## Diagnostic Interpretations

### Finesse Your EKG Interpretation Claims With This Can’t Miss Documentation Advice

**Does your chart include the required elements to stand up under audit?**

If you’re getting repeat denials when your ED physician interprets electrocardiograms (EKG), it’s time to stop and ask yourself some critical questions, including whether the documentation meets Medicare’s definition of interpretation and whether the notes clearly identify which ED provider did the interpreting and why the EKG was ordered.

**Reality:** One of the most frequently reported non-E/M services in the emergency department is for EKG interpretation; unfortunately, these codes are also among the most frequently contested services as well.

**E/M link:** A review of a previously interpreted EKG has value in E/M code Medical Decision Making, but in a totally different way from being separately billable.

Follow these tips from Caral Edelberg, CPC, CPMA, CAC, CCS-P, CHC, President of Edelberg Compliance Associates in Baton Rouge, Louisiana, to make sure you are meeting the required documentation for appropriate payment.

**Look for Rhythm Report Reason**

The CPT® book includes two codes describing interpretation and report of diagnostic cardiographs or the tracings of heart rhythms.

- 93010 (Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only)
- 93042 (Rhythm ECG, 1-3 leads; interpretation and report only)

The preamble to this code section of CPT® instructs that there must be a specific order for an electrocardiogram or rhythm strip followed by a separate, signed, written, and retrievable report. The need for an electrocardiogram or rhythm strip should be supported by documentation in the medical record.

In the case of the 93042 code, you would not report it when the ED physician simply reviews the telemetry monitor strips taken from a monitoring system. The required specific order for 93042 should be supported by a diagnosis or symptom as the triggering event. To support medical necessity for the service, clinical information demonstrating the need to evaluate for the presence or absence of an arrhythmia, cardiac ischemia, or other cardiovascular problem should be present within the medical record, instructs Edelberg.

In the ED, the physician would not typically report the global codes 93000 (Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report) or 93040 (Rhythm ECG, 1-3 leads; with interpretation and report) because the physician...
What Does Separately Identifiable Mean? Heed Medicare’s Advice on What Constitutes a Written Report

Medicare states that the EKG interpretative report must be a complete written report similar to that usually prepared by a specialist in the field and should be consistent with the service furnished.

Medicare policy also states an “interpretation and report” should address the current findings, relevant clinical issues, and comparative data when available.

Discern Review from Interpreted Report

A chart notation of “EKG normal” is deemed an insufficient interpretation and report and would be considered a “review” rather than an interpretive report. This is the type of “review” that would be included as part of the “Amount and Complexity of Data Reviewed” element of Medical Decision Making, says Caral Edelberg, CPC, CPMA, CAC, CCS-P, CHC, President of Edelberg Compliance Associates in Baton Rouge, Louisiana

Although individual payers may develop their own standards, some Medicare carriers follow the requirement that an EKG interpretation should include at least 3 of the following 7 elements:

- Rhythm
- Rate
- Axis
- Intervals
- ST Segment Change
- Comparison to a prior EKG
- Summary of clinical condition

Medicare does not require that the ECG interpretation be recorded on a separate piece of paper; rather a complete written interpretation can be recorded within the emergency department treatment records. However, some Medicare carriers have independently established more restrictive criteria.

Follow These Documentation Tips

To qualify as separately identifiable, consider chart documentation similar to a procedure note or include a separate area on a templated documentation form for EKG interpretation. Be sure it clearly identifies who is providing the interpretation, particularly when more than one provider (MD, PA or RNP) or residents are involved in the treatment of the patient.

When residents do the interpreting: Providers should be aware of the requirements that Medicare applies to resident physicians interpreting diagnostic studies: “If a resident prepares and signs the interpretation, the teaching physician must indicate that he/she has personally reviewed the image and the resident’s interpretation and either agrees with it or edits the findings. Medicare does not pay for an interpretation if the teaching physician only countersigns the resident’s interpretation.” states CMS Transmittal 2303, released Sept. 14, 2011.

While EKGs are not specifically mentioned in the transmittal, individual carriers may extrapolate this language to include EKGs. Many of the individual carrier policies simply echo national CMS policy as to what should be included in an interpretation and report, but some carriers have developed their own specific documentation requirements for EKG interpretations. You should check the Local Coverage Decision (LCD) for your state to be sure you are in compliance with your carrier.
does not typically own the EKG machine nor employ the staff who actually administers the test.

