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## Editor's Letter

Welcome to June edition of the ATS Coding and Billing Quarterly. This month includes important information about the Centers for Medicare and Medicaid Services (CMS) changing rules for split/shared critical care billing. For group practices that use physician/advance practice provider teams to treat critically ill patients, this will be important and potentially challenging rules change to note.

CMS adopted a new lung cancer screening policy that expands both the age band and the pack-year eligibility for lung cancer screening. This edition explains the policy changes.

This edition also includes articles on appropriate documentation and billing for SBRT and bronchoscopic lung reduction procedures and we respond to ATS member questions on page seven.

As always, we welcome your coding, billing and regulatory compliance questions. Questions can be sent to [Codingquestions@thoracic.org](mailto:Codingquestions@thoracic.org).

### **Katina Nicolacakis, MD**

Editor, ATS Coding & Billing Quarterly

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## CMS Changes Policies for Split/Shared Billing

Amy Ahasic, MD – Co-Chair, Joint ATS/CHEST Clinical Practice Committee

Split/shared visits are visits in the facility setting performed in part by both a physician and an advanced practice provider (APRN or PA) who are in the same group. This can be either evaluation and management (E/M) or critical care services.

Starting in 2023, the Centers for Medicare and Medicaid Services (CMS) will require that the practitioner providing the “substantive portion” of the service bill for the service. The CMS definition of “substantive portion” will be based on total time only and CMS will not allow providers to use medical decision-making to determine “substantive portion.” CMS is allowing 2022 to be a transition year and permitting critical care providers to use medical decision-making or total time to determine substantive portion.

Under the new policy, if an advance practice provider (APP) spends >50 percent of the time providing face-to-face and/or non-face-to-face critical care time, the APP must be the billing provider. The same will be true for E/M services as of CY23, even if visit level is chosen based on medical decision-making.

When fully implemented, this new policy could have significant implications for critical care clinicians. Critical care (CPT 99291, 99292) is a time-based code. The Medicare reimbursement for services provided by APPs is 85 percent of the physician payment rate. If, as expected, the new policy results in significantly more critical care services being billed by APPs instead of physicians, many group practices that use physician/APP team approach to providing critical care may see a significant drop in total Medicare reimbursement for critical care. Further, physicians that are reimbursed on a RVU generating model may lose significant RVUs as many critical care services will now be attributed to APPs instead of physicians.

The ATS strongly opposes the new CMS policy and is continuing to reach out to CMS to express our concerns. Our concerns are also shared by many other medical organizations. In March, the ATS joined the American Medical Association and over 30 other medical organizations in a letter to CMS urging them to rescind the policy for 2023.

## CMS Expands Medicare Lung Cancer Screening Criteria and Decreases Shared Decision-Making Requirements

Omar Hussain DO – Co-Chair Joint ATS/CHEST Clinical Practice Committee

On February 10, 2022, the Centers for Medicare & Medicaid Services (CMS) issued a revised National Coverage Determination (NCD) policy that expanded coverage for lung cancer screening with low dose computed tomography (LDCT)<sup>1</sup>. This revised NCD expands coverage for LDCT lung cancer screening by lowering the starting age for screening from 55 to 50 years and reducing the tobacco smoking history from at least 30 packs per year to at least 20 packs per year. This update closely aligns with the US Preventive Services Task Force (USPSTF) revised recommendation published in 2021<sup>2</sup> and broadens access for lung cancer screening to more at-risk populations. Of note, the updated NCD does differ from the USPSTF recommendations by maintain the upper age of screening to 77 years, whereas USPSTF recommends screening up to age 80. In the landmark National Lung Screening Trial (NSLT), published in 2011, randomly assigned patients were more than 90% adherent to annual LDCT screening and achieved a 20% relative reduction in mortality from lung cancer compared to annual single view posteroanterior chest radiography<sup>3</sup>.

