

# Internal Medicine Coding Alert

## Correct Coding for Cardiac Event and Holter Monitoring

Physicians must clearly define whether monitoring is cardiac event or holter to avoid incorrect coding of the procedure.

Because most physician groups use an outside service to provide the actual monitoring equipment, the physician should only report 93270 or G0005 for the hook-up and patient instructions, says **Barbara Cobuzzi, MBA, CPC**, president of Cash Flow Solutions Inc., a physician reimbursement consulting firm in Lakewood, N.J.

Cardiac event monitoring, sometimes confused with holter monitoring, is used to detect heart arrhythmias. Patients discharged from the hospital after a myocardial infarction, on antiarrhythmic medications or whose chest pain is difficult to diagnose, may be put on a cardiac event recorder. These patients are given a special ECG machine that allows them to record events at home and transmit data over the telephone to a central processing unit, which produces a printout of the data for physician interpretation.

For private payers, these services are reported as 93268 (patient-demand single or multiple event recording with presymptom memory loop, per 30 day period of time; includes transmission, physician review and interpretation), 93270 (recording [includes hook-up, recording, and disconnection]), 93271 (monitoring, receipt of transmissions, and analysis) or 93272 (physician review and interpretation only).

Medicare has established specific HCPCS codes for these services:

G0004patient demand single or multiple event recording with presymptom memory loop and 24-hour attended monitoring, per 30 day period; includes transmission, physician review and interpretation;

G0005recording (includes hook-up, recording, and disconnection);

G000624-hour attended monitoring, receipt of transmissions, and analysis; and

G0007physician review and interpretation only.

Tip: For more information, see the Medicare Coverage Issues Manual, policy 50-15. The manual can be downloaded from the Health Care Financing Administration Web site, [www.hcfa.gov](http://www.hcfa.gov).

### Billing for the Professional Service

G0004 and 93268 are the global codes for the initiation of cardiac event monitoring, explains **Alison Morris, CCS**, coding supervisor at Fayette Medical Clinic, in Fayetteville, Ga. The physician should report either G0007 or 93272 for event monitoring.

The physician should use either code to report the professional component for hook-up and patient instruction and can then report a code for the interpretation (93272 for private payers or G0007 for Medicare) once per month, adds Cobuzzi.

Note: This assumes the physician and not the provider of the equipment performs the hook-up and patient instruction. If the physician does not provide this service, he or she can only bill for an interpretation and report.

In Cobuzzis region, Medicare pays \$54.98 for code G0005. Then the physicians review and interpretation can only be charged one per month, no matter how many times it is done, she states. In New Jersey, that only pays \$35.50, and it doesnt matter how many times you review the data. You only report the code once every 30 days. If the patient still has

the recorder on for the next 30 days, you can report one instance of the code again.

At most, you get just under \$100 total for this service, she explains. Just because someone tells you that other doctors are doing it and getting paid, doesn't mean it is correct. It is good to get coding information from your vendors as a starting point, but you need to go back and check this information with Medicare rules and your other payer policies.

### **Cardiac Event Monitoring vs. Holter Monitoring**

Cardiac event recording is sometimes confused with holter monitoring, in which the patient wears a portable ECG machine to monitor the patient's heart during daily activities. The monitor is worn for 24 hours and then an interpretation and report is made by the physician. These services are reported with codes 93224-93237 for both Medicare and private payers, says Morris.

Unless the physician or group owns the equipment, the physician should report code 93227, 93233 or 93237, depending on which type of monitoring equipment is used.

According to Empire Medicare Services, the Medicare Part B contractor for New York and New Jersey, holter monitoring of less than 12-hour duration should be reported as a standard ECG with codes 93000, 93005 or 93010, as appropriate.

For cardiac event monitoring, Empire Medicare's local review policy indicates that physician documentation should include a history, physical, ECG and other work-up suggesting arrhythmias as a possible source of symptoms; recent discharge from the hospital after an acute myocardial infarction; documentation of chest pain with history, physical, ECG and other tests unable to identify the etiology of the symptoms; and the need for home service, if applicable.

In addition, Cobuzzi recommends that physicians record the from-through dates in the patient record. In other words, record the date of the first interpretation through the end of the period for which the physician is billing. Personally, because G0007 is supposed to indicate a month, I would include the from-through dates, from the first strip that you read through the end of the month.