

The 3CPM Company

Provider's Billing Guide

The 3CPM Electrogastrogram

- **Waterload Version**
- **Research Version**
- **Research Waterload Version**



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Tab 1 - ABOUT THIS GUIDE

INTRODUCTION

The 3CPM Company, 3CPM Electrogastrogram (EGG) is the first FDA-cleared, patented, non-invasive, diagnostic device that records, stores, displays and prints the myoelectric signals from the stomach as an aid to the diagnosis of potential and known gastric motility disorders. The significant advantage is that, it is only via a stimulatory challenge to the stomach, in this case a water load, that the device is able to uncover and detect motility abnormalities.

This 3CPM Analyzer is intended for use as a diagnostic device that receives records and produces a visual display of the myoelectrical signal produced by the stomach. It is to be used to record an electrogastrogram, as a component of a comprehensive clinical evaluation in patients with symptoms consistent with known or suspected gastrointestinal motility disorders.

- The Center for Devices and Radiology Health (CDRH) of the Food and Drug Administration completed its review for the classification of the (3CPM) EGG Machine designed by 3CPM on August 20, 1999.
- The 3CPM device is classified as a Class II device with clearance to market as an Electrogastrography (EGG) System under FDA regulations (21 CFR 807) under 510(k) number K984637.

The 3CPM Company is providing this guide to provide general information about coverage, coding, and payment of EGG when performed in the physician office, outpatient hospital setting, and ambulatory surgical center. In addition, the guide reviews the claims submission process, and provides sample letters to use when billing EGG procedures. The 3CPM Company suggests that providers work closely with each patient's health plan to ensure accurate coverage, coding, and payment practices.

This information represents the commitment of 3CPM Company in providing quality products and services to our customers. If you have additional billing questions, please contact:

The 3CPM Company provides billing assistance by calling 410-494-1846 x119 Monday through Friday between 10:00 AM and 4:00 PM. You will be connected with an experienced EGG billing manager within the current or next business day.

DISCLAIMER: The information contained in this document is provided for informational purposes only and represents no statement, promise or guarantee by The 3CPM Company concerning levels of reimbursement, payment, charge, or coverage issues.

TAB 2 - OVERVIEW OF REIMBURSEMENT

THIRD PARTY PAYERS

Physicians and hospitals receive payments for services rendered mainly through third party payers rather than directly from the patient. Third party payers are companies that underwrite and accept the financial risk of their enrollees' healthcare. Primarily, these payers fit into two categories: governmental and private payors.

The Centers for Medicare and Medicaid Services (CMS) is the federal agency that administers the Medicare program. Local insurance companies (carriers) contract with CMS to process claims for hospital outpatient procedures and physician services. These benefits are covered under Medicare Part B.

- Coverage policies may be developed from CMS or the local Medicare carriers. Generally, most policies are established by the local carriers and are applicable only in the geographic area in which that carrier operates.

State insurance commissions typically regulate private payers, also known as commercial payers. These insurance companies offer diverse health benefits through an assortment of health plan types. The most common plans are indemnity insurance programs, Health Maintenance Organization (HMO), and Preferred Provider Organization (PPO) plans.

- Private payers may also establish coverage policies at a national or local level.

The methods for determining coverage and payment differ among payers. Usually, the reimbursement process combines clinical evidence with health benefits coverage, coding, payment, and billing rules.

EGG TECHNOLOGY ADVANCEMENT

Electrogastrography describes the recording and interpretation of electrical activity of the stomach. Over the past 10 years, EGG has achieved recognition as a unique and reproducible method of diagnosing and subsequently treating gastric dysrhythmias (specific motility and neuromuscular disorders of the stomach.) Research has documented that abnormal gastric contraction and the stomach's myoelectrical patterns have been linked to specific disease states such as

- Functional dyspepsia
- Nausea
- Gastroparesis (Liberski, Koch 1990)
- Nausea related to post-operative concerns, or pregnancy
- Motion sickness
- Gastric reflux with dyspepsia symptoms
- Chronic mesenteric ischemia

Additionally, in a position paper on nausea and vomiting, developed by the American Gastroenterological Association, the EGG was indicated as a safe and cost effective test of gastric dysmotility in the patient with unexplained nausea.¹

By adding water challenge to the stomach a provocative test of the gastric myoelectric activity is created. The EGG signals can be compared to a control group of “normal healthy subjects”. The human response to water load has a predictable pattern in healthy individuals. (Koch KL, Hong S-P, Xu L: Reproducibility of gastric myoelectric activity and the water load test in patients with dysmotility-like dyspepsia symptoms and in control subjects. *J Clin Gastroenterology* 2000; 31:125-129).