Prior to the recent expansion of the screening population, available data indicated that uptake of lung cancer screening (LCS) is low. A 2019 study found that 14.4% of persons eligible for lung cancer screening (based on 2013 US Preventive Services Task Force criteria) had been screened in the prior 12 months<sup>4</sup>. In addition to improving uptake, adherence to annual screening is a major determinant for successful lung cancer screening. At centralized LCS programs, trained navigators and dedicated program coordinators place LDCT orders, report results and provide patients with follow up reminders. Most patients screened through the centralized approach are referred by their PCP either through a consultation in the electronic medical record or, for those outside the health care system, through a referral call. At decentralized programs, primary care or specialty providers are typically responsible for these tasks while addressing other medical problems during a time constrained visit. A recent retrospective evaluation of an LCS program compared adherence between a centralized and a decentralized approach and described 70% adherence in the centralized program and 41% with the decentralized approach ( $P < 0.001$ )<sup>5</sup>. Studies have also suggested that when the original 2013 USPSTF recommendations were applied to community health care settings, disparities in existing lung cancer diagnoses among women, racial and ethnic minority groups, and individuals of low socioeconomic status worsened<sup>6</sup>.

To help realize the benefits of lung cancer screening, the American Thoracic Society and American Lung Association published a toolkit and pragmatic implementation guide for a successful program. Navigating insurance requirements and reimbursement is a key component of initiating and sustaining a lung cancer screening program<sup>7</sup>.

Centers for Medicare and Medicaid Services (CMS) requirements for coverage include completing a shared decision-making (SDM) visit prior to the first screening LDCT. The SDM visit includes counseling to discuss the need for lung cancer screening using LDCT. Shared decision-making visit should include the following elements:

- Determination of beneficiary eligibility; The patient should be asymptomatic from lung cancer and smoked within the past 15 years.
- Shared decision-making, including the use of one or more decision aids;
- Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of comorbidities and ability or willingness to undergo diagnosis and treatment; and
- Counseling on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation interventions.

ATS and other national professional medical organizations have published decision aids<sup>8</sup>. Since February, CMS has removed the requirement that the order for screening LDCT is written. The order can be entered electronically.

CMS also removed specificity regarding the type of provider who must furnish the counseling and SDM. Specifically, CMS does not believe there is an evidentiary reason to continue to limit the SDM visit to physician and non-physician practitioners. Removing the specification for the type of practitioner should expand the individuals that can conduct shared decision-making to other health care practitioners, such as health educators and others beyond physicians or non-physician practitioners. This proposed change may broaden access to LDCT screening. CMS notes that this expansion can allow for this service to be furnished “incident to” a physician’s professional service. “Incident-to” service rules allow for 100% Medicare RBRVS reimbursement. Since “Incident-to” requires a physician to initiate the original care plan, this pathway may create a bottle neck to completing shared decision-making. Centralized LCS programs may consider foregoing an “incident to” billing strategy since this strategy may increase time to first LDCT for LCS. Understanding coding and billing regulations can help support a centralized LCS program. The Balanced Budget Act of 1997 eliminated the Medicare

Code	Description	RVU (if applicable)
G0296	<b>Shared decision making / counseling</b>	0.52
	<ul style="list-style-type: none"> <li>• Determination of beneficiary eligibility;</li> <li>• Shared decision-making, including the use of one or more decision aids;</li> <li>• Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of comorbidities and ability or willingness to undergo diagnosis and treatment; and</li> <li>• Counseling on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation interventions.</li> </ul>	
71271	Interpretation of LDCT for LCS.	1.02

Telehealth / Virtual Visit Documentation Requirements	
The telehealth visit for shared decision making is billed as code G0296 with modifier 95.	Specific documentation is required such as: “This visit was conducted with the use of an interactive audio and video telecommunication system that permits the real-time communication between the patient and provider. The patient consent for this visit was obtained before the visit.” If the visit is performed as audio only, it should be documented as such.

**Note:** Updated CMS rule in February included removal of the requirement that the counseling and shared decision-making visit must be furnished by a physician or non-physician practitioner (NPP). This expansion can allow for this service to be furnished by auxiliary personnel “incident to” a physician’s professional service. Therefore, there still exists a relationship between the physician or NPP and the auxiliary personnel furnishing the SDM visit as there are existing rules that apply.

requirement that Advanced Practice Providers (Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists) practice under the direct, physical supervision of a physician. These practitioners can receive direct Medicare payment. Medicare payment continues to be the lesser of 85% of the Medicare RBRVS or the actual charge. Medicare payment would be the same regardless of practice location.