Don’t Settle For Payers Bundling EKG Interpretations Into The E/M Service

Code choice aside, some payers refuse to reimburse for diagnostic interpretations in the ED setting, claiming they are bundled into the E/M service and counted in the amount and complexity of data reviewed component of medical decision making, warns Edelberg.

EKG services should be separately reimbursed unless there was simply a “review” of the tracing provided rather than the CPT® defined “separately distinctly identifiable signed written report.” CPT® is quite clear in the E/M services guidelines that the actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the levels of E/M services. Physician performance of diagnostic tests/studies for which specific CPT® codes are available may be reported separately, in addition to the appropriate E/M code if appropriately documented., she says.

**Edelberg’s Critical care tip:** Reporting EKGs with critical care services should also be allowed, as long as you report the critical care time net of the time spent providing the separately billable EKG or Rhythm Strip interpretation. Although CPT® does mention EKGs in the Critical Care preamble regarding services bundled into those codes, that reference to is specific to the specific code 99090 (Analysis of clinical data stored in computers e.g. ECGs, blood pressures, hematologic data). The services associated with codes 93010 and 93042 are not specifically listed, so they can be appropriately reported in addition to Critical Care Services.

**Ultrasound Coding**

**Probe Carefully to Ethically Maximize Ultrasound Reimbursement**

Diagnostic imaging services are under increased payer scrutiny. Learn these tips to make sure your code choices are secure.

More and more EDs are using ultrasound services for diagnosis, but ED coders may not be fully up to speed on reporting these quick and non-invasive visualizations. Take a close look at the advice that follows to get an easy-to-apply view of the requirements for successful ultrasound billing.

**Getting started:** For diagnostic ultrasound codes, look in the radiology section of the CPT® book using codes 76506 through 76999, instructs Michael A. Granovsky, MD, FACEP, CPC, President of LogixHealth, a medical coding and billing company in Bedford MA. The codes are organized by anatomic area with greater specificity of organs or structures visualized grouped by specific study. (See Sidebar for common ED ultrasound procedures)

**Check These 4 Overarching CPT® Requirements**

The preamble to the diagnostic ultrasound section of CPT® lists these 4 requirements:

1. Medical necessity – The medical record documentation must indicate why the test was medically necessary. Payers have expressed concerns that imaging in general and ultrasound in particular are being over utilized based on significant increases in reporting volume. Be sure the diagnosis or symptoms that indicated the need for the ultrasound study are included on your claim.

2. Interpretation – A written interpretation and report must be completed and be maintained in the patient’s medical record. The report should note the organs or anatomical areas studied, and include an interpretation of the findings.

3. Identify the provider – The record should be clear about who is performing and/or interpreting the study.

4. Image Retention – An appropriate image(s) of the relevant anatomy and/or pathology must be permanently stored and available for future review.

**Distinguish Complete vs. Limited exams**

CPT® makes a point to distinguish between those codes in certain anatomic regions that describe “complete” and “limited” ultrasound codes. The elements that comprise a “complete” exam are typically listed in the in the introductory section language or specific code descriptor, says Granovsky.

As an example, the CPT® language in the introduction to the abdominal and retroperitoneum ultrasound section reads as follows “A complete abdominal ultrasound (76700) would consist of real time scans of the: liver, gall bladder, common bile duct, pancreas, spleen, kidneys, upper abdominal aorta and inferior vena cava.”

(Continued on next page)
In this case, the report should contain a description of all the listed elements or the reason that an element could not be visualized, such as when the gall bladder has been previously surgically removed and not present for a complete abdominal exam. If less than all the required elements for a “complete” exam are reported, as when a limited number of organs or a limited portion of region evaluated is visualized or documented, the “limited” code for that anatomic region should be used instead., says Granovsky.

He goes on to say, all ultrasound diagnostic examinations require recorded images with measurements when such measurements are clinically indicated. In order for an ultrasound study to be separately coded, there must be a thorough evaluation of organ(s) or anatomic regions, image documentation, and a final, written report. Without all of these elements the examination is not separately reported and would be considered part of any Evaluation and Management service which occurred during that session.