Additional diagnostic benefits for using water load as the gastric challenge are that water evokes pure stomach neuromuscular activity without the influence of smell (olfactory), visual or gustatory cues of a caloric meal. Plus, a water load instead of food avoids the confounding effects of colonic neuromuscular activity, while still provoking symptoms such as bloating and nausea. (Lin HC, Hasler WL: Disorders of gastric emptying. In: Yamada T, ed. *Textbook of Gastroenterology*. Philadelphia: JB Lippincott; 1995:1318-1346).

¹ American Gastroenterological Association Medical Position Statement: Nausea and Vomiting. *Gastroenterology* 2001;120:261-286.

TAB 3 - CODING, PAYMENT, and COVERAGE

CODING

To obtain adequate reimbursement for electrogastrography with provocative water load testing, both physicians and hospitals must submit a properly coded claim form. All claims must include codes for the patient's diagnosis and the procedure performed.

Principal Diagnosis Codes

Hospitals and physicians must select at least one ICD-9-CM code for the claim form that describes the principal diagnosis responsible for the patient's condition. These codes explain the medical necessity of why the procedure was performed.

Because the 3CPM Electrogastrogram is indicated for nausea, upper abdominal discomfort, abdominal bloating/distention, and vomiting, a variety of ICD-9 codes are associated with this procedure. The following ICD-9 codes are potentially applicable diagnosis codes. The 3CPM Company does not recommend the use of any particular diagnosis for any patient.

- ICD-9 codes must specify the highest level of detail possible to describe the patient's diagnosis.
- The patient's medical record must support all diagnoses used on a claim form.

ICD-9 Principal Diagnosis Codes

531.41 Chronic or unspecified gastric ulcer with hemorrhage and obstruction
531.51 Chronic or unspecified gastric ulcer with perforation and obstruction
531.61 Chronic or unspecified gastric ulcer with hemorrhage, perforation, and obstruction
531.71 Chronic gastric ulcer without mention of hemorrhage or perforation, with obstruction
533.01 Acute peptic ulcer, unspecified site, with hemorrhage and obstruction
533.11 Acute peptic ulcer, unspecified site, with perforation and obstruction
533.21 Acute peptic ulcer, unspecified site, with hemorrhage, perforation, and obstruction
533.41 Chronic or unspecified peptic ulcer, unspecified site, with hemorrhage and obstruction
533.51 Chronic or unspecified peptic ulcer, unspecified site, with perforation and obstruction
533.61 Chronic or unspecified peptic ulcer, unspecified site, with hemorrhage, perforation, and obstruction
536.1 Acute dilatation of stomach
536.2 Persistent vomiting
536.3 Gastroparesis
536.8 Dyspepsia and other specified disorders of function of stomach
536.9 Unspecified functional disorder of stomach
537.0 Acquired hypertrophic pyloric stenosis
537.1 Gastric diverticulum
537.81 Pylorospasm
780.94 Early satiety
787.01 Nausea and vomiting
787.02 Nausea alone
787.03 Vomiting alone

CPT - 4 Procedure Codes

The American Medical Association (AMA) establishes and maintains the Current Procedure Terminology (CPT-4) Coding System, which describes services and procedures performed by physicians and other providers. When a code is established the AMA initially makes a recommendation to CMS for payment. CMS and other payers ultimately decide if they will pay for the procedure and how much to pay.

- To report diagnostic testing with the use of the 3CPM Electrogastragram, providers can report code CPT code 91133.

CPT Code	Descriptor	When used
91133	Electrogastragraphy, diagnostic, transcutaneous; with provocative testing	The 3CPM Electrogastragram provides EGG testing with the administration of water loading (provocative testing.)

