Part B Insider (Multispecialty) Coding Alert

Documentaton: The Denial Is in the Details for Routine EKGs

Documentation doesn't have to be separate, but it must be identifiable

When an emergency physician interprets a routine electrocardiogram (EKG), he may believe that "routine" means simple. But in fact, if the physician isn't documenting the results of that EKG in some detail, he can kiss his reimbursement goodbye.

If a doctor writes something like "Reviewed EKG, and EKG is within normal levels," he probably won't get paid, says **Steve Verno**, director of reimbursement for Emergency Medicine Specialists in Hollywood, Fla.

"A lot of carriers consider interpretation of an EKG bundled with the evaluation and management procedure," Verno says. "They're wrong." He cites the language on page 2 of the CPT manual that states performance and interpretation of diagnostic tests aren't included in E/M services, and providers should use modifier -26 (Professional component). It also says you need a "distinctly identifiable written signed report" to prove that a diagnostic test was separate. And here's where many ED physicians fail to make their cases.

The danger with insufficient documentation is that it'll look like a review of diagnostic information to be included in medical decision-making, which most definitely is part of E/M services, says **Kenneth DeHart**, president of Carolina Health Specialists in Myrtle Beach, S.C.

"As far as brass tacks," a report on an EKG interpretation would need to comment on "at least the rhythm, the rate, QRS morphology, and ST segment morphology," DeHart says. "The sniff test is, is this interpretation and report similar or dissimilar to that which I might be seeing from a cardiologist?" The ED physician's documentation needs to look as much like a cardiologist's as possible, DeHart says.

While the Centers for Medicare & Medicaid Services doesn't specifically require those four measures, they're a good benchmark. Your physician should come up with policies that conform to accepted local medical standards, DeHart says.

If the physician failed to note the details of an EKG interpretation at the time, he can always amend the medical record with more information, Verno says. (See box below.) If coders see a file with insufficient documentation, "They should send the record back to have the documentation support what you're going to code," Verno adds.