For services performed in a facility, the physician would typically report the interpretation with modifier 26. Even if the physician personally performs the ultrasound rather than a tech, use of the code without a modifier may not be appropriate as the facility has provided the room and most likely the equipment, Granovsky adds.

Be Aware of These Barriers to Successful Ultrasound Reporting

Your emergency physician group may perform ultrasound testing but may not separately bill for those procedures due to several recurring factors. A recent survey by the American College of Emergency Physicians (ACEP) Ultrasound Section lists these potential barriers to successfully ultrasound reporting:

- Archiving the required images
- Documenting a full report
- Political issues within the hospital
- Low reimbursement for the codes
- Payers not recognizing emergency physician training to provide ultrasound services
- Payers rejecting ultrasound services as being separately payable with an E/M code

The survey results didn’t identify any of these as “major barriers” to billing for the codes, but be aware that they can present some challenges.

Although CPT® does not specifically require an emergency physician to be credentialed to provide ultrasound services, a hospital or payer may. If your hospital, state, or a certain payer requires some certification process before deeming a provider eligible to report ultrasound, it will negatively impact your ability to get paid.

**Capture MDM Points for E/M With Ultrasound**

Even if you do not bill separately for ultrasounds because of credentialing or turf issues in your facility, the ultrasound may contribute to the overall medical decision making (MDM). Ordering a test and the direct visualization of the study can add points in the amount and complexity of data reviewed section, which are counted towards the overall MDM score.

Consider these coding examples from Granovsky:

**Example 1** A 35-year-old male drives into a tree at 30 miles per hour. His vital signs are stable but he then becomes tachycardic and complains of abdominal pain. He experiences no loss of consciousness but complains of neck pain.

The workup included a physical exam, a C-spine x-ray series, lab work, and a FAST exam with documentation of direct visualization of the images for the abdominal and cardiac components of the FAST (see EDCA archive story on FAST exams Vol. 14, No 6, p. 37).

According to a typical Marshfield Clinic Score Sheet grid, you have supported one of the requirements for high complexity MDM by scoring a total of four data points:

- 1 point for ordering the C spine X ray
- 1 point for review of the lab work,
- And with addition of the ultrasound study,
- 2 points for the independent visualization of the ultrasound images.

**Example 2** A 55-year-old male presents with a painfully red swollen area on the right lower leg. He has a history of insulin dependent diabetes and a pulse of 102 with a low grade fever.

The clinical course includes a CBC, an order for the old records, as well as ordering an ultrasound exam of the lower extremity to evaluate for the presence of an abscess.

<table>
<thead>
<tr>
<th>Common ED Ultrasound Codes</th>
</tr>
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<tbody>
<tr>
<td>76536 Ultrasound, soft tissues of head and neck (e.g., thyroid, parathyroid, parotid), real time with image documentation</td>
</tr>
<tr>
<td>76604 Ultrasound, chest (includes mediastinum), real time with image documentation</td>
</tr>
<tr>
<td>76705 Ultrasound, abdominal, real time with image documentation; limited</td>
</tr>
<tr>
<td>76775 Ultrasound, retroperitoneal (e.g., renal, aorta, nodes), real time with image documentation; limited</td>
</tr>
<tr>
<td>76857 Ultrasound, pelvic (non-obstetric), real time with image documentation; limited</td>
</tr>
<tr>
<td>93308 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study</td>
</tr>
</tbody>
</table>
According to a typical Marshfield Clinic-type scoring grid, you might score the following with regard to amount and complexity of data reviewed:

» 1 point for ordering for a clinical lab test (CBC)
» 1 point for decision to obtain old records (the ultrasound)
» 1 point order of a radiology study

You have now supported 1 area of moderate complexity medical decision making.

**Example 3** A 25-year-old male presents to the ED following a rollover MVA. Vitals are as follows:

BP 80’s, HR 120, Belly firm. The physician is concerned about a ruptured spleen and performs a FAST exam evaluating both the abdomen and the pericardial area. Documentation of both the abdominal and cardiac components are present in the record.

The following ultrasound codes would be reported:

» 76705 (Ultrasound, abdominal, real time with image documentation; limited)
» 93308 (Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study).