Modifiers: Where necessary, the CPT-4 system allows the inclusion of two digit modifiers to define services more specifically. Electrogastragraphy code 91133 is classified as a diagnostic test, which allows providers to add a modifier that describes how the test was provided. The following defines technical, professional, and global reporting of diagnostic tests.

- **Professional Component Only** - This category describes situations when the physician supervises and interprets the test but does not provide the equipment and staff. If the physician performs this service at the hospital. Modifier 26 is added to the procedure code.
- **Technical Component Only** - This category describes situations when the facility is only reporting the equipment and staff components. If provided in a physician's office or ambulatory surgical center, modifier TC is added to the procedure code. If provided at the hospital, the modifier does not need to be reported. (Hospital billing systems are set to only report technical components.)
- **Global Procedure** - This category describes situations when a physician provides the equipment, staff and supervises and interprets the results. This is usually reported in the office setting. When a physician bills globally he/she must have either: (1) personally performed both the professional and the technical components; or (2) personally performed the professional component and supervised employees who performed the technical component. No modifier is required.

PAYMENT

Physician Services - Medicare

Payment under the Medicare payment system for physicians is paid according to the Physician Fee Schedule for services performed in the office, hospital, and/or ambulatory surgical center. The fee schedule is based on a relative value (RVU) system. Medicare assigns weights to the costs associated with the service, which is multiplied by a dollar conversion factor. Payments are updated annually and adjusted for geographic locality.

To better understand payments for electrogastrography, the following payment scenarios are presented below.

- Global Procedure
 - Submit appropriate code without modifier when a physician provides the equipment, staff, supervises, and interprets the results.
 - Medicare payment: Each Medicare carrier can establish a payment on an individual case basis following review of documentation.

Electrogastrography	Medicare Payment
91133	Carrier establishes

- Professional Component
 - Submit appropriate code with the -26 modifiers if the physician performs this service at the hospital.
 - Medicare payment: Payment for this component has been established.

Electrogastrography	Medicare National Unadjusted Payment
91133 - 26	\$33

- Technical Component
 - Submit appropriate code with TC modifier when the physician office and ASC only provides the equipment and staff to perform the test but does not provide supervision and interpretation.
 - Medicare payment: Each Medicare carrier can establish a payment on an individual case basis following review of documentation.

Electrogastrography	Medicare Payment
91133 - TC	Carrier establishes

Ambulatory Surgical Center - Medicare

A number of items and services covered under Medicare may be furnished in an ASC, which are not considered facility services such as EGG with provocative water load. Consequently, when this test is provided in an ASC, payment is based on the Physicians Fee Schedule as described above.

Hospital Services - When EGG with provocative water load is performed in the hospital outpatient setting, the hospital reports the service according to the Ambulatory Patient Classification (APC) system. Payment is calculated based on resources associated with equipment, staff, and overhead expenses and converted to relative weights. Payments are updated annually and adjusted to reflect geographic wage variations using the hospital wage index.

Electrogastronomy CPT Code	2004 APC Classification	National Medicare Payment
91133	0360	\$94.46

Physician and Hospital Services - Private Payers

Payers reimburse covered physician and outpatient facility services according to the terms of the member's benefit contract. Payment rates are based on the contract and the payment rate in effect at the time the provider performs the service.

COVERAGE

Coverage refers to whether a health plan may pay for a device, drugs, or service based on eligibility within the benefits categories.

With EGG technology advancements, payers are establishing payments and coverage policies. In cases where payers deny claims, medical directors may consider reimbursement on a case-by-case basis. In considering payment, each patient's unique clinical circumstances will be considered in light of the current peer-reviewed literature. Payers, in part, decide coverage based on the following criteria:

- The device/service must have received final approval from the appropriate regulatory agency (e.g., FDA), and
- Peer-reviewed literature must demonstrate the impact of the service/procedure on health outcomes, and
- The evidence must show that the technology improves health outcomes, and
- The technology must be at least as effective as established technology, and
- The outcomes must be obtainable outside investigational settings²

Provision of EGG with provocative water load may be a covered service if it is medically necessary and meets all of the requirements established by Medicare and private third-party payers. Medical necessity definitions vary by health plans, but are generally defined, as a need for a particular item or service, required for the diagnosis or treatment of disease, injury or defect. It is essential that each claim be coded properly and supported with adequate documentation in the medical record.

