Reimbursement for the Universal ECG™

Electrocardiography CPT Codes

The following common procedure terminology codes (CPT) describe the various resting electrocardiograph procedures and the national average reimbursement amount. They include but are not limited to:

CPT Code	Description	Nat'l Fee
93000	Electrocardiogram, complete Routine ECG with at least 12 leads; with interpretation and report	$19.06
93005	Electrocardiogram, tracing Routine ECG with at least 12 leads; tracing only – without interpretation and report	$10.55
93010	Electrocardiogram, report Routine ECG with at least 12 leads; interpretation and report only.	$8.51

**Source: Medicare Physician's Fee Schedule for Calendar Year 2012.*

Electrocardiography ICD-9 Codes

The following ICD-9 Codes support the medical necessity for the use of an electrocardiograph. It is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis or clinical suspicion must be present for the procedure to be paid. They include but are not limited to:

ICD-9 Code	Description	ICD-9 Code	Description
240-246.9	Disease of the thyroid gland	**245-245.9**	Thyroiditis
243	Congenital Hypothyroidism	**304-304.93**	Drug Dependency
276.7	Hyperpotassemia	**410-414.9**	Ischemic heart disease
401-405.99	Hypertensive disease	**420-420.99**	Acute pericarditis
415-417.9	Disease of pulmonary circulation	**428-428.9**	Heart failure
422-422.99	Acute myocarditis	**648.6-648.64**	Other cardiovascular diseases complicating pregnancy childbirth or the puerperium
648.5-648.54	Congenital cardiovascular disorders complicating pregnancy childbirth or the puerperium	**669.1-669.14**	Obstetric Shock
669-669.04	Maternal distress	**780.4**	Dizziness and giddiness
780.7	Malaise and fatigue	**785.1**	Palpitations
714-714.9	Rheumatoid arthritis and other inflammatory polyarthropathies	**785.3**	Other abnormal heart sounds
785.0	Tachycardia, unspecified	**786.1**	Stridor
785.2	Undiagnosed cardiac murmurs	**786**	Respiratory abnormality, unspecified
785.5-785.59	Shock without mention of trauma	**786.3**	Hemoptysis
786.2	Cough	**786.5-786.59**	Chest Pain
786.4	Abnormal sputum	**991.6**	Hypothermia
807-807.09	Fracture of ribs	**994.4-994.5**	Exhaustion due to exposure or to excessive exertion

***Source: ICD9Data.com; Alkaline Software*

Medicare

Medicare covers 80% of the fee schedule (Table 1) or the actual charge from the physician, whichever is lower. Physicians may bill the Medicare beneficiary and/or the secondary carrier for the remaining 20% of the allowed amount. Non-participating physicians may bill the patient a maximum of 115% of the Medicare physician fee schedule amount. Contact your local Medicare carrier to determine the exact payment methodology for these procedures under the Medicare fee schedule.

Private Insurance

Private payers may have different coding and reimbursement guidelines. Generally private payers offer significantly higher amounts than Medicare.

FAQs

Q. When discussing reimbursement with a physician, which fee should I use?

A. When discussing the reimbursement for a particular procedure, use the National Average Fee (Table 1). This fee is an average and can be used as a guide when discussing reimbursement. Average reimbursements are based on nationwide data by the Medicare fee analyzer and other agencies that track reimbursement schedules. The National Average Fee cannot be used to calculate Medicare reimbursement without the composite components, regional geographic cost adjustment factors and conversion factors. In other words, use the National Average Fee as a guide for reimbursement – physicians should determine their own reasonable charges for tests based on their locale.

Q. Are there restrictions I should be aware of?

A. There is no reimbursement for an ECG unless signs and symptoms or other clinical reasoning exists. (I.e. an ECG as part of a routine exam is not reimbursable.) See Table 2, ICD-9 Codes.

ECGs need to be performed by a physician in order to be reimbursable.

When an ECG is performed in the home, if cost to perform the ECG is higher than the clinic cost, then the company performing the ECG must justify the need for home services.

The attending physician must justify the medical necessity of each procedure for each patient to secure the proper reimbursement. See Table 2, ICD-9 Codes.

- *The information listed in this document is for information purposes only. QRS does not guarantee coverage or levels of reimbursement. It is the responsibility of the provider to determine the correct coding and coverage for services they provide.*
- *The National Average Fees listed are for Non-Facilities which includes all settings except hospitals (inpatient, outpatient and emergency department), ambulatory surgery centers (ASCs) and skilled nursing facilities (SNFs).*
- *CPT Copyright 2011 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*
- **Centers for Medicare and Medicaid Services (CMS), Medicare Program: Medicare Physician Fee Schedule for CY, http://www.cms.gov/PhysicianFeeSched/. Please note: Medicare fee schedule is subject to change without notification.*
- ***ICD9Data.com: http://www.icd9data.com/2012/Volume1/default.htm ; Alkaline Software*

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