The Coding Institute

Internal Medicine Coding Alert

The practical adviser for ethically optimizing coding, payment, and efficiency for internal medicine practices

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What's Inside

Turn to 'G' Codes for New Patient ECG Screens 27
▶ *For medically necessary ECG + IPPE, add this tool.*

4 Q&As Reveal How to Handle 95905 for Nerve Conduction Studies 28
▶ *Attention: New NCS code changes how units are reported.*

You Be the Coder 29
• White Coat Hypertension Hinges on 3 Points

Reader Questions

Interpretation Does Not Equal Established Patient 30

Consider All Aspects for Hypothyroidism Diagnosis. 30

Apply 99211 to E/M Nurse Visits. 31

Don't Overlook Shared-Visit Billing for Inpatients. 31

Follow 5 Sure-Fire Tips to ECG Coding Success

▶ ***E/M code lets you capture review credit.***

Attaching an incorrect modifier to an electrocardiogram (ECG or EKG) code can lead to denials and more time spent correcting the claim. Read on for time-saving advice that will get your claim paid on initial submission.

1: Drop 26 and TC from ECG Codes

An ECG is one diagnostic test for which you won't need to append the usual 26 (*Professional component*) or TC (*Technical component*) modifiers.

"For an EKG the professional and technical components are captured through the CPT codes," notes **Catherine Gray, RHIT, CCS, CPC-I/Cardio/GI,** a medical services auditor with the Henry Ford Health System in Detroit. Code 93000 is for the professional and technical components together, 93005 represents the technical component alone, and 93010 is for the professional component alone, she says. Here's how it breaks down:

- 93000 — *Electrocardiogram, routine ECG with at least 12 leads;* ***with interpretation and report***
- 93005 — *Electrocardiogram, routine ECG with at least 12 leads; tracing only,* ***without interpretation and report***
- 93010 — *Electrocardiogram, routine ECG with at least 12 leads;* ***interpretation and report only.***

Example: If the internist provides only the interpretation and report for an ECG performed at a hospital, you should report 93010, not 93000-26 (*Professional component*).

2: Code One Physician Interpretation per Test

Make sure that another physician is not also reporting 93000 or 93010 for interpretation of the same ECG tracing. "Most payers will pay for an interpretation only one time," says Gray.

Generally, payers reimburse for only one EKG interpretation for an emergency room patient, points out **Bruce Rappoport, MD, CPC, CHCC,** a board-certified internist and medical director of Broward Health's Best Choice Plus and Total Claims Administration in Fort Lauderdale, Fla. Thus, if another physician is already reporting

the interpretation and report, you may not report your internist's review of the same diagnostic test.

Exception: Contractors may cover a second interpretation only under unusual, documented circumstances, 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 tracing, according to the *Medicare Claims Processing Manual* (*MCPM*)*,* Chapter 13, Section 100.1 (www.cms.gov/Manuals/IOM/list.asp).

Modifier: To report a second review under the above-described circumstances, append modifier 77 (*Repeat procedure by another physician*) to the ECG interpretation code (93000 or 93010) on the claim, instructs the *MCPM*. Modifier 77 tells the payer that the second physician provided a medically necessary repeat service — in this case, a second EGG interpretation and report.

3: Count Test Reviews toward E/M Level

Although your internist may not be able to report a second interpretation, don't forget to consider this work when selecting the correct E/M level for a patient encounter.

If a patient receives an ECG study with interpretation and report elsewhere, and the internist then reviews the earlier diagnostic studies as part of a patient visit, report an E/M code (99201-99239, depending on the place of service, whether the patient is new or established, and the complexity of medical decision making) for the visit that captures the internist's review of relevant ECGs and other tests.

Tip: Reviewing more data points may qualify the encounter for a higher E/M code, so make sure that the review of diagnostic studies is documented adequately in the chart, suggests Gray.

Example: "Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data being reviewed," states the *1995 Documentation Guidelines for Evaluation and Management Services* (www.cms.gov/MLNProducts/Downloads/1995dg.pdf). Be sure to document "the direct visualization and independent interpretation of an image, tracing or specimen previously or subsequently interpreted by another physician," state the E/M documentation guidelines.

Reminder: Medicare covers review and interpretation of ECGs only when performed by a physician, according to the ECG national coverage determination (NCD) found here: www.cms.hhs.gov/transmittals/downloads/r26ncd.pdf.

4: Justify 12 Leads with Diagnosis

Add a diagnosis code to the claim form that describes the patient's condition and reflects medical necessity for an ECG.

An ECG is of significant value in evaluating and managing certain conditions, says **Ashleigh A. Raubenolt,**

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CONTACT INFORMATION

We would love to hear from you. Please send your comments, questions, tips, cases, and suggestions for articles related to Internal Medicine Coding Alert to the editor indicated below.