² Place marker for footnotes containing applicable literature.

Medicare

A national coverage policy for electrogastrography testing has not been established by CMS. Consequently, the decision to cover the procedure is left to each Medicare carrier. Providers should contact their Medicare carriers to determine coverage for electrogastrography testing.

Providers should consider having the patient sign an Advanced Beneficiary Notice (ABN) prior to treatment, which allows providers to charge a Medicare beneficiary if Medicare does deny the claim (see Tab 5).

Private Payers

When necessary, providers may contact the patient's individual health plan to obtain prior authorization for electrogastrography with provocative water load. (see Tab 4).

Documentation

Medical record documentation provides a Medicare carrier or other third-party payer with information about the service performed and plays a significant role in any review of a claim that they might conduct. The medical record should document:

- Why the procedure was performed
- What was done
- The expected outcome or benefit to be derived from this procedure.

The final report should support the medical necessity of the service to the payer and provide information about the work involved.

TAB 4 - PRIOR AUTHORIZATION

PRIOR AUTHORIZATION AND THE CLAIMS REVIEW PROCESS

Prior Authorization

Prior to the EGG procedure, follow the following steps:

1. Collect Information
 - Obtain all patient and insurance information
 - Identify diagnoses, ICD-9 codes and corresponding CPT codes
2. Contact payers, when necessary
 - Verify existence of benefits
 - Verify existence of coverage for EGG
 - Determine requirements for prior authorization

If verbal authorization is given, document the contact person, phone number, and date received. For written authorization, the carrier may require the following:

- Patient records
- Explanation of the procedure
- Product information
- Letter of Medical Necessity - (see Tab 5) The letter should contain the following:
 - Rationale to support why the procedure is appropriate for the patient
 - Complete description of the procedure
 - Medical diagnosis, history, procedures, medications, etc. appropriate to the patient and to the procedure
 - Statement of the medical necessity and appropriateness of the procedure
 - Expected outcome
 - Medical opinion of the potential outcome if the procedure is not performed

3. Follow-up with payer until a decision has been made.

Appeal Denials

If a claim has been denied, it may be the result of health plans' error, inaccurate coding, other clerical errors, or coverage determinations.

- Clarify the reason for the denial
- If there is an issue regarding medical necessity substantiation, request a review of claims for payment.
- Write a letter addressing the specific reason for denial, which may require substantiation of the service, based on the patient's clinical presentation, diagnosis, and standard of practice as it relates to the diagnosis. (see Tab 5)

Sample of Medical Necessity Letter

(Date)

(Insurer Name)
Claims Review Department
(Insurer Address)
(City, State, Zip Code)

Re: (Patient's Name)
(Policy Number/Patient ID)
(Group Number)
(Date of Birth)

Medical Necessity of Electrogastrography (EGG) with provocative water load

To Whom It May Concern:

I am writing on behalf of my patient, (patient's name), to document the medical necessity of Electrogastrography (EGG) with provocative water load for the treatment of (*provide diagnosis*).

Electrogastrography describes the recording and interpretation of electrical activity of the stomach. **By adding water challenge to the stomach a provocative test of the gastric myoelectric activity is created. The human response to water load has a predictable pattern in healthy individuals, so EGG signals of the patient can be compared to a control group of "normal healthy subjects".** (Koch KL, Hong S-P, Xu L: Reproducibility of gastric myoelectric activity and the water load test in patients with dysmotility-like dyspepsia symptoms and in control subjects. *J Clin Gastroenterology* 2000; 31:125-129).

Additional diagnostic benefits for using water load as the gastric challenge are that water evokes pure stomach neuromuscular activity without the influence of smell, visual or gustatory cues of a caloric meal. Plus, a water load instead of food avoids the confounding effects of colonic neuromuscular activity, while still provoking symptoms such as bloating and nausea. (Lin HC, Hasler WL: Disorders of gastric emptying. In: Yamada T, ed. *Textbook of Gastroenterology*. Philadelphia: JB Lippincott; 1995:1318-1346.)

