notation in the medical records saying "ECG-normal" would not suffice as a separately payable ECG interpretation and report of the procedure and should be considered a review of the findings payable through the E/M code, states the *MCPM*.

What to do: To report an ECG interpretation, the internist must provide a written report similar to that which a cardiologist would prepare.

Additionally, "interpretation and report" should address the findings, relevant clinical issues, and comparative data when available, adds Raubenolt.

Example: "An ECG with interpretation must have the full graphic tracings with formal written interpretation on file for review … at a minimum, interpretations should include appropriate comments on rhythm, rate, axis, acute or chronic changes, and a comparison with the most recent tracing (if available). Appropriate measurements must be mentioned if the purpose of repeated ECGs is to monitor the effects of a given parameter, e.g., the QT interval," states the Highmark LCD. Also, ECGs that are electronically read must be over-read, corrected, and signed. A physician's order must be documented in the medical record requesting ECG performance.

Be sure to check individual carriers for their specific requirements. ❑

4 Q&As Reveal How to Handle 95905 for Nerve Conduction Studies

▶ *Attention: New NCS code changes how units are reported.*

If you've been hesitant on how to report pre-configured nerve conduction studies (NCS), clarity has arrived. CPT 2010 debuted a new code effective Jan. 1, 2010 that allows you to accurately report this once hard-to-code nerve conduction test.

Benefit: CPT 95905 (*Motor and/or sensory nerve conduction, using preconfigured electrode array[s], amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report*) provides a code for reporting pre-configured nerve conduction studies that reflects the work involved, says **James Vavricek,** manager of medical economics for the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM).

Change: CPT 95905 overrides the old practice of reporting a pre-configured NCS to Medicare with a code from the 95900-95904 range (which describes NCS tests per nerve) or the unlisted CPT procedure code 95999 (*Unlisted neurological or neuromuscular diagnostic procedure*), explains **Marvel J Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO,** with MJH Consulting in Denver, Colo.

Avoid making some common errors the new code has caused using this Q&A:

1: How Do I Report 95905 for Multiple Limbs?

CPT 95905 creates a whole new way of counting units — and eliminates the need for two modifiers, as do other NCS codes.

Per limb: "Units of service for 95905 is per each extremity tested, not per nerve," says Hammer. For example, if an internist tested both upper extremities with the pre-configured device, she would bill 95905 with two units of service. Units for other NCS codes, such as 95900 (*Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study*), are based on each nerve studied.

"As the 'pre-configured' adjective indicates, the hand-held devices only provide information on those nerves that are pre-determined by the adhesive electrode 'templates'," says Hammer. Codes 95900-95904 (Nerve Conduction

Tests), in contrast, describe nerve conduction studies that require handling of individually placed stimulating, recording, and ground electrodes.

Leave two modifiers — 50 (*Bilateral procedure*) and 51 (*Multiple procedures*) — behind when reporting 95905. "Similarly to the traditional NCS codes, the new code carries a '0' bilateral status indicator, which means the code should not be reported with modifier 50," Hammer says. The same goes for modifier 51 — 95905 and the other NCS codes are exempt from the multiple procedure discount, so you should not append modifier 51 to these codes.

Append modifier 26 (*Professional component*) to 95905 if you do not have the pre-configured device in the office and the internist provides the interpretation and report only.

Note: Do not report 95905 with the other NCS codes (95900-95904) or 95934-95936 (*H-reflex, amplitude and latency study …*).

2: Which Diagnoses are Reportable with NCS?

Patients may present to the internist with a variety of complaints that indicate the need for NCS.

Two common conditions the NCS helps diagnose and manage include carpal tunnel syndrome (354.0) and lesion of ulnar nerve (354.2), notes Vavricek.

The pre-configured device is also useful in assessing conditions such as:

- diabetic peripheral neuropathy (250.6x, *Diabetes with neurological manifestations* **or** 249.6x, *Secondary diabetes mellitus with neurological manifestations* **with** 357.x, *Inflammatory and toxic neuropathy*, **or** 337.x, *Disorders of the autonomic nervous system*)
- lumbosacral radiculopathy (724.3, *Sciatica*).

Example: A 42-year-old female data entry clerk reported that, although she had had no injuries and during the day she was okay, she had been awakened in the middle of each night for the past two weeks with a numb, aching, burning feeling in her right hand that was relieved by holding her hand down and shaking it, rubbing it and running cold water over it, explains a *CPT Changes 2010: An Insider's View* scenario. Physical examination reveals weakness of right thumb abduction, wasting of the right thenar eminence, numbness of the palmar aspects of the right thumb, index finger, and middle finger, and a Tinel's sign over the right median nerve at the carpal tunnel. (History and exam reported separately as E/M.) The internist orders nerve conduction testing using preconfigured arrays (95905) for the right arm.

