

Internal Medicine Coding Alert

Annual Visits: Be Cautious Reporting EKG With AWV

New Medicare stance steers you away from modifier 25.

Medicare now requires a modifier on claims reporting EKGs as part of a patient's annual wellness visit (AWV) for dates of service on or after July 1, 2011.

Scenario: You submit a claim to Medicare with G0438 (Annual wellness visit; includes a personalized prevention plan of service [PPS], initial visit) and EKG code 93000 (Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report). Medicare pays for G0438, but denies the EKG on the grounds that your claim either includes an invalid modifier or is missing a modifier.

"When I called Medicare, they stated that a modifier is now required and it's not modifier 25," says **Nancy Vento**, office manager for Kenosha Family Practice in Kenosha, Wis. "They said I should check the CCI edits. When I did, CCI edits show that a modifier is required, but doesn't say which modifier to use."

If Medicare won't accept modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) on these claims, what are the acceptable options? Read on for advice from real-world coders on how to submit correct claims for EKG during an AWV.

Shift to Modifier 59

Since Medicare no longer accepts modifier 25 for these situations, your best alternative is modifier 59 (Distinct procedural services).

"When I ran the scenario through our code checker for CCI edits after receiving denials, it indicated that -59 is the only acceptable modifier for code 93000," says **Lisa Reno, ACS-EM**, a coder in Exeter, N.H. "Our software is based on Medicare guidelines, and our claims have been paid once we started adding modifier 59."

Difference: One way to help decide whether to append modifier 25 or modifier 59 to your claim is to take a closer look at the service your internist provides. You should only append modifier 25 to an E/M service code. When the physician conducts an EKG along with an annual wellness visit, you don't include an additional E/M code. Because you don't have a separate E/M code, you can't report modifier 25.

Verify Diagnosis and Referrals

Although you should always code based on the physician's documentation, payers always have policies outlining which diagnoses support medical necessity for procedures. Vento says the two diagnoses they use most often for EKG as part of an AWV are 272.4 (Other and unspecified hyperlipidemia) and 401.9 (Unspecified essential hypertension).

Surgeons often want the physician to include an EKG with the patient's history and physical prior to surgery. Payers sometimes require a referring physician's name and NPI (National Provider Identifier) before approving charges for an EKG. Check guidelines for the payer in question to verify whether the patient needs a referring physician before having the EKG.