Originally, the SDM visit was intended to be a face-to-face encounter, but the face-to-face requirement was waived during the COVID public health emergency. The code for a shared decision-making visit is **G0296**. It is a 15-minute code with a work RVU 0.52 and approximate reimbursement of \$29.07 in the physician's office. CPT code **G0296** is listed as a permanent telehealth code<sup>9</sup>. Audio-only interaction can meet the requirements of SDM<sup>10</sup>. The code is payable in the facility and the non-facility setting. The National Coverage Determination (NCD) does not prevent the SDM visit from occurring on the same day as the lung cancer screening exam or from occurring in conjunction with the actual lung cancer screening exam. As long as the counseling and shared decision-making visit occurs before the beneficiary's first lung cancer screening exam then it satisfies the NCD. **G0296** can be billed on the same day as an E/M visit, assuming there is medical necessity. If this occurs, it should be billed with a -25 modifier added to the E/M service. The time to perform the E/M service is exclusive of the time to perform the shared decision-making. Billing **G0296** requires ICD-10 diagnosis code **Z87.891** (personal history of tobacco use/personal history of nicotine dependence). ICD-10 code **F17.2** can be used for current smokers (nicotine dependence). Coinsurance and Part B deductibles are waived. Since January 31, 2021 radiologists use code **71271**, and no longer use HCPCS code **G0297**, when interpreting a LDCT for LCS<sup>11</sup>. **71271** has a work RVU of 1.02. Since February, CMS has removed the requirement that radiology imaging facilities participate in a registry.

Lung cancer screening coverage can vary widely among private insurance plans. It is recommended to contact the insurer directly for coverage questions in advance of providing LCS services. Medicare Advantage Plans may charge co-pay, coinsurance or deductible if out of network. Individual private plans may charge additional costs associated with screening, such as facility fees.

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## Bronchoscopic Lung Volume Reduction (BLVR): Description and Coding Tips to Optimize Physician and Hospital Reimbursement

Neeraj R Desai, MD, MBA, FCCP D-AABIP

**Background:** BLVR is a nonsurgical, minimally invasive technique to achieve lung volume reduction via endobronchial valves. One-way valves are placed in the targeted diseased lobe allowing for air and secretions to exit and achieving lobar atelectasis. Presently, there are two types of valves in use: Zephyr (Pulmonx Inc., Redwood City, CA, USA) and Spiration (Spiration Inc, Olympus Respiratory America, Redmond, WA, USA)<sup>1</sup>.

Both valves require a thorough preprocedural selection process to identify appropriate patients and qualify them for treatment. This includes analysis of pulmonary function, functional assessment, and high-resolution CT to assess for collateral ventilation and fissure completeness (SeleCT<sup>®</sup> patient selection for Spiration, or StratX<sup>®</sup> Lung Analysis Platform for Zephyr). For the Pulmonx system, the Chartis<sup>™</sup> Pulmonary Assessment System is additionally used to confirm the lack of collateral ventilation prior to valve placement. A dedicated balloon catheter is placed endoscopically into the

targeted lobe to occlude the intended airway and monitor airflow and pressure to assess the presence or absence of collateral ventilation. The Spiration system relies on the degree of CT fissure integrity to assess for lack of collateral ventilation. If there is minimal or no collateral ventilation in the targeted lobe, appropriately sized valves are placed. Once the targeted airway is in view, the dedicated catheter (with compressed valve at the distal aspect) is advanced into position in the bronchus. The valve is deployed and self-expands. Multiple valves are typically deployed based on the size of airway branches and how many are needed to fully block ventilation. There is some ability to maneuver a valve once deployed; however, a valve cannot be re-used or re-deployed<sup>1</sup>.

