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Letter from the Editor

Welcome to the January 2015 edition of the ATS Coding and Billing Quarterly. The New Year will bring a number of important changes to medicine for practitioners of pulmonary, critical care and sleep medicine. Below are some issues that ATS members and their staff need to be aware of and prepared for:

ICD-10 Transition – Barring another last minute intervention by Congress (which is possible but very unlikely), 2015 will be the year of the ICD-10 transition. I hope providers and practices are well underway preparing for the transition. Over the past year, the ATS Coding and Billing Quarterly has featured articles on the transition. The April 2015 edition will cover ICD-10 for pediatric pulmonary services.

Lung Cancer Screening Coverage – Earlier this month, the Centers for Medicare and Medicaid Services (CMS) released its final coverage policy for lung cancer screening. In this issue, Dr. Kovitz describes the final coverage policy, its impact on Medicare and private coverage, as well as tips for coding services related to screening.

New ECMO codes – Also covered in this issue is the new and expanded family of codes for EMCO services. Dr. Hussain describes the new codes and how they will likely be used by pediatric and adult providers.

Sustainable Growth Rate Factor – Yes, the looming SGR problem is still with us. Despite the significant progress made by Congress last year, they still were unable to pass a permanent fix to the SGR crisis and for the 17th time, passed a short-term patch. The short-term patch extended the 0.5% Medicare update through 2014 – please note, providers will see a 0.5% cut in reimbursement starting January 1, 2015 – and delayed the 24% SGR payment cut through March 31, 2015. So once again, Congress will start the New Year having to act fast on an SGR bill – or jeopardize destabilizing the Medicare program.

While the above issues are on the ATS radar screen, I am confident 2015 will hold many more surprises and challenges for the pulmonary, critical care and sleep community. We will continue to do our best to share timely and accurate information with ATS members on billing, coding and regulatory compliance issues.

Sincerely,

Alan L. Plummer, MD
Editor

LOW DOSE CT (LDCT) LUNG CANCER SCREENING COVERAGE—IMPLICATIONS FOR THE PRACTITIONER

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No Conflicts.

National coverage for lung cancer screening has arrived. In February 2015, Centers for Medicare & Medicaid Services (CMS) issued a final coverage policy. Heretofore, screening programs have had varying levels of success in attracting providers and patients alike with the major barrier being lack of reimbursement. The purpose of this discussion is separate from the utility of screening. Rather, the focus is on obtaining coverage for the patient encounters and scans required. The Affordable Care Act and the CMS lung cancer screening policy significantly change coverage.

There are 2 main areas to understand, CMS coverage and commercial carrier coverage.

CMS Coverage

From a CMS perspective, we can take the specific criteria from their announcement.[1] The ATS, like many organizations, submitted comments to improve and clarify the initial CMS proposal. Specifically, the ATS recommended extending the screening coverage to include Medicare beneficiaries aged 75-80, sought clarification on the shared decision making visits, recommended clarifying language on the term "asymptomatic" and noted the importance of a multidisciplinary team in diagnosing and managing lung cancer. The final CMS policy addresses these issues, with the age reaching 77, shared decision making clarified, and "asymptomatic" focused to symptoms related to lung cancer. Practitioners and programs should carefully review the final policy prior to establishing a site-specific screening protocol.

The CMS proposal is very detailed, mostly follows the National Lung Screening Trial (NLST) criteria, and requires specific personnel, shared decision making with the patient, specific documentation, smoking cessation counseling, detailed orders, specific radiology requirements, and participation in a registry. The specific CMS decision summary of the policy, copied directly from the website, is noted below1 for reference as there are extensive and very detailed requirements. Please review these carefully.