The comparison of my patient's EGG data to that of healthy control subjects revealed that symptoms are related to (doctor adapts-- a gastric dysrhythmia or are not related to gastric myoelectric issues).

The patient's medical history and treatment pattern is as follows:

(Document and report an overview of medical condition, any previous treatments, related signs and symptoms, and any related test results. Describe the anticipated outcomes of utilizing EGG vs. non-utilization of EGG.)

Overview of EGG with provocative water load:

The 3CPM Electrogastrogram is a patented (US Patent # 6,353,665 and 7,160,254) and FDA cleared (510(k) # K984637) diagnostic device used for electrogastrography, which identifies and analyzes gastric dysrhythmias associated with symptoms and disorders such as dyspepsia, unexplained nausea, vomiting, GERD, or gastroparesis. The 3CPM

Electrogastrogram is designed to do its analysis with a water load challenge to the stomach.

Procedure Description:

The patient (*put patient name in*) is directed to fast overnight and consume a special small meal two hours before the EGG recording period. The water load test requires a minimum of 45 to 60 minutes to complete the patient data collection.

The EGG is recorded for 15 minutes in the semi-fasting state (preprandial), and then the patient ingests water until feeling full, the EGG is recorded for 30 minutes after the water load (postprandial). During the EGG, the patient sits comfortably in a chair. Respiration is monitored by clinical staff and recorded in parallel with the EGG recording to help identify motion or respiration artifacts. Three electrodes are positioned on the epigastrium after the skin is prepped. These electrodes are connected to amplifiers through couplers with appropriate filters.

The patient is encouraged to rest comfortably with as little movement as possible while the technician activates the EGG recording and documents any patient movements using specially designed software for 15 minutes. Then the patient is asked to challenge their stomach by drinking water until full within 5 minutes. The last phase is a 30-minute recording of the EGG and respiration while the patient processes the water load. A technician observes the patient during the entire test period so movements and visual responses to the water can be documented using the EGG software. The data is stored and sections with artifacts are eliminated to prepare the outputs. The physician reviews the EGG recordings, technician observations, and computer analysis and renders a diagnosis by evaluating three outputs:

1. Summary graphs of the patient's results plotted next to normal health control subjects' result range
2. Running Spectral Analysis of the selected minutes
3. Raw wave (tracings) review of the entire test

Treatment Plan:

Based on (*insert findings*), the treatment plan is (*Insert the patient treatment plan here, if applicable*)

In summary, Electrogastrography with water load testing is a highly effective, proven diagnostic tool used in detecting and subsequently treating gastric dysrhythmias. The use of this diagnostic test is both medically necessary and reasonable for my patient's medical condition. Please contact me if any additional information is required to ensure the prompt approval of this diagnostic test.

Sincerely,

(Physician name)

**Sample - Informed Consent and
Waiver of Liability**

I, _____, acknowledge that Electrogastrography (EGG) with provocative water load may not be covered by my insurance plan because of a medical necessity determination. My physician, Dr. _____ feels the service is medically necessary for my condition, and I agree to follow his/her medical care, which includes acceptance of this EGG service.

I have been fully informed in writing of the potential risks and complications of EGG, and do hereby choose of my own free will and consent to have this diagnostic test performed.

I agree to pay in full, for EGG, directly to Dr. _____. If I cannot pay this amount in full, I agree to make payment arrangements with the doctor's billing staff.

Dated at _____, this _____ day of _____

Patient Signature: _____

Witness: _____

Sample Letter of Appeal (Medical Necessity/Coverage)

(Date)

(Insurer Name)

(Insurer Address)

(City, State, Zip Code)

Re: (Patient's Name)
(Policy Number/Patient ID)
(Group Number)
(Date of Birth)

To whom it may concern:

This letter is in response to your denial of the enclosed claim for electrogastrography with water load testing. I am submitting a review of the claim on behalf of your beneficiary for your reconsideration. Electrogastrography (EGG) has been cleared for marketing by the Food and Drug Administration, (510(k) # K984637). This letter provides the rationale for performing this procedure, a description of the procedure, and a summary of the clinical results associated with EGG with provocative water load.

Reason for Test

My patient's condition and medical history in this case warranted this diagnostic test.