Frequency: TrailBlazer Health covers 95905 once per limb per year, or no more than four per year, according to local coverage determination (LCD) L26776. Payment for additional tests will require medical record review during a requested redetermination. Please check with your Medicare Administrative Contractor (MAC) or commercial payer for diagnostic codes that will be able to be used for 95905 and the frequency of testing.

Offer: Email the editor at stacieb@inhealthcare.com to receive a copy of the TrailBlazer LCD.

3: Does 95904 Require Real-Time Review and Direct Supervision?

Differentiate the CPT header notes that apply to per-nerve NCS only.

"Real-time review" and "on-site report" apply to the traditional NCS and not the pre-configured automated NCS test, explains Hammer.

Also, Medicare requires only general supervision, level 1, for the technical component of this service, says Vavricek, so the testing work could be done by a technician.

General supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure, notes Hammer.

4: Won't 95905 Mean Lowered Reimbursement for NCS?

CPT 95905 pays $76.14 **per limb** while 95900 pays $54.13 **per nerve**. Thus, if you are using a traditional NCS to test two or more nerves per limb, it's true that 95900 leads to higher reimbursement.

Difference: Internists are more likely to perform a pre-configured NCS (95905) while 95900 is more likely

(Continued on next page)

YOU Be the Coder!

Question & Answer

White Coat Hypertension Hinges on 3 Points

Question: *We have a patient who was diagnosed with white coat hypertension. Is there an ICD-9 code for this?*

Idaho Subscriber

Answer: See page 31. ❑

to be used by neurologists. The creation of 95905 means internists have a valid Category I CPT code with an established 2.11 relative value units (RVUs), which is better than having to report an unlisted CPT code (95999) or even an S HCPCS code (S3905, *Non-invasive electrodiagnostic testing with automatic computerized hand-held device to stimulate and measure neuromuscular signals in diagnosing and evaluating systemic and entrapment neuropathies evaluating systemic and entrapment neuropathies*) that doesn't have any established valuation or, in the case of S codes, that most carriers will not accept, opines Hammer.

"The code was defined per limb rather than per nerve because that was viewed as an appropriate increment of service for the work performed," notes Vavricek. "Relatively, there is less work per limb for this service than there is per nerve for the other NCS codes." ❑

READER QUESTIONS

Interpretation Does Not Equal Established Patient

Question: *The internist performed the interpretation and report of a patient's ECG for another doctor, but she never met with the patient. Now this same patient has been referred to our office for treatment. Would I code this encounter as a new or established patient visit?*

Indiana Subscriber

Answer: If your internist has reported an interpretation and report for a patient in the past — for instance, 93010 (*Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only*) — this does not disqualify you from reporting a new patient code if the internist later sees the patient.

"An interpretation of a diagnostic test, reading an x-ray, or EKG, etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient," states *Medicare Claims Processing Manual*, Chapter 12, Section 30.6.7. This means that if the internist only reviewed the patient's tracing but did not actively treat the patient, this patient still qualifies as a new patient upon the next face-to-face encounter with the internist.

If documentation supports coding a visit as a new patient level-five E/M service, for example, knowing the difference between new and established has an impact on your bottom line. The Medicare non-facility national rate for a level-five new patient visit (99205, *Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity* ...) pays $57.74 more than a level-five established patient visit (99215, *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity* ...) according to the 2010 Medicare Physician Fee Schedule.

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Consider All Aspects for Hypothyroidism Diagnosis

Question: *An established patient who recently had surgery and radiation therapy to treat her thyroid cancer reports to the internist complaining of weakness, depression, and a lack of tolerance for cold weather. The physician performs a level-four E/M and diagnoses the patient with hypothyroidism caused by the recent treatments. Should I use 244.9 as an ICD-9 code for the hypothyroidism?*

Minnesota Subscriber

Answer: Your diagnosis coding should be more precise for this patient, as 244.9 (*Unspecified hypothyroidism*) does not reflect the postsurgical/postradiation state of the patient's condition.

When the patient has recently had thyroid surgery or radiation therapy that caused the hypothyroidism, choose the fourth digit based on the most recent factor influencing the hypothyroidism. If the patient most recently had surgery, report 244.0 (*Postsurgical hypothyroidism*). If the radiation therapy was more recent, report 244.1 (*Other postablative hypothyroidism*).

So let's say that the encounter notes indicate that the patient had radiation therapy more recently than thyroid surgery. On the claim, report the following:

- 99214 — *Office or other outpatient visit for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision-making of moderate complexity*, for the E/M
- 244.1 linked to 99214, to indicate that the primary reason for the encounter is acquired hypothyroidism due to the radiation treatment that the patient had recently; and
- 193 — *Malignant neoplasm of thyroid gland*, linked to 99214 as a secondary diagnosis to represent the patient's thyroid cancer.

❑