blue of california

Payment Policy

EKG and Imaging Interpretation in Emergency Room	
Original effect date:	Revision date:
01/01/2007	08/03/2018

IMPORTANT INFORMATION

Blue Shield of California payment policy may follow industry standard recommendations from various sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), Current Procedural Terminology (CPT) and/or other professional organizations and societies for individual provider scope of practice or other coding guidelines. The above referenced payment policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms or their electronic equivalent. This payment policy is intended to serve as a general overview and does not address every aspect of the claims reimbursement methodology. This information is intended to serve only as a general reference regarding Blue Shield's payment policy and is not intended to address every facet of a reimbursement situation. Blue Shield of California may use sound discretion in interpreting and applying this policy to health care services provided in a particular case. Furthermore, the policy does not address all payment attributes related to reimbursement for health care services provided to a member. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy such as coding methodology, industry-standard reimbursement logic, regulatory/legislative requirements, benefit design, medical and drug policies. Coverage is subject to the terms, conditions and limitation of an individual member's programs benefits.

Application

Blue Shield of California's Emergency Room Services reimbursement guidelines comply with CMS Medicare Claims Processing Manual, Chapter 13 - Radiology Services and Other Diagnostic Procedures, Section 100.1, X-rays and EKGs Furnished to Emergency Room Patients, that states, "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."

Policy

Blue Shield's payment policy adopts the CMS policy to deny professional services such as ECG testing services (93000-93042) or the review/interpretation of radiological imaging (70010-79999), when billed in conjunction with an emergency department evaluation and management CPT Code (99281-99288) are considered to be incidental to the Emergency Room professional services.

Blue Shield's position is that these services are included in the routine or standard services that an emergency medicine practitioner is expected to perform.

Modifiers should be applied appropriately, as per the CMS and Standard AMA coding guidelines.

Rationale

Certain procedures are commonly performed in conjunction with other procedures as a component of the overall service provided. An incidental procedure is one that is performed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure.

A patient care provider who reviews the results of echocardiographic studies performed in an inpatient or facility-based outpatient setting, is performing an integral part of a global service rendered under the provider's E&M service. E&M codes are structured to determine the complexity of the work effort and the time involved in the evaluation and management of the patient. CPT instructions for E&M codes state that medical decision making includes "the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed." According to the AMA, E&M codes also include the review of test results performed by other providers. This logic is supported by CPT guidelines for reporting echocardiographic studies which states, "Report of an echocardiographic study, whether complete or limited, includes an interpretation of all obtained information, documentation of all clinically relevant findings including quantitative measurements obtained, plus a description of any recognized abnormalities. Pertinent images, videotape, and/or digital data are archived for permanent storage and are available for subsequent review. Use of echocardiography not meeting these criteria is not separately reportable.

Reimbursement Guideline

Blue Shield of California will reference national or regional industry standards, such as Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and MUE (Medically Unlikely Edits) rules, and American Medical Association's (AMA) CPT guidelines, as coding standards and as guidance for payment policy. In claims payment scenarios where CMS and/or CPT reference is lacking or insufficient, the Payment Policy Committee (PPC) may develop customized payment policies that are based on other accepted or analogous industry payment standards and or expert input.

Resources
• **American Medical Association** https://www.ama-assn.org/ama • **Centers for Medicare & Medicaid Services** https://www.cms.gov/

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Payment Policy.

Effective Date	Action	Reason
01/01/2007	New Policy Adoption	Payment Policy Committee
07/08/2017	Policy Revision	Payment Policy Committee
08/03/2018	Maintenance	Payment Policy Committee

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under an enrollee's contract.

These Policies are subject to change as new information becomes available.