**Scenarios during the procedure<sup>2,3</sup>:**

**A. During the procedure you perform evaluation using Chartis™**

- Possible Scenarios following Chartis assessment:
  - Scenario 1: Collateral ventilation present (CV+), Valve procedure is not performed (outpatient)
    - Only Chartis assessment performed (CPT **31634**)
  - Scenario 2: CV-, Valve placement procedure is performed (inpatient)
    - Chartis and Valve procedures bundled (CPT **31647, +31651**)

**B. During the procedure you perform the valve procedure without intraprocedural collateral ventilation assessment**

- Valve placement procedures is performed (inpatient)<sup>3</sup> (CPT **31647, +31651**)

**Common ICD-10 Diagnosis Codes associated with BLVR:**

ICD-10	ICD-10 Description
J43.0	Unilateral pulmonary emphysema
J43.1	Panlobular emphysema
J43.2	Centrilobular emphysema
J43.8	Other emphysema
J43.9	Emphysema, unspecified

**Typical MS-DRG Assignment<sup>5</sup>:**

MS-DRG	Description
163	Major Chest Procedures with MCC
164	Major Chest Procedures with CC
165	Major Chest Procedures without CC/MCC

CC = complication or comorbidity

MCC = major complication or comorbidity, lists codes which are assigned as a Major CC only for patients discharged alive.

**CPT description and total RVUs<sup>1,4</sup>:**

CPT Code/short description	Description	Work RVU	Total RVU
<b>31647</b> Insertion of valves (initial)	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe	4.15	6.05
<b>31648</b> Removal of valves	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe	3.95	5.79
<b>31651</b> Insertion of valves (additional lobe)	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (Use <b>31651</b> in conjunction with <b>31647</b> )	1.58	2.22
<b>31649</b> Removal of valves (additional lobe)	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure) (Use <b>31649</b> in conjunction with <b>31648</b> )	1.44	1.96

**CPT codes for Intraoperative Assessment of collateral ventilation using balloon occlusion (e.g., during Chartis™ assessment)**

<b>31634</b> Balloon Occlusion	Bronchoscopy, rigid with balloon occlusion, with assessment of air leak or flexible, including fluoroscopic guidance, when performed; with administration of occlusive substance (e.g., fibrin glue), if performed (Do not report <b>31634</b> in conjunction with <b>31647, 31651</b> at the same session)	3.75	5.54
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In addition to documenting the procedure performed, it is important to document patient comorbidities and/or post-procedure complications during the patient stay so that the appropriate MS-DRG assignment is selected.

### Endobronchial Valve Removal

CPT 31648 is for valve(s) removal from one lobe and CPT add-on +31649 for removal from each additional lobe regardless of number removed from each.

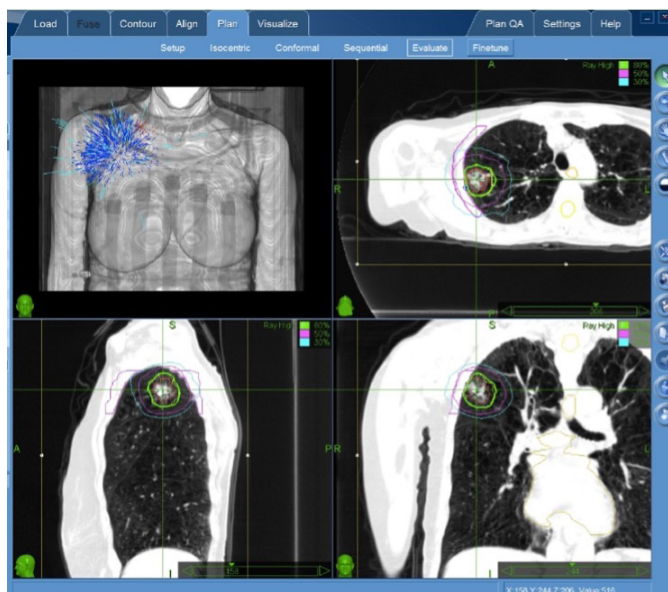
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## SBRT Planning CPT Code 32701: Description and Documentation Tips