Private Insurance

Commercial carriers face a different issue. As most are aware, the USPSTF has recommended lung cancer screening for a broader age range.[2] The grade of B was given for the validity of the supporting data. According to the Affordable Care Act, 3 all preventative services that received an A or B grade from the USPSTF must be covered by private insurance at no costs to the consumer.[3] Commercial carriers are required incorporate category A and B recommendations with the plans annual renewal. It is important to note that the annual renewal date for private plans can happen through the calendar year. Private insurance coverage for lung cancers screening did not necessarily start in January for private patients. Providers should consult with patients and insurance companies to ensure lung cancer screening is covered.

Age and Coverage Policy

The coverage criteria are similar in all respects aside from age. This is not an issue in most situations as the 55-64 year old and the 65-77 year old with commercial insurance or Medicare should be covered. The most common scenario is of the younger patient with commercial insurance and the older group with Medicare. Interestingly, the 78-80 year old with Medicare is not covered unless they have commercial insurance as primary coverage. The commercially insured older patient is likely to represent a small group and CMS coverage is an issue if one is of the opinion that screening needs to be done in this age group.

Coding

Coding is multifactorial. However, there is no specific CPT code for the Evaluation and Management of a patient that presents for Lung Cancer Screening evaluation. Traditional outpatient consults (where applicable), new patient or established patient E & M coding should be used. The E & M selected must be commensurate with the level of service as determined by specific actions or counseling as one would with any visit. The diagnoses may include, but are not limited to: special screening for malignant neoplasm of the respiratory organs, V76.0 (ICD-9) or Z12.2 (ICD-10)[4] and all diagnoses appropriate to the patient's problems. Consider including a code for the tobacco history such as nicotine dependence (ICD-9 305.1, ICD-10 F17.200) or history of same (ICD-9 V15.82, ICD-10 Z87.891). The tobacco code is not specified but makes sense as these patients need a smoking history and pack years need to be documented in order to qualify for screening.

The radiologist will have a specific HCPCS code of S8032 Low-dose computed tomography for lung cancer screening.[5]

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The above summary reflects the current point in time. Practitioners and programs are urged to carefully review the final policy before establishing program policies. Additionally, it is important to review the policies of individual commercial carriers as they often differ from CMS.

References

1. http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=274 accessed 2/10/15). See below.
2. Moyer VA on behalf of the U.S. Preventive Services Task Force. Screening for lung cancer: U.S. preventive services task force recommendation statement. Ann Intern Med. 2014;160(5):330-338.
3. http://www.law.cornell.edu/cfr/text/29/2590.715-2713 (accessed 12/3/14) by way of http://newsatjama.jama.com/2014/10/15/jama-forum-lung-cancer-screening-and-evidence-based-policy/ accessed 12/3/14.
4. Current Procedural Terminology (versions 9 and 10) and Healthcare Procedural Coding System (HCPCS) codes referenced are the property of the American Medical Association.

The following is copied directly from the CMS website[1]:

*The Centers for Medicare & Medicaid Services (CMS) has determined that the evidence is sufficient to add a lung cancer screening counseling and shared decision making visit, and for appropriate beneficiaries, annual screening for lung cancer with low dose computed tomography (LDCT), as an additional preventive service benefit under the Medicare program only if all of the following criteria are met:

Beneficiary eligibility criteria:

- Age 55 – 77 years;
- Asymptomatic (no signs or symptoms of lung cancer);
- Tobacco smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes);
- Current smoker or one who has quit smoking within the last 15 years; and
- Receives a written order for LDCT lung cancer screening that meets the following criteria:
  - For the initial LDCT lung cancer screening service: a beneficiary must receive a written order for LDCT lung cancer screening during a lung cancer screening counseling and shared decision making visit, furnished by a physician (as defined in Section 1861(r)(1) of the Social Security Act) or qualified non-physician practitioner (meaning a physician assistant, nurse practitioner, or clinical nurse specialist as defined in §1861(aa)(5) of the Social Security Act). A lung cancer screening counseling and shared decision making visit includes the following elements (and is appropriately documented in the beneficiary's medical records):
- Determination of beneficiary eligibility including age, absence of signs or symptoms of lung cancer, a specific calculation of cigarette smoking pack-years; and if a former smoker, the number of years since quitting;
- Shared decision making, including the use of one or more decision aids, to include benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false positive rate, and total radiation exposure;
- Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of comorbidities and ability or willingness to undergo diagnosis and treatment;
- 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; and
- If appropriate, the furnishing of a written order for lung cancer screening with LDCT.
  - For subsequent LDCT lung cancer screenings: the beneficiary must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician (as defined in Section 1861(r)(1) of the Social Security Act) or qualified non-physician practitioner (meaning a physician assistant, nurse practitioner, or clinical nurse specialist as defined in Section 1861(aa)(5) of the Social Security Act). If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the criteria described above for a counseling and shared decision making visit.
  - Written orders for both initial and subsequent LDCT lung cancer screenings must contain the following information, which must also be appropriately documented in the beneficiary's medical records:
- Beneficiary date of birth;
- Actual pack - year smoking history (number);
- Current smoking status, and for former smokers, the number of years since quitting smoking;

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- Statement that the beneficiary is asymptomatic (no signs or symptoms of lung cancer); and
- National Provider Identifier (NPI) of the ordering practitioner.

Reading radiologist eligibility criteria:

- Board certification or board eligibility with the American Board of Radiology or equivalent organization;
- Documented training in diagnostic radiology and radiation safety;
- Involvement in the supervision and interpretation of at least 300 chest computed tomography acquisitions in the past 3 years;
- Documented participation in continuing medical education in accordance with current American College of Radiology standards; and
- Furnish lung cancer screening with LDCT in a radiology imaging facility that meets the radiology imaging facility eligibility criteria below.

Radiology imaging facility eligibility criteria:

- Performs LDCT with volumetric CT dose index (CTDIvol) of ≤ 3.0 mGy (milligray) for standard size patients (defined to be 5' 7" and approximately 155 pounds) with appropriate reductions in CTDIvol for smaller patients and appropriate increases in CTDIvol for larger patients;
- Utilizes a standardized lung nodule identification, classification and reporting system;
- Makes available smoking cessation interventions for current smokers; and
- Collects and submits data to a CMS-approved registry for each LDCT lung cancer screening performed. The data collected and submitted to a CMS-approved registry must include, at minimum, all of the following elements:

Data Type	Minimum Required Data Elements
Facility	Identifier
Radiologist (reading)	National Provider Identifier (NPI)
Patient	Identifier
Ordering Practitioner	National Provider Identifier (NPI)
CT scanner	Manufacturer, Model.
Indication	Lung cancer LDCT screening – absence of signs or symptoms of lung cancer
System	Lung nodule identification, classification and reporting system
Smoking history	Current status (current, former, never). If former smoker, years since quitting. Pack-years as reported by the ordering practitioner. For current smokers, smoking cessation interventions available.
Effective radiation dose	CT Dose Index (CTDIvol).
Screening	Screen date Initial screen or subsequent screen

2015 BRINGS NEW EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)/EXTRACORPOREAL LIFE SUPPORT (ECLS) COMMON PROCEDURAL TERMINOLOGY (CPT) CODES

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On January 1, 2015 Medicare deleted CPT codes **33960** (Prolonged extracorporeal circulation (ECMO) for cardiopulmonary insufficiency; initial day), **33961** (Prolonged extracorporeal circulation (EMCO) for cardiopulmonary insufficiency; each subsequent day), and **36822** (Insertion of Cannula(s) for Prolonged ECMO) and replaced these three codes with a new family of ECMO codes. These three codes were identified by CMS as potentially misvalued codes. CMS noted the services were originally valued when they were primarily provided to premature neonates. But the services are now typically used in treating adults with severe influenza, pneumonia, and the respiratory distress syndrome. For 2015, these codes will be replaced with 25 new codes to describe this treatment. The new codes will differentiate initiation vs continuation, patient age, veno-venous vs veno-arterial, insertion site, removal, and repositioning.

