

Welch Allyn ECG

2010 REIMBURSEMENT INFORMATION



CPT® CODING OPTIONS FOR RESTING ECG AND MEDICARE FEE SCHEDULE

Code	Description	National Average ¹	Alabama	San Francisco
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	\$19.85	\$17.46	\$25.51
93005	Electrocardiogram, routine ECG with at least 12 leads; Tracing only, without interpretation and report	\$10.83	\$9.11	\$15.23
93010	Electrocardiogram, routine ECG with at least 12 leads; Interpretation and report only	\$9.02	\$8.36	\$10.29

Fee schedule as of 1/1/2009.

CPT® CODING OPTIONS FOR EXERCISE TESTING ECG AND MEDICARE FEE SCHEDULE

Code	Description	National Average ¹	Alabama	San Francisco
93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report	\$92.74	\$82.21	\$122.18
93016	Physician supervision only, without interpretation and report	\$23.82	\$22.28	\$27.75
93017	Tracing only, without interpretation and report	\$53.04	\$45.12	\$76.07
93018	Interpretation and report only	\$15.88	\$14.81	\$18.37

Fee schedule as of 1/1/2010.

For reference only. Information does not constitute a guarantee of coverage or payment.

¹ National Average Medicare Physician Fee Schedule Amounts: 70 Fed. Reg. 68132-68215 (2005) (to be codified at 42 CFR § 484).

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MEDICARE ■ **ECG monitoring** is covered by Medicare for patients with clinical evidence of cardiovascular disease or for monitoring an established cardiovascular disorder.

- ECG interpretation is only paid when performed by a physician. In addition, the ordering physician must be identified on any claim from a laboratory or other setting at which the ECG services were furnished.
- Since Medicare does not cover screening ECG tests for routine examinations, claims should indicate signs, symptoms, or other clinical justification for the services.

- **Cardiovascular stress testing** is generally covered by Medicare for symptomatic patients with known or suspected ischemic heart disease.
 - Specific indications for coverage may vary by Medicare Carrier. Providers should refer to their Medicare Carrier's Local Medical Review Policy for specific coverage and billing guidelines.
 - All Medicare claims for cardiovascular stress testing must include primary and secondary ICD-9-CM diagnosis codes to support medical necessity for the procedure. The primary diagnosis code indicates the patient's presenting symptoms or acute myocardial infarction. The secondary diagnosis code indicates the patient's risk factors or disease process.
 - The Customer Care Line may be contacted for assistance in these areas.

PRIVATE PAYERS ECG monitoring procedures may be covered by private payers when medically necessary. Coverage guidelines and payment levels vary by payer and specific plan. Providers should contact each specific plan to determine coverage and payment for the use of Welch Allyn ECG products or call the Customer Care Line for assistance.

MEDICAID ECG monitoring procedures may be covered by Medicaid programs when medically necessary. Coverage guidelines and payment levels vary by Medicaid program. Providers should contact their state Medicaid program to determine coverage and payment for the use of Welch Allyn ECG products or call the Customer Care Line for assistance.

OTHER CONSIDERATIONS

- Include documentation in the patient's records to indicate medical necessity for a separate service, including:
 - Reason for patient encounter
 - Patient symptoms
 - Who performs the service
 - Time and effort spent in performing procedure
 - Results of the ECG testing services provided
- Confirm that proper ICD-9-CM diagnosis codes are reported to justify medical necessity of ECG monitoring.
- When ECG monitoring is billed with an E/M code, modifier -25 may be indicated to identify the E/M as a significant, separately identifiable service in medically appropriate cases.
- Some payers may have specific requirements for using certain codes, including prior authorization, restricted medical diagnoses, or specialty provider types.

Be sure to confirm the requirements and specific coding, coverage, medical necessity, and reimbursement guidelines of the payer you are billing before submitting claims by reviewing your managed care contracts, consulting the *Physicians' Current Procedural Terminology, Fourth Edition (CPT-4)* or *The Federal Register*, or contacting provider services.