### Influenza Vaccine Coding

**Look Sharp at New Vaccine Codes For The 2011 Flu Season**

Double check your code assignments to make sure you comply with payer instructions.

Flu season can be a busy time in the emergency department, especially if an epidemic hits the area. Although ideally not the place for preventive care, your ED physician may provide flu shots for certain patient populations that seek treatment there. To better recoup deserved reimbursement for these services, take note of the differences between CPT® and Medicare for flu vaccine codes.

CPT® has several codes describing administration of influenza virus vaccine depending on the formula of the vaccine, method of administration, and age of the patient.

For example, the variables of “split virus” and “preservative free” and “pandemic formula H1N1” are used to differentiate codes describing specific vaccinations.

**Tip:** Watch for intramuscular as opposed to intranasal delivery in the notes to select the code that accurately describes the service provided.

### 2011 CPT Codes for Influenza Vaccine Administration

» 90656 Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
» 90657 Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use
» 90658 Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use
» 90660 Influenza virus vaccine, live, for intranasal use
» 90661 Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use

» 90662 Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use
» 90664 Influenza virus vaccine, pandemic formulation, live, for intranasal use
» 90666 Influenza virus vaccine, pandemic formulation, split virus, preservative free, for intramuscular use
» 90667 Influenza virus vaccine, pandemic formulation, split virus, adjuvanted, for intramuscular use
» 90668 Influenza virus vaccine, pandemic formulation, split virus, for intramuscular use

You Be the Coder

**Nail Down the Correct Code For This Finger Injury**

**Question:**

Wound Repair of 1cm (0.4 in) involving nail bed laceration to dorsal aspect of distal phalanx of left middle finger. Irregularly shaped. Skin/tissue flap noted. Distal neuro/vascular/tendon intact. Anesthesia: Digital block administered with 4 mls of 1% lidocaine. 
Wound prep: Moderate cleansing with Betadine, Wound explored moderately, Copious irrigation. Subungal hematoma is drained. Nail avulsed fully and removed. Closed with 8 5-0 chronic and nail bed repaired, nail reattached and tacked down with 2) 5-0 vicryl sutures. Dressed with Bacitracin, tube gauze.

**Answer:** See page 79.
Medicare Has Its Own Codes

Medicare has its own G code, G0008 (Administration of influenza vaccine), to use in place of the CPT® code alternatives describing administration of the vaccine.

CMS also created a set of Q codes to differentiate the brand of vaccine in use in order to base payment accordingly. Those codes along with the pricing as of Oct. 1, 2011 are as follows:

- Q2035 (Afluria). The national limit is $11.543.
- Q2036 (Flulaval). The national limit is $8.784.
- Q2037 (Fluvirin). The national limit is $13.652.
- Q2038 (Fluzone). The national limit is $13.306.
- Q2039 (Not otherwise specified flu vaccine). (Payment limit set by Local carrier/MAC).

Reader Questions

Solve Nasal FBR Coding Dilemma

Question:
I’m a bit confused. When reporting a foreign body removal of the nose, would I use the CPT® code 30300? I also see an ICD-9 code for nasal foreign body removal of 98.12. I was told not to code the 30300 by one person, but then I was told I should code it by another. It was for an ER procedure. They used tweezers to remove a bead from a child’s nostril. New York Subscriber

Answer:
The code assignment will depend on whether you are coding for the professional service or the facility fee. On the professional side, you would report the procedure using the appropriate CPT® code, in this case 30300 (Removal foreign body, intranasal; office type procedure) to describe the service. Depending on the facility’s coding and reporting process, you may report the ICD-9 procedure code from Volume 3 of 98.12 (Removal of intraluminal foreign body from nose without incision) to demonstrate the medical necessity for the service, but this would not be part of the physician coding process.

Can Pre-Hospital Direction To EMS Be Included In Critical Care Time?

Question:
Can you count the time a physician is involved in “prehospital care” in critical care time? All I can really find is that the patient needs to be “directly available to the physician.” We have some controversy on this with the physicians that I am hoping to solve. Any help would be appreciated.

Georgia Subscriber

Answer:
The critical care codes do have some pre-service time allocated in assigning their relative value units. It is not uncommon to have some notification that a major trauma patient or patients are on their way, giving the emergency physician a little time to prepare for their arrival. In fact, the facility trauma response team activation code, G0390 (Trauma response team associated with hospital critical care service) specifically requires hospital notification by two-way radio.