Neeraj R Desai MD MBA FCCP D-AABIP  
Kim French MHSA CAPPM FCCP

**Background:** Beginning of January 1, 2013, a new contouring code was made available for lung specialists—the CPT code is **32701**. This code has been historically underutilized by lung specialists (only ~100 cases in the 2019 Medicare patients). SBRT (Thoracic) Planning CPT **32701** is defined as thoracic target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), for the entire course of treatment. SBRT planning is a collaborative service between the surgeon or operator, and the radiation oncologist that is distinct from treatment, dosimetry, or management by the radiation oncologist. Planning occurs prior to treatment and is billed once to capture the planning for the entire treatment course. During the planning process, thoracic targets, borders, volume, relation to adjacent structures, and if available, fiducial markers (FMs) are delineated. Note that placement of FMs (CPT **31626** if done via bronchoscopy) is a distinct procedure from SBRT planning, done separately, and does not impact the coding of SBRT planning or treatment. SBRT planning may also help validate the target in tracking systems that does not use fiducials, depending on software capabilities. Planning systems have become more comprehensive and offer the ability to generate detailed reports prior to treatment<sup>1-3</sup>. CPT Code **32701**  
**Description:** thoracic target(s) delineation for SBRT, entire course



of treatment. Thoracic Target(s) delineation for stereotactic body radiation therapy (SRS/SBRT), (photon or particle beam), entire course of treatment.

**Relative Value Unit:** The relative value units (RVUs) for this code in 2021, which determines the reimbursement for CMS Medicare and often considered by commercial insurers when setting rates, is 6.19 total RVUs, which includes 4.18 physician wRVUs<sup>4</sup>.

**Global Service Period for 32701:** CPT **32701** has a 0-day global period. This allows physicians to bill for other services in conjunction with treatment planning and may include placement of FMs and office and hospital visits. **32701** may be billed only once (1) during the full course of treatment. Adding this code supports the importance of collaboration in providing overall quality patient care.

#### Sample Criteria to Optimize Documentation and Use of CPT 32701 Checklist:

Documentation requirements:

- Collaboration between physician and radiation oncologist
- Correlation between tumor and contiguous body structures
- Determination of borders and volume of tumor
- Identification of FM and/or target

Reporting requirements:

- Computer planning with image infusion
- Using available imaging with personal review, collaboration to outline target and help develop dosimetry plans, and select the

plan with focus on maximal treatment to the target lesion and minimal impact on surrounding structures

- Communication with patient, family, and treating physicians
- Availability to assist optimal patient positioning or to adjust plan
- Supporting notes and orders
- Signature, credentials, date, time and location if performed under Telemedicine services
- Final plans should be uploaded to EMR of record.

**References:**

1. Desai NR, Gildea TR, Kessler E, et al. Advanced Diagnostic and Therapeutic Bronchoscopy: Technology and Reimbursement. *Chest*. 2021;160(1):259-267.
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**Answer:** When using time to bill for New and Established patients in the office setting, the 2021 guidelines allow for all the time spent on the calendar day of the service to be used. This includes time to prepare for the visit reviewing records, face to face time with the patient obtaining history and a medically appropriate examination, counseling and educating the patient and family, communicating with other health care professionals (when not separately reported), independently interpreting results (not separately reported) and communicating with the patient/family, ordering medications and tests, as well as documenting in the electronic or other health record. In this example a total 95 minutes was spent. This exceeds the 89-minute threshold and therefore you would bill the New **99205** (60-74 min) as well as HCPCS code **G2212** Prolonged services for each 15 minutes beyond 89 (for new) or 69 (for established), and not **99417**. Also, total time should be documented in the note.

Remember however that Medical Decision Making (MDM) may also be used for selecting the level of service, and in most instances, may be easier to document than using time for the more typical patient encounters.

## Q&As

### E/M New Patient Billing

**Question:** Using the new 2021 E&M guidelines, how do I bill a New Patient E&M in the office using time in the following example? I spent 40 minutes face to face with the patient and another 55 minutes reviewing the chart and preparing for the visit, ordering medications and tests, and documenting the visit in the electronic record.

