Internal Medicine Coding Alert

Follow 5 Sure-Fire Tips to ECG Coding Success

E/M code lets you capture review credit.

Attaching an incorrect modifier to an electrocardiogram (ECG or EKG) code can lead to denials and more time spent correcting the claim. Read on for time-saving advice that will get your claim paid on initial submission.

1: Drop 26 and TC from ECG Codes

An ECG is one diagnostic test for which you won't need to append the usual 26 (Professional component) or TC (Technical component) modifiers.

"For an EKG the professional and technical components are captured through the CPT codes," notes **Catherine Gray, RHIT, CCS, CPC-I/Cardio/GI,** a medical services auditor with the Henry Ford Health System in Detroit. Code 93000 is for the professional and technical components together, 93005 represents the technical component alone, and 93010 is for the professional component alone, she says. Here's how it breaks down:

93000 -- Electrocardiogram, routine ECG with at least 12 leads; **with interpretation and report**

93005 -- Electrocardiogram, routine ECG with at least 12 leads; tracing only,**without interpretation and report**

93010 -- Electrocardiogram, routine ECG with at least 12 leads; **interpretation and report only.**

Example: If the internist provides only the interpretation and report for an ECG performed at a hospital, you should report 93010, not 93000-26 (Professional component).

2: Code One Physician Interpretation per Test

Make sure that another physician is not also reporting 93000 or 93010 for interpretation of the same ECG tracing. "Most payers will pay for an interpretation only one time," says Gray.

Generally, payers reimburse for only one EKG interpretation for an emergency room patient, points out **Bruce Rappoport, MD, CPC, CHCC,** a board-certified internist and medical director of Broward Health's Best Choice Plus and Total Claims Administration in Fort Lauderdale, Fla. Thus, if another physician is already reporting the interpretation and report, you may not report your internist's review of the same diagnostic test.

Exception: Contractors may cover a second interpretation only under unusual, documented circumstances, such as a questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed, or a changed diagnosis resulting from a second interpretation of the tracing, according to the Medicare Claims Processing Manual(MCPM), Chapter 13, Section 100.1 (www.cms.gov/Manuals/IOM/list.asp).

Modifier: To report a second review under the above described circumstances, append modifier 77 (Repeat procedure by another physician) to the ECG interpretation code (93000 or 93010) on the claim, instructs the MCPM.Modifier 77 tells the payer that the second physician provided a medically necessary repeat service -- in thiscase, a second EGG interpretation and report.

3: Count Test Reviews toward E/M Level

Although your internist may not be able to report a second interpretation, don't forget to consider this work when selecting the correct E/M level for a patient encounter.

If a patient receives an ECG study with interpretation and report elsewhere, and the internist then reviews the earlier diagnostic studies as part of a patient visit, report an E/M code (99201-99239, depending on the place of service, whether the patient is new or established, and the complexity of medical decision making) for the visit that captures the internist's review of relevant ECGs and other tests.

Tip: Reviewing more data points may qualify the encounter for a higher E/M code, so make sure that the review of diagnostic studies is documented adequately in the chart, suggests Gray.

Example: "Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data being reviewed," states the 1995 Documentation Guidelines for Evaluation and Management Services (www.cms.gov/MLNProducts/Downloads/1995dg.pdf). Besure to document "the direct visualization and independent interpretation of an image, tracing or specimen previously or subsequently interpreted by another physician," state the E/M documentation guidelines.

Reminder: Medicare covers review and interpretation of ECGs only when performed by a physician, according to the ECG national coverage determination (NCD) found here: www.cms.hhs.gov/transmittals/downloads/r26ncd.pdf.

4: Justify 12 Leads with Diagnosis

Add a diagnosis code to the claim form that describes the patient's condition and reflects medical necessity for an ECG.

An ECG is of significant value in evaluating and managing certain conditions, says **Ashleigh A. Raubenolt, CPC, CPC-H, CPC-P, CPMA, CEMC, CHCA,** director of chart watch auditing and review, and credentialing and physician contracting, at S.A. Medical of Virginia Inc. in Fredericksburg. Examples of these conditions include:

- acute myocarditis (422)
- cardiac arrhythmias, such as sinus bradycardia (427.81, Sinoatrial node dysfunction)
- acute myocardial infarction (410.xx)
- unstable ischemic heart disease without infarction (411.x)
- patients with implanted cardiac devices (V45.xx)
- acute pericardial disease (420, Acute pericarditis)
- mitral stenosis (394.0).

The above is a summary; for a more thorough list of conditions which would support medical necessity for an ECG, review an example ECG Local Coverage Determination (LCD) on Highmark's Web site: www.highmarkmedicareservices.com/policy/mac-ab/l27490-r5.html.

Don't forget to support the medical necessity of the ECG service as well as the frequency for which it is performed in the patient's record. Documentation may include history and physical, progress notes with presenting symptoms, laboratory/diagnostic test results, and active treatment protocol, states the Highmark LCD. Office/progress notes must contain the date of service and the physician's signature.

5: Include a Detailed Written Report

Stay alert to what Medicare will accept as documentation for ECG interpretation.

Carriers distinguish between an ECG "interpretation and report," which is reportable with an ECG code, and a "review," which is included in the E/M service, according to MCPM, Chapter 13, Section 100.1.

Why: The "review" is already included in the emergency department E/M payment. For example, a notation in the medical records saying "ECG-normal" would not suffice as a separately payable ECG interpretation nd report of the procedure and should be considered a review of the findings payable through the E/M code, states the MCPM.

What to do: To report an ECG interpretation, the internist must provide a written report similar to that which a cardiologist would prepare.

Additionally, "interpretation and report" should address the findings, relevant clinical issues, and comparative data when available, adds Raubenolt.

Example: "An ECG with interpretation must have the full graphic tracings with formal written interpretation on file for review ... at a minimum, interpretations should include appropriate comments on rhythm, rate, axis, acute or chronic changes, and a comparison with the most recent tracing (if available). Appropriate measurements must be mentioned if the purpose of repeated ECGs is to monitor the effects of a given parameter, e.g., the QT interval,"states the Highmark LCD. Also, ECGs that are electronically read must be over-read, corrected, and signed. A physician's order must be documented in the medical record requesting ECG performance.

Be sure to check individual carriers for their specific requirements.