The ATS played an important role in the creation and valuation of the new family of CPT codes. The ATS worked closely with the AMA CPT committee, CMS, and sister organizations to ensure the new family of CPT codes accurately reflected the expanded use of ECMO in clinical care. The ATS also worked to ensure CMS adopted appropriate RUC values to ensure fair compensation for these procedures.

Adult and Pediatric Codes:

The following codes should be used for ECMO veno-venous and veno- arterial initiation and ECMO veno-venous and veno-arterial daily management for patients of any age. For patients requiring alternative insertion methods, repositioning, and removal, please see the adult and pediatric sections for the correct code.

33946 Extracorporeal membrane oxygenation (ECMO)/ extracorporeal life support (ECLS) provided by physician; **initiation, veno-venous**

33947 Extracorporeal membrane oxygenation (ECMO)/ extracorporeal life support (ECLS) provided by physician; **initiation, veno-arterial.**

33948 Extracorporeal membrane oxygenation (ECMO)/ extracorporeal life support (ECLS) provided by physician; **daily management**, each day, **veno-venous.**

33949 Extracorporeal membrane oxygenation (ECMO)/ extracorporeal life support (ECLS) provided by physician; **daily management**, each day, **veno-arterial.**

Adult Codes

The following codes are used to describe the alternate insertion methods, repositioning, and removal of ECMO in patients 6-years old and older.

33952 Extracorporeal membrane oxygenation (ECMO)/ extracorporeal life support (ECLS) provided by physician; **insertion** of **peripheral** (arterial and/or venous) cannula(e), **percutaneous**, 6 years and older (includes fluoroscopic guidance, when performed).

33954 Extracorporeal membrane oxygenation (ECMO)/ extracorporeal life support (ECLS) provided by physician; **insertion** of **peripheral** (arterial and/or venous) cannula(e), **open**, 6 years and older.

33956 Extracorporeal membrane oxygenation (ECMO)/ extracorporeal life support (ECLS) provided by physician; **insertion** of **central** cannula(e) by **sternotomy** or **thoracotomy**, 6 years and older.

33958 Extracorporeal membrane oxygenation (ECMO)/ extracorporeal life support (ECLS) provided by physician; **reposition peripheral** (arterial and/or venous) cannula(e), **percutaneous**, 6 years and older (includes fluoroscopic guidance, when performed).

33962 Extracorporeal membrane oxygenation (ecmo ECMO)/extracorporeal life support (ECLS) provided by physician; **reposition central** (arterial and/or venous) cannula(e), **open**, 6 years and older (includes fluoroscopic guidance, when performed).

33964 Extracorporeal membrane oxygenation (ecmo ECMO)/extracorporeal life support (ECLS) provided by physician; **reposition central** cannula(e) by **sternotomy** or **thoracotomy**, 6 years and older (includes fluoroscopic guidance, when performed).

33966 Extracorporeal membrane oxygenation (ECMO)/ extracorporeal life support (ECLS) provided by physician; **removal** of **peripheral** (arterial and/or venous) cannula(e), **percutaneous**, 6 years and older.

33984 Extracorporeal membrane oxygenation (ECMO)/ extracorporeal life support (ECLS) provided by physician; **removal** of **peripheral** (arterial and/or venous) cannula(e), **open**, 6 years and older.

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33986 Extracorporeal membrane oxygenation (ECMO)/ extracorporeal life support (ECLS) provided by physician; **removal** of **central** cannula(e) by **sternotomy** or **thoracotomy**, 6 years and older.

ECMO Adult Vignette

A 60 year old with ARDS and persistent, severe hypoxemia, despite high levels of PEEP and appropriate salvage therapies, is considered for ECMO. His respiratory failure is potentially reversible. The patient also requires norepinephrine for hemodynamic support. Cardiovascular surgery places the veno-arterial cannulas percutaneously by Seldinger technique into the inferior vena cava and into the femoral artery. The MICU team manages the blood flow of the ECMO circuit on the first day. On the subsequent day, the MICU team continues to monitor venous oximetry and make adjustments.

