X-rays and EKGs Furnished to Emergency Room Patients Generated on 05/21/13

The purpose of this memo is to clarify the coding and documentation requirements to be followed that support the billing for these services. This document refers to emergency room services and doesn't include outpatient, inpatient, or observation services.

The professional component of a diagnostic procedure furnished to a beneficiary in a hospital includes an interpretation and written report for inclusion in the beneficiary's medical record maintained by the hospital. (See 42 CFR 415.120(a).)

Carriers generally distinguish between an "interpretation and report" of an x-ray or an EKG procedure and a "review" of the procedure. A professional component billing based on a review of the findings of these procedures, without a complete, written report similar to that which would be prepared by a specialist in the field, does not meet the conditions for separate payment of the service. This is because the review is already included in the emergency department evaluation and management (E/M) payment.

- For example, a notation in the medical records saying "fx-tibia" or EKG-normal would not suffice as a separately payable interpretation and report of the procedure and should be considered a review of the findings payable through the E/M code.
- An "interpretation and report" should address the findings, relevant clinical issues, and comparative data (when available).
    - Example of Professional Interpretation and report:
        - Sinus tachycardia; right axis deviation; anterior infarct (cited on or before {Date}; left posterior fascicular block v. RVH, more likely the former; abnormal ECG; when compared with ECG of {Date}; no significant change – Signed with reviewed and interpreted by statement

Generally, one interpretation should be paid per EKG tracing. ECG interpretations (including "over-readings") that are not made contemporaneous to patient care and/or that do not directly contribute to the diagnosis and treatment of the individual patient are not covered and should not be billed to Medicare.

- Example of such non-covered over-reading services includes those that are performed by a physician whether or not that physician is treating the patient in such a manner that the interpretation is unavailable to the treating physician timely for use in decision-making regarding patient care.

Medicare will pay for a second interpretation of an EKG or X-ray (which may be identified through the use of modifier "-77") only under unusual circumstances (for which documentation is provided) 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 results of the procedure.

When carriers receive only one claim for an interpretation, they must presume that the one service billed was a service to the individual beneficiary rather than a quality control measure and pay the claim if it otherwise meets any applicable reasonable and necessary test.

When carriers receive multiple claims for the same interpretation, they must generally pay for the first bill received. <u>Carriers must pay for the interpretation and report that directly contributed to the diagnosis and treatment of the individual patient</u>. Consideration is not given to physician specialty as the primary factor in deciding which interpretation and report to pay regardless of when the service is performed. Consideration is not given to designation as the hospital's "official interpretation" as a factor in determining which claim to pay. <u>Carriers pay for the interpretation billed by the cardiologist or radiologist if the interpretation of the procedure is performed at the same</u>

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time as the diagnosis and treatment of the beneficiary. (This interpretation may be an oral report to the treating physician that will be written at a later time.)

If the first claim received is from a radiologist, carriers generally pay the claim because they would not know in advance that a second claim would be forthcoming. When carriers receive the claim from the emergency room (ER) physician and can identify that the two claims are for the same interpretation, they must determine whether the claim from the ER physician was the interpretation that contributed to the diagnosis and treatment of the patient and, if so, they pay that claim. In such cases, carriers must determine that the radiologist's claim was actually quality control and institute recovery action.

The two parties should reach an accommodation about who should bill for these interpretations.

The following examples apply to carriers:

EXAMPLE A:

A physician sees a beneficiary in the ER on January 1 and orders an ECG. The physician reviews the ECG, treats, and discharges the beneficiary. A carrier receives a claim from a cardiologist for CPT code 93010 indicating an interpretation with written report with a date of service of January 3. The carrier will pay the cardiologist's claim as the first bill received. Carriers do not have any indication as to whether the interpretation was a quality control service.

EXAMPLE B:

Same circumstances as Example A, except that the physician who sees the beneficiary in the ER also bills for CPT code 93010 with a date of service of January 1. The carrier will pay the first claim received. If the first claim is from the treating physician in the ER, and there is no indication the claim should not be paid, e.g., no reason to think that a complete, written interpretation has not been performed, payment of the claim is appropriate. The carrier will deny a claim subsequently received from a cardiologist for the same interpretation as a quality control service to the hospital rather than a service to the individual beneficiary.

EXAMPLE C:

Same as Example B except that the claim from the cardiologist uses modifier "-77" and indicates that, while the ER physician's finding that the patient did not have an MI was correct; there was also a suspicious area on the tracing that might contribute to a different cardiac problem and that may require further testing. In such situations, the carrier pays for both claims under the fee schedule.

EXAMPLE D:

The carrier receives separate claims for CPT code 93010 from a cardiologist and a physician who treated that patient in the ER, both with a date of service of January 1. The first claim processed in the system is paid and the second claims will be identified and denied as a duplicate. If the denied "provider" is the cardiologist and he raises an issue the carrier will develop the claim to determine whether the findings of the cardiologist's interpretation were conveyed to the treating physician (orally or in writing) in time to contribute to the diagnosis and treatment of the patient. If the cardiologist's interpretation was furnished in time to serve this purpose, that claim should be paid, and the claim from the other physician should be denied as not reasonable and necessary.

Resources:
Novitas LCD L32721 Electrocardiogram (ECG or EKG) – Effective 11/19/12
CMS, Publication 100-04, Medicare Claims Processing Manual, Chapter 13, Section 100.1

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