There is a CPT® code 99288 (Physician direction of emergency medical systems [EMS] emergency care, advanced life support) that describes two-way communications with EMS personnel during transport to the ED, but it has no

Health Information Compliance Companion
RVUs assigned and is not paid by Medicare. There are no CCI edits dealing with reporting codes 99291 and 99288 together.

Although code 99288 can include physician direction of procedures on a critically ill patient, those services are not performed or provided under their direct supervision. The CPT® Assistant published an article in the November 2007 issue dealing with code 99288, acknowledging that it “represents true physician work and significant medical liability.”

(Nearly) Dead Men Tell No Tales: Apply History Exemption Caveat for Critical Care

Question:
If a patient comes to the ED in critical condition and is not able to give a history, can we apply a caveat? Does that caveat also apply to physical exam or does the doctor need to perform and document a physical exam?

West Virginia Subscriber

Answer:
If the patient qualifies for critical care, code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) does not have the typical E/M code requirements of history, physical exam, and medical decision making. As such, the typical history and physical exam required elements (HPI, ROS etc.) are not in place; rather, the documentation must support that the patient was critically ill and the time requirements for 99291 were met.

If however the time thresholds for critical care are not met but the urgency of the patient’s clinical condition and/or mental status make obtaining the required H&P elements for code 99285 (comprehensive history and exam), you can invoke the ED acuity caveat as long as you have documentation of the reasons why aspects of your history and physical exam were unobtainable. Reasons such as the patient being unconscious, intubated, becoming unstable or requiring urgent immediate treatment are common in the ED setting.

In The Midnight Hour: How To Report An ED Visit That Transcends The Calendar Date

Question: On what day do I report an ED visit when the patient arrives and physician treatment begins at 11:30 PM on Monday but the emergency physician does not complete their full evaluation until after midnight on Tuesday morning?

Kentucky Subscriber

Answer: Emergency department visits by nature are unscheduled and can begin at any hour of the day. As such it is not unusual for an ED visit to begin in the evening of one day and last several hours concluding after midnight on the next calendar day. Typically, the date of registration in the department is the one used as the date of service on the claim.

Since ED E/M codes are not time or calendar day based, it should not impact your payment.

Of note: new language in the 2011 CPT® book introduction reads, “For continuous services that last beyond midnight, use the date in which the service began and report the total units of time provided continuously.” So the same concept would apply to critical care codes that transcend midnight.

— Reader Questions and You Be the Coder reviewed by Michael A. Granovsky, MD, FACEP, president of Logix Health, a medical coding and billing company in Bedford, Mass.

You Be the Coder

Nail Down the Correct Code For This Finger Injury

(Question on page 77)

Answer:
The question to answer in coding this case is determining whether it is a nail bed repair or a laceration repair and which discrete services may be reported. CPT® Assistant has provided the following description of a nail bed repair as opposed to a laceration repair of the area.

“For lacerations to the nail bed, a portion or all of the nail plate is removed in order to visualize the laceration. The laceration of the nail bed is repaired meticulously with sutures. When the nail bed wound extends under the proximal nail fold, bilateral incisions may be made on either side of the proximal nail fold to access the wound. The nail fold is raised, and the nail bed wound is repaired with sutures.”

Code the scenario above as a nail repair using 11760 (Repair of nail bed).

Other codes you might have considered are typically bundled into the nail bed repair code:

» 11730 (Avulsion of nail plate, partial or complete, simple; single) has a CCI edit with 11760 and in this case can’t be reported.

» 11740 (Evacuation of subungual hematoma) also has a CCI edit in place with 11760 and can’t be separately reported

Keep in mind the 12000 laceration repair codes also have CCI edits and are bundled into the nail bed repair.

The digital block 64450 (Injection, anesthetic agent; other peripheral nerve or branch) is bundled both by CCI edits for 11760 and according to the CPT surgical package instructions.

Payment for 11760 is $ 130.13 on 3.83 totals RVUs.
We would love to hear from you. Please send your comments, questions, tips, cases, and suggestions for articles related to Emergency Medicine coding and reimbursement to the Editor indicated below.

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