Correct Coding:
Day 1: CV surgery bills 33952, MICU bills 33947
Day 2: MICU bills 33949

Please note, initiation codes (**33946**/**33947**) and daily management codes (**33948**, **33949**) cannot be billed on the same day.

Pediatrics codes

The following codes are used to describe the alternative insertion methods, repositioning, and removal of ECMO in the pediatric population (<6 years old).

33951 Extracorporeal membrane oxygenation (ECMO)/ extracorporeal life support (ECLS) provided by physician; **insertion** of **peripheral** (arterial and/or venous) cannula(e), **percutaneous**, birth through 5 years of age (includes fluoroscopic guidance, when performed).

33953 Extracorporeal membrane oxygenation (ECMO)/ extracorporeal life support (ECLS) provided by physician; **insertion** of **peripheral** (arterial and/or venous) cannula(e), **open**, birth through 5 years of age.

33955 Extracorporeal membrane oxygenation (ECMO)/ extracorporeal life support (ECLS) provided by physician; **insertion** of **central** cannula(e) by **sternotomy** or **thoracotomy**, birth through 5 years of age.

33957 Extracorporeal membrane oxygenation (ECMO)/ extracorporeal life support (ECLS) provided by physician; **reposition peripheral** (arterial and/or venous) cannula(e), **percutaneous**, birth through 5 years of age (includes fluoroscopic guidance, when performed).

33959 Extracorporeal membrane oxygenation (ECMO)/ extracorporeal life support (ECLS) provided by physician; **reposition central** (arterial and/or venous) cannula(e), **open**, birth through 5 years of age. (includes fluoroscopic guidance, when performed).

33963 Extracorporeal membrane oxygenation (ECMO)/ extracorporeal life support (ECLS) provided by physician; **reposition central** cannula(e) by **sternotomy** or **thoracotomy**, birth through 5 years of age. (includes fluoroscopic guidance, when performed).

33965 Extracorporeal membrane oxygenation (ECMO)/ extracorporeal life support (ECLS) provided by physician; **removal** of **peripheral** (arterial and/or venous) cannula(e), **percutaneous**, birth through 5 years of age.

33969 Extracorporeal membrane oxygenation (ECMO)/ extracorporeal life support (ECLS) provided by physician; **removal** of **peripheral** (arterial and/or venous) cannula(e), **open**, birth through 5 years of age.

33985 Extracorporeal membrane oxygenation (ECMO)/ extracorporeal life support (ECLS) provided by physician; **removal** of **central** cannula(e) by **sternotomy** or **thoracotomy**, birth through 5 years of age.

ECMO Pediatric Vignette

An infant with severe persistent pulmonary hypertension of the newborn remains hypoxic on maximal ventilator support despite inhaled nitric oxide. In order to maintain tissue oxygen delivery and avoid permanent lung injury, ECMO is considered. Pediatric surgery places the large catheters into the right jugular vein and into the right carotid artery. The NICU team manages the ECMO circuit on the first day and subsequent days.

Correct Coding:
Day 1: Surgery bills 33951, NICU bills 33947
Day 2: NICU bills 33949

Please note, initiation codes (**33946**/**33947**) and daily management codes (**33948**, **33949**) cannot be billed on the same day.

Online resource:

https://www.federalregister.gov/articles/2014/11/13/2014-26183/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-clinical-laboratory#h-178

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INITIATION and DAILY MANAGEMENT ECMO Codes:

CY 2015 CF $35.7547

CPT/ HCPCS	Modifier	Short Description	Physician Work RVUs	2015 FAC Allowable
•33946		ECMO/ECLS initiation venous	6.00	$321.43
•33947		ECMO/ECLS initiation artery	6.63	$355.04
•33948		ECMO/ECLS daily mgmt-venous	4.73	$253.86
•33949		ECMO/ECLS daily mgmt artery	4.60	$247.06