- (Insert text about):
 - patient's diagnosis
 - history,
 - the procedure,
 - why it was selected, *EGG with water load was chosen to enable comparative analysis to healthy control group data and to provoke the patient's gastric symptoms*
 - (Select the appropriate intervention for the case at hand – choosing from:
The results of EGG with provocative water load test guides our approach to
 - therapy with Prokinetic agents
 - Anti-arrhythmic agents,
 - Identification of an obstructed gastric outlet
 - GERD corrective procedures- Radiofrequency ablation of the LES region
 - Corrective diet changes.

Indications and Clinical Evidence

The clinical use of EGG with provocative water load has been validated based on research done at Penn State's Hershey Medical Center³. A review of the published peer reviewed literature confirms:

- The technical feasibility and reproducibility of the test;
- Diagnostic performance of the test as measured by the sensitivity, specificity and positive and negative predictive values; and
- How the results of the test will be used in the management of the patient and whether or not such treatment decisions result in an improvement in health outcomes.

³ Place marker for footnotes containing applicable literature.

Technical Feasibility:

EKG recording has been possible and documented as early as 1921 by Andrea Alvarez. However the gastric wave tracings were difficult to obtain with the weak amplification equipment at the time. Conductive adhesive surface electrodes, application of computer assisted Fourier analysis of the raw wave lead to reliable amplitude and frequency charting using Running Spectral Analysis (RSA) in 1980, which enabled clinicians to visualize the data in a useful way. The 3CPM (3CPM) software was created to compare the patient's EKG recording to that of the healthy group using a standardized water load test protocol and data presentation. (Koch and Stern; HB on Electrogastrography, pp. 1-11).

Diagnostic Performance:

Objective EKG information assists in the accurate diagnosis of gastric dysrhythmia or normal gastric waves and leads to more selective application of appropriate drug therapies or interventions. Diagnostic accuracy is enhanced with the EKG data, which reduces the chance of applying an ineffective therapeutic approach with the trial of prokinetic agents, or unneeded interventions.

Patient Management:

EKG recordings with water load distinguish patients with normal gastric myoelectrical rhythm from those with gastric dysrhythmias. The information assists in creating or modifying the treatment plan. Evaluating the impact of the selected drug therapy, a diet change or procedural intervention on gastric myoelectrical activity provides information to optimize the treatment plan and improve outcomes. Identification of gastric dysthmias in adult or pediatric patients with unexplained dyspepsia symptoms establishes an objective diagnosis, helps the physician to educate the patient about their neuromuscular disorder and directs interventions based on quantified pathophysiological abnormalities. (Koch & Stern pp 144-5). Once a gastric dysrhythmia is verified then further diagnostic tests may be unnecessary. A "normal EKG" will lead the diagnostician to consider non-neuromuscular causes for the systems.

Furthermore, in a position paper on nausea and vomiting, developed by the American Gastroenterological Association, the EKG was indicated as a safe and cost effective test of gastric dysmotility in the patient with unexplained nausea.

Conclusion

In summary, the EKG findings provide both an objective diagnosis and a direction for rational treatment approaches for patients with unexplained nausea and dyspepsia symptoms.

In light of my patient's medical condition, it is my opinion that this procedure was medically necessary. I request that you review this claim and provide a favorable coverage determination.

Please contact me if you have further questions about this procedure.

Sincerely,

(Physician name)

**Sample Letter of Appeal: Payment Justification for EGG
with provocative water load**

(Date)

Medical Director
(Insurer Name)
(Insurer Address)
(City, State, Zip Code)

Re: (Patient's Name)
(Policy Number/Patient ID)
(Group Number)
(Date of Birth)

To whom it may concern:

This letter is a request for reconsideration of the allowable amount for the enclosed claim for EGG with provocative water load. Please see attached claim and explanation of benefits (EOB).