Mail: PO Box 50028, Provo, UT 84605-0028
Phone: (800) 508-2582 **Fax:** (801) 705-3942
Email: customerservice@supercoder.com

Editor in Chief: Stacie Borrello, MA (stacieb@inhealthcare.com)
Consulting Editor: Bruce Rappoport, MD, CPC
President & CEO: Dan Fellars (danf@inhealthcare.com)
Content Director: Jennifer Godreau, CPC, CPEDC (jenniferg@inhealthcare.com)
Editorial Director: Mary Compton, PhD, CPC (maryc@inhealthcare.com)
Associate Publisher: Melanie Parker (melaniep@inhealthcare.com)
Marketing & Sales Director: Dave Sherwin (daves@inhealthcare.com)
Director of Operations: Kyle Widdison (kylew@inhealthcare.com)

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CPC, CPC-H, CPC-P, CPMA, CEMC, CHCA, director of chart watch auditing and review, and credentialing and physician contracting, at S.A. Medical of Virginia Inc. in Fredericksburg. Examples of these conditions include:

- acute myocarditis (422)
- cardiac arrhythmias, such as sinus bradycardia (427.81, *Sinoatrial node dysfunction*)
- acute myocardial infarction (410.xx)
- unstable ischemic heart disease without infarction (411.x)
- patients with implanted cardiac devices (V45.xx)
- acute pericardial disease (420, *Acute pericarditis*)
- mitral stenosis (394.0).

The above is a summary; for a more thorough list of conditions which would support medical necessity for an ECG, review an example ECG Local Coverage Determination (LCD) on Highmark's Web site: www.highmarkmedicareservices.com/policy/mac-ab/l27490-r5.html.

Don't forget to support the medical necessity of the ECG service as well as the frequency for which it is performed in the patient's record. Documentation may include history and physical, progress notes with presenting symptoms, laboratory/diagnostic test results, and active treatment protocol, states the Highmark LCD. Office/progress notes must contain the date of service and the physician's signature.

5: Include a Detailed Written Report

Stay alert to what Medicare will accept as documentation for ECG interpretation.

Carriers distinguish between an ECG "interpretation and report," which is reportable with an ECG code, and a "review," which is included in the E/M service, according to *MCPM*, Chapter 13, Section 100.1.

Why: The "review" is already included in the emergency department E/M payment. For example, a

(Continued on next page)

Turn to 'G' Codes for New Patient ECG Screens

▶ *For medically necessary ECG + IPPE, add this tool.*

ECG CPT codes (93000, 93005, 93010) apply only when there are documented signs and symptoms or other clinical indications for providing the service. When you're in preventive territory, switch to HCPCS codes.

Reason: "ECG services are not covered when rendered as a screening test or in conjunction with a routine examination," says **Ashleigh A. Raubenolt, CPC, CPC-H, CPC-P, CPMA, CEMC, CHCA,** director of chart watch auditing and review, and credentialing and physician contracting, at S.A. Medical of Virginia Inc. in Fredericksburg, "unless performed as part of the one-time, 'Welcome to Medicare' initial preventive physical examination (IPPE) (G0402, *Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment to new beneficiary during the first 12 months of Medicare enrollment*) under section 611 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003."

To report a one-time ECG screening for a new Medicare beneficiary, choose from one of the following codes — and do not append modifier 26 (*Professional component*) or TC (*Technical component*):

- G0403 — *Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination **with interpretation and report***
- G0404 — *Electrocardiogram, routine ECG with 12 leads; tracing only, **without interpretation and report**, performed as a screening for the initial preventive physical examination*
- G0405 — *Electrocardiogram, routine ECG with 12 leads; **interpretation and report only**, performed as a screening for the initial preventive physical examination.*

Attention: The day of the IPPE is not the only opportunity to report an ECG screening service. If the primary physician or qualified non-physician practitioner does not perform a screening ECG as a result of the IPPE visit, another physician or entity may perform and/or interpret the ECG, states the *Medicare Preventive Services* Guide, page 24 (www2.cms.hhs.gov/MLNProducts/downloads/PSGUID.pdf).

You may report other covered preventive services that the internist performs in addition to HCPCS code G0402 and the appropriate ECG HCPCS G code.

Also, if the patient requires an additional, medically necessary ECG in the 93000 series on the same day as the IPPE, report the appropriate ECG CPT code(s) with modifier 59 (*Distinct procedural service*), states the Medicare guide. ❑

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. ❑

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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 electro-diagnostic 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.

❑

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.

❑

Apply 99211 to E/M Nurse Visits

Question: *I am unsure when I can bill 99211 for a nurse visit, and when to not. Could you explain the rules surrounding reporting 99211 for a nurse episode of care?*

Oregon Subscriber

Answer: You may report 99211 (*Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem[s] are minimal. Typically, 5 minutes are spent performing or supervising these services*) to earn deserved reimbursement when the nurse provides an E/M service that exceeds a simple task.

