CODING Q&A

Electrocardiogram Data Points and Evaluation and Management Visit Level; Gait Training

■ DAVID STERN, MD, CPC

Q. When counting data points for the complexity of medical decision-making (CMDM) portion of the evaluation and management (E/M) visit level, what is the correct way to assign data points for an electrocardiogram? For example, the *Current Procedural Terminology* (CPT) code is 71020 for a chest radiograph with interpretation and report. The description itself has the interpretation and analysis included in the code already. Is it considered double-dipping if we count the interpretation as 1 point in the data review section of the CMDM and also bill the CPT code separately?

A. The E/M and the CPT sometimes appear to have overlapping elements and appear to result in double-dipping, meaning billing twice for the same service.

You are correct that (1) the global CPT code for a chest radiograph includes a reading of the film and that (2) the complexity of medical decision-making *appears* to give credit for reading the film. Although the Centers for Medicare & Medicaid Services (CMS) has not issued a specific guideline on this, it has been understood that CMDM credit is not for the reading itself but for the integration of the provider's own reading into the E/M. Although these items appear to be the same work, they each are really different kinds of work. The CMDM work is generally a smaller amount of work and will rarely change the actual resulting E/M code. It is for the work of integration of reading the film into the actual evaluation and management of the problem.

- Example 1—chest x-ray:
  - **CPT professional component:** This gives credit for the work of reading the film. The radiologic reading is "infiltrate in the right middle lobe."
  - **CMDM**: On the basis of the medical history and physical examination findings, the provider integrates the x-ray finding and determines that the infiltrate is caused by pneumonia and orders antibiotics, or determines that the infiltrate is due to sarcoidosis and refers the patient to a pulmonologist, or determines that the infiltrate is actually unchanged from previous film a month ago and orders a computed tomography scan to rule out cancer.
- Example 2—calcaneus x-ray:
  - **CPT professional component:** This gives credit for the work of reading the film. The radiologic reading is "negative fracture calcaneus."
  - **CMDM:** On the basis of the medical history and physical examination findings, the provider integrates the x-ray finding and determines that there is no fracture and that no further treatment is needed, or determines that magnetic resonance imaging (MRI) is needed to rule out a fracture, or determines that splinting and advising the patient to avoid weight-bearing is appropriate until a repeat examination and x-ray in 10 days.

These examples illustrate that the work of reading the film and the work for integrating that reading into the CMDM for the E/M code are similar but discrete. Thus, it is appropriate to assign a point to the data review section of CMDM for "reading an image, tracing, or specimen" to the coding algorithm for the E/M code; on the same visit, it is also appropriate to use the global CPT code, which includes the professional component for the actual work of reading the study. ■

Q. Can we bill for gait training when showing a patient how to use crutches after being treated for a fracture?

A. Yes, gait training is a billable procedure as long as there is direct, one-on-one patient contact with a physician or other qualified health-care professional for at least 8 minutes. According to the CMS *Medicare Benefit Policy Manual* (publication 100-02, Chapter 15, Section 20),[1] a qualified health-

[1]http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf.

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"CMS considers time spent under 8 minutes as unreportable. Details are outlined in Chapter 5, section 20.2 of the Medicare Claims Processing Manual *(publication 100-04)."*

care professional is defined as

> . . . a physical therapist, occupational therapist, speech-language pathologist, physician, nurse practitioner, clinical nurse specialist, or physician's assistant, who is licensed or certified by the state to furnish therapy services, and who also may appropriately furnish therapy services under Medicare policies. Qualified professional may also include a physical therapist assistant (PTA) or an occupational therapy assistant (OTA) when furnishing services under the supervision of a qualified therapist, who is working within the state scope of practice in the state in which the services are furnished. Assistants are limited in the services they may furnish (see section 230.1 and 230.2) and may not supervise other therapy caregivers.

You would bill CPT code 97116, "therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility, gait training (includes stair climbing)." You will need to document the findings as well as the time spent, because this is a timed procedure.

Medical necessity is an essential element of therapy services. Medicare carriers may establish unique local carrier determination (LCD) policies for medical necessity that affect reimbursement. Refer to your carrier's website for LCD policy information.

CMS considers time spent under 8 minutes as unreportable. Details are outlined in Chapter 5, section 20.2 of the *Medicare Claims Processing Manual* (publication 100-04).[2] Contact individual payors for specific requirements for billing therapeutic procedures during contracting. ■

[2]http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf.

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