Understanding that you consider multiple factors in establishing payment levels, I am presenting this information to clarify Electrogastronomy with provocative water load test. Electrogastronomy describes the recording and interpretation of electrical activity of the stomach. **By adding water challenge to the stomach a provocative test of the gastric myoelectric activity is created. The human response to water load has a predictable pattern in healthy individuals, so EGG signals of the patient can be compared to a control group of "normal healthy subjects"..** (Koch KL, Hong S-P, Xu L: Reproducibility of gastric myoelectric activity and the water load test in patients with dysmotility-like dyspepsia symptoms and in control subjects. *J Clin Gastroenterology* 2000; 31:125-129). **Additional diagnostic benefits for using water load as the gastric challenge are that water evokes pure stomach neuromuscular activity without the influence of smell, visual or gustatory cues of a caloric meal. Plus, a water load instead of food avoids the confounding effects of colonic neuromuscular activity, while still provoking symptoms such as bloating and nausea.** (Lin HC, Hasler WL: Disorders of gastric emptying. In: Yamada T, ed. *Textbook of Gastroenterology*. Philadelphia: JB Lippincott; 1995:1318-1346.)

Electrogastronomy with provocative water load test requires approximately 60 minutes of office time from preparation through test analysis. The test is performed in a dedicated quiet room equipped with a reclining chair. The special equipment (3CPM Analyzer) necessary to perform this test includes

- Bioamplifier for EGG signal acquisition
- Pressure Transducer Amplifier for respiration acquisition
- Computer with analog/digital board for digitization, recording and analysis
- EGG isolation cables, electrodes

CPT code 91133, Electrogastronomy, diagnostic, transcutaneous; with provocative testing, accurately describes the procedure performed.

I submitted a charge of (xxx), which represents the time, skill, overhead, and special equipment costs necessary to perform this procedure. There aren't any non-invasive motility procedures that this test can be compared. The test that is most similar in terms of time, equipment, and user training/experience to operate it is esophageal manometry.

Relative to other diagnostic tests for nausea, electrogastrography with provocative water load is a cost effective and low risk approach for diagnosing patients.

In this case, my patient (*insert name*) has experienced an objective outcome (*insert treatment and result*). I am requesting you reconsider the allowable amount for this claim. If you require additional information, please contact me at (*insert phone number*)

Sincerely,

(Physician Name)

GLOSSARY OF REIMBURSEMENT TERMS

ADVANCE BENEFICIARY NOTICE (ABN) A notice that a doctor or supplier should give a Medicare beneficiary to sign in the following cases: The doctor gives a service that he or she believes that Medicare does not consider medically necessary; and the doctor gives a service that he or she believes that Medicare will not pay for. If the beneficiary does not get an ABN to sign before the service is performed and Medicare does not pay for it, then the beneficiary doesn't have to pay for it. If the beneficiary signs the ABN prior to the service, and Medicare does not pay for it, then the beneficiary must pay the doctor.

ASSIGNMENT In the Original Medicare Plan, this means a doctor agrees to accept Medicare's fee as full payment.

BALANCE BILLING An arrangement where a health care provider may bill a covered person for charges above the amount reimbursed by the health plan (i.e., the difference between billed charges and the amount paid). This may or may not be appropriate, depending upon the contractual arrangements between the health care provider and carrier and/or any government regulations (i.e., Medicare).

BENEFICIARY A person entitled to receive Medicare or other payer benefits and who maintains a health insurance policy claim number.

CARRIER A private company that has a contract with Medicare to pay Medicare Part B bills.

CENTERS FOR MEDICARE & MEDICAID SERVICES The HHS agency responsible for Medicare and parts of Medicaid.

COINSURANCE The percent of the Medicare-approved amount that a beneficiary pays after paying the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the approved amount for the service (like 20%).

COORDINATION OF BENEFITS A program that determines which plan or insurance policy will pay first if two health plans or insurance policies cover the same benefits. If one of the plans is a Medicare health plan, Federal law may decide who pays first.

CORRECT CODING INITIATIVE (CCI) A list of codes from the official Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Policy Manual for Part B Medicare Carriers that are considered to be either an integral part of a comprehensive code or mutually exclusive of it and should not be reported separately.

CPT MODIFIERS Additional codes or digits used to indicate that a service was altered in some way from the stated CPT description without actually changing the basic definition of the service. Modifiers can indicate a service or procedure has both a professional and a technical component, a service or procedure was performed by more than one physician, only part of a service was performed, an adjunctive service was performed, a bilateral procedure was performed, a service or procedure was provided more than once, unusual events occurred, or a procedure or service was altered in some way. A complete listing of all modifiers used in CPT coding is located in an appendix of CPT.