Example: A patient picks up a medication refill and tells the receptionist that the medication causes some unpleasant side effects. The nurse documents the problem and checks with the physician who is in the office during the patient encounter regarding changing the patient's dose. Because the service involves the nurse and a problem, you can most likely report 99211.

In contrast, a patient presents for a blood draw. If the nurse only draws blood, report 36415 (*Collection of venous blood by venipuncture*) instead of 99211.

Don't forget to meet the documentation requirements for an E/M service, which include:

1. reason for the visit: Documentation for code 99211 (or any other E/M code in this circumstance) must demonstrate a need for clinical evaluation and management (for instance, patient's report of symptoms or signs that are significant enough to necessitate evaluation).

2. current medications listed (with notation of level of compliance)

3. indication of doctor's evaluation of the clinical information obtained and her management recommendation

4. identity and credentials of provider(s) listed.

Don't Overlook Shared-Visit Billing for Inpatients

Question: *I know I cannot bill services incident-to in the hospital setting. Is there any other option to capture the most value from time a nonphysician practitioner (NPP) spent with a patient?*

Tennessee Subscriber

Answer: Yes, you can bill split/shared E/M services in the hospital setting under the internist's National Provider Identifier (NPI).

YOU Be the Coder!

White Coat Hypertension Hinges on 3 Points

Answer: Use 796.2 (*Elevated blood pressure reading without diagnosis of hypertension*) as your ICD-9 code. Remember that white coat hypertension (WCH) is diagnosed only when a patient has elevated blood pressure (BP) in the clinic setting but otherwise has normal BP outside the office.

According to *Medicare Claims Processing Manual*, Chapter 32, Section 10, WCH should be suspected when a patient has all three of the following:

1. clinic/office blood pressure greater than 140/90 mm Hg on at least three separate clinic/office visits with two separate measurements made at each visit

2. at least two documented separate blood pressure measurements taken outside the clinic/office that are less than 140/90 mm Hg, and

3. no evidence of end-organ damage.

To establish a diagnosis of white coat hypertension, the patient undergoes ambulatory blood pressure monitoring (ABPM). Medicare will cover ABPM only for patients with WCH. In addition, ABPM must be done for at least 24 hours to meet coverage criteria. A device stores the 24-hour measurements so the physician can interpret them. "In the rare circumstance that ABPM needs to be performed more than once for a beneficiary, the qualifying criteria described above must be met for each subsequent ABPM test," the manual states.

CPT: The following codes describe ABPM:

- 93784 — *Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report*
- 93786 — *… recording only*
- 93788 — *… scanning analysis with report*
- 93790 — *… physician review with interpretation and report*. ❑

The catch: The physician must provide a substantive portion of the service. This definition comes from the Medicare carrier First Coast: a split/shared visit is a medically necessary encounter with a patient where the physician **and** a qualified non-physician practitioner (NPP) each performs a substantive portion of the evaluation and management (E/M) visit, face-to-face with the same

(Continued on next page)

patient on the same date of service. A substantive portion of an E/M visit involves all or some portion of the history, examination, and medical decision making components of the E/M service. Simply signing off on the NPP's note does not meet the criteria for a split/shared visit. The physician and NPP both must be in the same group practice or employed by the same employer.

Furthermore, the split/shared visit applies only to selected E/M visits and settings; it does not apply to consultation services, critical care services, or procedures. View the First Coast split/shared visit policy at http://medicare.fcso.com/Wrapped/157200.asp.

When the encounter meets the criteria above, you may report the service under either the physician's or the NPP's UPIN [unique physician identification number]/PIN number," states *Medicare Claims Processing Manual*, Chapter 12, Section 30.6.1. When you bill under the NPP's NPI, you'll receive 15 percent less for the same service.

If there was no face-to-face encounter between the patient and the internist (for instance, if the internist participated only by reviewing the patient's medical record), then you would bill the service only under the NPP's UPIN/PIN.

Example: On morning rounds the NPP sees a patient with pneumonia (for instance, 480.2, *Pneumonia due to parainfluenza virus*). The NPP documents a level 2 subsequent hospital visit note (99232, *Subsequent hospital care, per day, …*). Later in the day, the internist examines the patient and documents the substantive components of the face-to-face patient encounter in the medical record. In addition, the internist reviews and documents agreement with the NPP's note. In this example, it would be appropriate to bill a subsequent hospital care code (99232) under the internist's NPI, because the physician provided a substantive portion of the service that included a face-to-face interaction with the patient.

— Answers to You Be the Coder *and* Reader Questions *were reviewed by* ***Bruce Rappoport, MD, CPC, CHCC,*** *a board-certified internist and medical director of Broward Health's Best Choice Plus and Total Claims Administration in Fort Lauderdale, Fla.* ❑

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