Yes ☒ No ☐</th>
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<tbody>
<tr>
<td>If REQUIRED, submit supporting clinical documentation pertinent to service request.</td>
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Applies to:

COMMERCIAL Products
☒ Tufts Health Plan Commercial products; Fax: 617.972.9409
• CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products
☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404
☒ Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 857.304.6304
*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products
• Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List
• Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

To obtain InterQual® SmartSheets™:
• Tufts Health Plan Commercial Plan products: If you are a registered Tufts Health Plan provider click here to access the Provider website. If you are not a Tufts Health Plan provider please click on the Provider Log-in and follow instructions to register on the Provider website or call Provider Services at 888.884.2404.
• Tufts Health Public Plans products: InterQual SmartSheet(s) available as part of the prior authorization process.

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

Tufts Health Plan requires the use of an InterQual SmartSheet to obtain prior authorization for certain Mobile Cardiac Telemetry when used in the outpatient setting.

In order to obtain prior authorization, choose the appropriate InterQual SmartSheet(s) listed below. The completed SmartSheet(s) must be sent to the applicable fax number indicated above, according to Plan.
  • Electrocardiography, Ambulatory

<table>
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<th>CODES</th>
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<tr>
<td>PROCEDURES REQUIRING PRIOR AUTHORIZATION:</td>
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<tr>
<td>Tufts Health Plan will be using InterQual SmartSheet(s) for the following procedure code(s).</td>
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<table>
<thead>
<tr>
<th>ELECTROCARDIOGRAPHY, AMBULATORY</th>
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<td>The following CPT codes require prior authorization:</td>
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<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>93228</td>
<td>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</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Description</td>
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<tr>
<td>93229</td>
<td>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. 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.</td>
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**APPROVAL HISTORY**

January 14, 2015: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC). Effective July 1, 2015, Ambulatory Electrocardiography will require an InterQual SmartSheet(s) for prior authorization of CPT codes 93228 and 93229 only.

Subsequent endorsement date(s) and changes made:
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- December 9, 2015: Reviewed by IMPAC, renewed without changes.
- December 14, 2016: Reviewed by IMPAC, renewed without changes.
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017.
- December 13, 2017: Reviewed by IMPAC, renewed without changes.
- October, 2018: Template and disclaimer updated.
- November 14, 2018: Reviewed by IMPAC, renewed without changes.
- November 20, 2019: Reviewed by IMPAC, renewed without changes.
- November 18, 2020: Reviewed by IMPAC, renewed without changes.
- December 8, 2020: Fax number for Unify updated.
- October 20, 2021: Reviewed by IMPAC, renewed without changes.
- February 1, 2022: Template updated.

**BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION**

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member’s health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of payment, and benefit document.
benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.

Provider Services