CURRENT PROCEDURAL TERMINOLOGY A medical code set of physician and other services, maintained and copyrighted by the American Medical Association (AMA), and adopted by the Secretary of HHS as the standard for reporting physician and other services on standard transactions

DEDUCTIBLE The annual amount payable by the beneficiary for covered services before Medicare makes reimbursement.

DIAGNOSIS CODE ICD-9-CM diagnosis codes describes the principal diagnosis and additional conditions that coexisted at the time of treatment.

DOWNCODE Reduce the value and code of a claim when the documentation does not support the level of service billed by a provider.

EXPLANATION OF MEDICARE BENEFITS (EOMB) A notice that is sent to the beneficiary after the doctor files a claim for Part B services under the Original Medicare Plan. This notice explains what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what the beneficiary must pay.

FEDERAL REGISTER The "Federal Register" is the official daily publication for rules, proposed rules and notices of federal agencies and organizations, as well as Executive Orders and other Presidential documents.

FEE SCHEDULE A complete listing of fees used by health plans to pay doctors or other providers.

FISCAL INTERMEDIARY A private company that has a contract with Medicare to pay Part A and some Part B bills.

HEALTHCARE COMMON PROCEDURAL CODING SYSTEM A medical code set that identifies health care procedures, equipment, and supplies for claim submission purposes. It has been selected for use in the HIPAA transactions. HCPCS Level I contains numeric CPT codes which are maintained by the AMA. HCPCS Level II contains alphanumeric codes used to identify various items and services that are not included in the CPT medical code set. HCPCS Level III contains alphanumeric codes that are assigned by Medicaid state agencies to identify additional items and services not included in levels I or II.

LOCAL CODE(S) A generic term for code values that are defined for a State or other local division or for a specific payer. Commonly used to describe HCPCS Level III Codes.

MEDICALLY NECESSARY Services or supplies that: are proper and needed for the diagnosis, or treatment of a medical condition; are provided for the diagnosis, direct care, and treatment of a medical condition; meet the standards of good medical practice in the local area; and are not mainly for the convenience of the patient or doctor.

MEDICARE CARRIER A private company that contracts with Medicare to pay Part B bills.

MEDIGAP POLICY A Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage.

NATIONAL COVERAGE POLICY A policy developed by CMS that indicates whether and under what circumstances certain services are covered under the Medicare program. It is published in CMS regulations, published in the Federal Register as a final notice, contained in a CMS ruling, or issued as a program instruction.

NON-COVERED SERVICE The service:

- does not meet the requirements of a Medicare benefit category,
- Is statutorily excluded from coverage on ground other than 1862(a)(1), or
- is not reasonable and necessary under 1862 (a)(1).

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM The way that Medicare pays for most outpatient services at hospitals or community mental health centers under Medicare Part B.

REASONABLE AND CUSTOMARY (R & C). A term used to refer to the commonly charged or prevailing fees for health services within a geographic area. A fee is considered to be reasonable if it falls within the parameters of the average or commonly charged fee for a particular service within that specific community.

REASONABLE-COST BASIS The calculation to determine the reasonable cost incurred by individual providers when furnishing covered services to beneficiaries. The reasonable cost is based on the actual cost of providing such services, including direct and indirect costs of providers, and excluding any costs that are unnecessary in the efficient delivery of services covered by a health insurance program.

RESOURCE-BASED RELATIVE VALUE SCALE A scale of national uniform relative values for all physicians' services. The relative value of each service must be the sum of relative value units representing physicians' work, practice expenses net of malpractice expenses, and the cost of professional liability insurance.

THIRD PARTY ADMINISTRATOR An independent person or corporate entity (third party) that administers group benefits, claims, and administration for a self-insured company/group. A TPA does not underwrite the risk.

UNBUNDLING Separately packaging costs or services that might otherwise be billed together. For claims processing, this includes providers billing separately for health care services that should be combined according to the industry standards or commonly accepted coding practices.

USUAL, CUSTOMARY AND REASONABLE (UCR). UCR is a term indicating fees charged for medical services that are considered normal, common, and in line with the prevailing fees in the provider's area.