### New (99202-99205) and Established (99212-99215) Time Ranges

New Patient E&M Code	Total Time Required	Established Patient E&M Code	Total Time Required
<b>99202</b>	15-29	<b>99212</b>	10-19
<b>99203</b>	30-44	<b>99213</b>	20-29
<b>99204</b>	45-59	<b>99214</b>	30-39
<b>99205</b>	60-74	<b>99215</b>	40-54

### G2212 Time Thresholds

New Patient E&M Code	Total Time Required	Not Reported Separately	G2212 x 1	G2212 X 2	G2212 x 3 or more
<b>99205</b>	60-74	Less than 89 minutes	89-103 minutes	104-118 minutes	119 min or more for each additional 15 minutes
<b>99215</b>	40-54	Less than 69 minutes	69-83 minutes	84-98 minutes	99 minutes or more for each additional 15 minutes

**Critical care**

**NPP sees patient at 9 a.m. and records 90 minutes of critical care then MD sees the patient at 2 p.m. and records 25 minutes of critical care services. They are in the same group practice. Would we post 99291 and 99292, or just one 99291?**

This would be considered split/shared and the time would be aggregated for a total of 115 minutes so you would bill **99291** and **99292** for the NPP since they are performing the substantive portion with the FS modifier.

**Reference**

[CMS IOM Pub. 100-04, Medicare Claims Processing Manual Chapter 12, section 30.6.12.5](#)

**If the MD and NPP are part of the same group, if they are in the room together with the patient, we can only count that time once, correct?**

Yes, this situation would be considered split/shared and the time together can only be counted once. Consistent with all split/shared visits, when two or more practitioners spend time jointly meeting with or discussing the patient as part of a critical care service, the time can be counted only once for purposes of reporting the split (or shared) critical care visit.

**Reference**

[CMS IOM Pub. 100-04, Medicare Claims Processing Manual Chapter 12, section 30.6.12.5](#)

**To clarify, if a physician sees a patient for critical care for 20 minutes, runs to see another patient for 10 minutes and then back to the critical care patient for 40 minutes, you can still charge the 99291?**

For **99291**, it does not have to be continuous, but it does require the full attention of the provider. So yes, 20 minutes plus 40 minutes would be a total of 60 minutes which would meet the definition of **99291** which is 30 - 74 minutes.

**Reference**

[CMS IOM Pub. 100-04, Medicare Claims Processing Manual Chapter 12, section 30.6.12.1](#)

**E/M Prolong Service Codes**

**Question: Can I still use the prolonged service codes 99358 (Prolonged E&M service before and/or after direct patient care, 1<sup>st</sup> hour) and 99359 (each additional 30 minutes) for non-face to face time with the new 2021 Outpatient E&M coding guidelines for New and Established visits?**

**Answer:** Yes, these prolonged services codes **99358** and **99359** may still be used in certain situations. For new and established patients in the outpatient setting, use these only when the prolonged service is on a day other than the date of the face-to-face encounter. For example, if you obtain records several days after the office visit and provide extensive record review. Remember this must relate to a service where patient care has occurred or will occur and also must pertain to ongoing patient management. Remember to report the date of the related face-to-face service and the total duration of the non-face-to-face time spent. Time does not have to be continuous, though must be on a single day. These codes are not to be reported on the same day of service as **99202-99205** or **99212-99215** or **G2212/99417**. They may be used in the office when Consultation codes are used (**99241-99245**) and additional Non-face-to face prolonged services are provided the same or a different day. They may also be used with inpatient E&M services when prolonged services which are non-face-to-face have occurred. Documentation must be clear as to the time spent and what non-face-to-face services were provided (such as extensive record review and care coordination with other healthcare professionals related to ongoing management of the patient) in addition to the face-to-face-time.

In addition to the non-face-to-face prolonged services codes, there are also Face-to-face prolonged services codes, **99354** (Prolonged service requiring face to face contact beyond the typical time, first hour – 30 min minimum) and **99355** (each additional 30 min) which may be used. They may not be reported with **99202-99215**. They may be reported with office consultations **99241-99245** and with other codes such as psychotherapy codes (**90837, 90847**), domiciliary codes (**99324-99337**), home visit codes (**99341-99350**) and with cognitive assessment **99483**.

**Time Threshold for 99354 and 99355 with Office Consultations**

Consult Code	Consult Time in Minutes	Total Time Needed to Bill 99354	Total Time Needed to Bill 99354 and 99355
<b>99241</b>	15	<b>45-89</b>	90-129
<b>99242</b>	30	<b>60-104</b>	105-144
<b>99243</b>	40	<b>70-114</b>	115-154
<b>99244</b>	60	<b>90-134</b>	135-174
<b>99245</b>	80	<b>110-154</b>	155-194



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