# Internal Medicine Coding Alert

## Optimize Reimbursement for Preoperative EKGs

Internists are frequently asked to perform an electrocardiogram (EKG or ECG) as part of a preoperative evaluation of a patient. Local Medicare carriers, however, have recently either dropped the ICD-9 diagnosis code for preoperative cardiovascular evaluations (V72.81) from their list of covered diagnoses or have added criteria that must be met before a preoperative code can be used. Internists seeking reimbursement from Medicare for a preoperative EKG may need to revise the diagnosis codes used to bill this service, in addition to meeting the other documentation requirements stipulated by their local carrier.

An EKG is the most commonly used laboratory procedure for the diagnosis of heart disease. The test can be used to identify cardiovascular disease, assess the effectiveness of treatment and detect potentially serious cardiac disorders as part of a preoperative clinical evaluation.

This procedure contains a technical component that represents the value assigned to the ownership and maintenance of the equipment used to do the EKG and the use of any technicians, and a professional component that represents the physicians interpretation of test results. With the EKG, however, the standard modifiers -TC for the technical component and -26 for the professional component are not used.

Instead, 93000 (electrocardiogram, routine ECG with at least 12 leads; with interpretation and report) is the global code used when the internist owns (or partially owns by being a partner in a practice) the EKG equipment being used and interprets the test results, according to **Jim Stephenson,** billing manager for Premium Medical Management, a multispecialty physician group practice in Elyria, Ohio. When the internist does only the interpretation of the test results, 93010 (electrocardiogram, routine ECG with at least 12 leads; interpretation and report only) should be reported. Code 93005 (electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report) should be reported only for the administration of the EKG by the owner of the equipment.

**Code for Underlying Condition**

Medicare reimburses only for diagnostic EKGs; it does not cover screening tests for asymptomatic patients. Usually an EKG is done for diagnostic purposes unless one is run for an annual physical or possibly for pre-op clearance, says Stephenson. Anything that can be associated with a routine physical is going to be denied by Medicare.

Because of fears that the EKG has been overused as a preoperative clearance tool, several local carriers have revised their reimbursement policies. On May 1, 2000, Empire Medicare Services of New Jersey dropped the ICD-9 diagnosis code for preoperative cardiovascular examination from its list of covered diagnoses for an EKG. Carriers in other states such as New York (Empire Medicare Services and the Upstate Medicare Division), Virginia and Colorado also exclude this diagnosis code from coverage.

Internists whose Medicare carrier does not specifically reimburse for the pre-op evaluation code need to indicate on the claim form the reason they have been asked to do the evaluation, according to **Felecia Bernstein, CPC, EMT,** an independent coding consultant in Deal, N.J., and president of the Monmouth County N.J. chapter of the American Academy of Professional Coders. Not doing an EKG in a pre-op clearance would be poor medical judgment, but using the pre-op cardiovascular exam code means not getting paid in some states, she says. If the patient has a cardiovascular problem, most of those codes are covered and could be used. If the patient is being tested because of other covered conditions such as diabetes (250.00-250.93) or hypothyroidism (244.0-244.9), those could be indicated also.

The internist may want to assign the primary diagnosis code for the EKG based on the final test results if the exam indicates a definitive diagnosis, Bernstein adds. If the exam is normal and a definitive diagnosis was not made, then the

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internist should code for the appropriate signs or symptoms that prompted the EKG in the first place.

**Secondary Diagnosis Code May Be Required**

Even when a carrier does include a pre-op examination code in its list of covered diagnoses, there may be secondary diagnoses that must be coded or additional stipulations that must be met in order to receive reimbursement. Effective June 1, 2000, Nationwide Medicare, the Part B carrier in Ohio and West Virginia, requires when an EKG is used as part of a pre-op evaluation that the patient must have one of the following conditions, which must be coded on the claim in addition to code V72.81: diabetes mellitus (250.40-250.73), atherosclerosis of extremity arteries (440.20-440.9, 443.9-444.9), aortic aneurysm (441.00-441.9), cerebrovascular disease, carotid artery (433.10-433.11) or cerebrovascular disease, other (434.00-436).

Both Florida and California also cover the pre-op examination code, but each has two additional restrictions with that diagnosis code. National Heritage Insurance of California will only reimburse for a pre-op EKG when the patient is a male over the age of 40 or a female over the age of 50 **and** the surgery for which the preoperative test is being doing requires general or regional anesthetic. First Coast Service Options of Florida will only reimburse when the pre-op patient has a medical condition associated with a significant risk of serious cardiac arrhythmia and/or myocardial disease, **or** is undergoing cardiac surgery.

Whether the pre-op code is explicitly covered or not, Bernstein suggests that internists get their EKG patients to sign a waiver acknowledging that they will be financially responsible for services denied by Medicare. The waivers may also be used with patients from commercial insurance companies, which may take their cue from Medicare and also deny claims for preoperative EKGs. Usually where Medicare goes, all the other payers follow, says Bernstein.

**Billing for Two Interpretations**

Occasionally, an internist who does an interpretation of an EKG may call in a cardiologist to do a second interpretation of the test results on the same day. In this situation, can both physicians bill for the test interpretation? Stephenson and Bernstein agree that usually when multiple claims are filed for the same interpretation, payment will be made on the first claim received. Bernstein, however, also believes that there may be occasions when both physicians will be paid.

Consideration for a second interpretation may be made if unusual circumstances are documented by the provider, she says. For example, if theres a questionable finding for which the internist performing the initial interpretation believes another physicians expertise is needed. In that case a modifier -77 (repeat procedure by another physician) should be attached to the second interpretation.

**Notation in Patient Record Not Enough**

Regardless of whether the EKG is being done as a pre-op exam or to diagnose a possible cardiovascular condition, internists need to properly document their test results to satisfy Medicares requirements that an interpretation and not just a review of the EKG was performed.

A notation in the medical records saying an EKG is normal would not be enough to qualify as a separately payable interpretation and instead should be considered a review of the findings payable through an evaluation and management code, explains Bernstein. An interpretation and report should address the findings, relevant clinical issues and comparative data. In addition, documentation supporting an interpretation and report should be evident in the patients medical record.

The computer interpretation produced by the EKG machine is also not considered a suitable interpretation and report. Because of frequent and often significant errors of interpretation, it is mandatory that all computer-interpreted ECGs are verified and appropriately corrected by the interpreting physician, reads National Heritage Insurance of Californias local medical review policy. If the physician agrees with the printout, he or she may indicate this without rewriting the results by documenting review and agreement. The physician must sign his or her official interpretation of the test.

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In Stephensons practice, the internists use computer-generated EKG interpretations, but they may also write their own notes on the computer printout. In addition, they will make notes pertaining to the findings in the patients chart, where there will also be a copy of the interpretation itself, he explains.

Because local Medicare carriers and commercial insurance companies are reviewing and revising their polices regarding preoperative EKGs, internists should contact their local payers for instructions regarding CPT and ICD-9 coding instructions for this procedure.

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