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Internal Medicine Coding Alert

Clinical Decision-Making Support Necessary: How to Accurately Document When Reporting ECG Codes that Include Interpretation

Many internists either have electrocardiograms (ECGs) performed in their office and interpret the findings or have the patient go to the hospital, where the test is performed and a report is sent back to the physician.

In both situations, how should the internist document that he or she interpreted the test results in order to bill 93000 (electrocardiogram, routine ECG with at least 12 leads; with interpretation of report) or 93010 (ECG, interpretation and report only)?

Note: Code 93005 is for tracing only, without interpretation and report.

According to HCFA, there should be documentation when a physician charges for reading an ECG, writes **Teresa Burnett,** reimbursement specialist with the Clark-Holder Clinic, a 42-physician multi-specialty clinic in LaGrange, GA. However, most ECGs have a machine-printed interpretation and many doctors just sign off on that. The last time I contacted HCFA, this was not acceptable. Has this regulation changed?

The HCFA official contacted by ICA instructed us to contact the regional carrier to determine the medical policy regarding ECG documentation. The regional carrier for the state of Georgia is Cahaba Government Benefits Administrators, Inc. in Savannah, which directed us to their medical review policy on their Website.

According to the review policy for ECGs, these are the documentation requirements:

1. Documentation supporting the necessity of this service, such as ICD-9 codes, must be submitted with each claim. Claims submitted without such evidence will be denied as being not medically necessary.

2. For ECG services furnished by a laboratory or portable x-ray supplier, identify the physician ordering the service, and when appropriate, the physician performing the interpretation.

3. When ECGs are performed in a patients home, documentation must show the medical necessity of such a service.

4. The documentation required in the various situations mentioned above (in the carriers ECG coding guidelines) must be furnished on the 1500 claim form where requested, both at the time when the laboratory or portable x-ray supplier bills the patient and carrier for its services, and also when such a facility bills the attending physician who, in turn, bills the patient or carrier for the ECG services. (In addition to the evidence required to document the claim, the laboratory or x-ray supplier must maintain in its records, the referring physicians written order and the identity of the employee taking the tracing.)

Is Separate Report Necessary?

Because these stipulations did not address what constitutes adequate documentation of an ECG interpretation, we contacted three independent coding experts to get their opinion of whether an interpretation requires a separate report. Here are their opinions:

1. Independent interpretation necessary.

Even if the machine prints out a technical interpretation, there must be some documentation to support how the

physician arrived at a clinical interpretation, states **Randy Thompson, CPC,** a consultant with Healthcare Consultants of America, Inc., in Augusta, GA.
They have to have some kind of separate note th
ere, even if it is on the ECG printout, that indicates their interpretation of the findings, he says. Otherwise, they are just letting the machine do the interpretation which is within the technical component of the test.

Sue Prophet, RRA, CCS, director of classification and coding with the Chicago, IL-based American Health Information Management Association, the representative organization of 38,000 health information management professionals, says If you charge an individual fee for something, it has to be supported by individual documentation. However, a lot of times what physicians will do is get a technical readout from the machine that has the technical information, such as lead S1 indicated this, etc., and then the machine will conclude that the test was normal or have an indication that states atrial fibrillation. I have seen physicians indicate that they agree with that interpretation and write normal or atrial fibrillation on the printout to indicate that they reviewed the technical information as well and reached that conclusion.

Thompson says that he still prefers to see a separate note in the patients chart when he audits charts for clients, but that he will accept a notation on the ECG printout that is included in the chart.

There is really not that much documentation that is required for an ECG interpretation, but if they just sign off on what the machine said then, no, I wouldnt give them credit for it, he says. They need something that they can call a written report.

2. Interpretation cannot be reported twice.

On a related note, Thompson emphasizes that if the physician used his ECG interpretation to count toward a particular level of evaluation and management (E/M) service then the interpretation cannot be billed separately with the ECG code.

If they have an E/M service and they give the interpretation of the ECG in their visit notethere is a place in the E/M documentation guidelines where you get credit for review of test results and other informationyou can count the ECG interpretation in one place or another but not in both, he says. You cant count it in the visit portion as review of test results and with the ECG code as an interpretation, that is double-dipping.

3. Interpretation should be reported on the date read, not on date ECG was performed.

Some carriers even prefer to see the code for ECG with interpretation reported with the date of service given as the date the test was read by the physician, even if that date is later than the date the test was performed, says **Jim Stephenson, CPC,** billing manager for Premium Medical Management Services, a 20-physician multi-speciality practice in Elyria, OH.

Stephenson, whose previous experience was entirely in internal medicine coding, recently took the position with Premium, which also employs two cardiologists.

These guys read 20-30 ECGs a day for patients, he notes. He recently consulted an expert in cardiology billing to ensure that he was up to speed on all of the requirements.
:One thing that threw me for a loop was that our billing for the interpretation should be the day that it is read, when the test is performed on a different day, he explains. It might seem like there would be some unnecessary denials from that, but it seems that this is what Medicare prefers.

However, Stephenson does note that the date
requirement is not explicitly spelled out in the carrier manual, so coders might want to check with their carrier representative.