ADULT ECMO Codes:

CY 2015 CF $35.7547

CPT/ HCPCS	Modifier	Short Description	Physician Work RVUs	2015 FAC Allowable
•33952		ECMO/ECLS insj prph cannula	8.15	$448.36
•33958		ECMO/ECLS repos perph cnula	3.51	$199.51
#•33962		ECMO/ECLS repos perph cnula	4.47	$245.99
#•33966		ECMO/ECLS rmvl prph cannula	4.50	$247.78
#•33984		ECMO/ECLS rmvl prph cannula	5.46	$298.19

PEDIATRIC ECMO codes:

CY 2015 CF $35.7547

CPT/ HCPCS	Modifier	Short Description	Physician Work RVUs	2015 FAC Allowable
•33951		ECMO/ECLS insj prph cannula	8.15	$461.24
•33955		ECMO/ECLS insj ctr cannula	16.00	$928.91
•33957		ECMO/ECLS repos perph cnula	3.51	$206.30
#•33965		ECMO/ECLS rmvl perph cannula	3.51	$206.30
#•33969		ECMO/ECLS rmvl perph cannula	5.22	$303.91
#•33985		ECMO/ECLS rmvl ctr cannula	9.89	$572.43

Disclaimer

The information provided herein was current at the time of this communication. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference. The opinions referenced are those of the members of the ATS Clinical Practice Committee and their consultants based on their coding experience. They are based on the commonly used codes in pulmonary, sleep and the critical care sections in CPT and HCPCS level II, which are not all inclusive. Always check with your local insurance carriers as policies vary by region. The final decision for the coding of a procedure must be made by the physician considering regulations of insurance carriers and any local, state or federal laws that apply to the physicians practice. The ATS and its representatives disclaim any liability arising from the use of these opinions. ®CPT is a registered trademark of the American Medical Association, CPT only copyright 2014 American Medical Association.

Q&A

Advance Care Planning Services

Q. CPT has created two new codes for advance care planning CPT **99497** and **99498**, both effective January 1, 2015 how much is Medicare paying for this service?

A. Unfortunately Medicare for CY 2015 has decided that these services are paid using existing CPT codes such as E&M services, therefore these two codes if billed have no Medicare payment. For Medicare if you provide these services continue to use your E&M codes to report. If you are billing to third party payers, check with those payers as they may have different payer policies from Medicare.

Complex Chronic Care Services (CCM)

Q. Can all physicians including specialists' bill the CCM services, or are they just for primary care physicians?

A. Yes, any physician or qualified health care professional meeting the reporting requirements are able to bill for CCM. Physicians treating patients with at least two or more chronic conditions could be eligible to bill the codes. Only one physician per month may report these services.

Q. For a Medicare patient, since Medicare is only paying for the single CPT code **99490**, if a patient meets the elements of **99487** or a combination of **99487** and **99489** can I bill the **99490** rather than the higher complexity code?

A. Yes, similar to how Medicare is not recognizing the consultation codes and they instruct providers to use other E&M codes in their place we would see no difference for these codes, therefore CPT would defer to the payer policies and allow billing the less intense code when Medicare is not recognizing the higher complexity services.

Q. Are there only certain diagnoses that CCM codes can be reported with?

A. There is not a defined list of diagnosis codes that meet the requirements of CCM. What is required is that the chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline and that management requires a care plan. There has been no guidance as to whether claims will require two or more diagnoses. Some examples of patients with two or more of the following conditions that may be appropriate for the use of chronic care management services:

- congestive heart failure
- COPD
- poorly controlled diabetes mellitus
- neurocognitive disorders including Alzheimer's disease, dementia and Parkinson's disease
- stroke with late effects that place the patient at risk for falls, fractures and aspiration pneumonia

*Please note this is not an all-inclusive list.

Q. Does a specialist such as a neurologist or pulmonologist have to manage all of the chronic conditions in order to utilize the CCM code? Or is it sufficient if he/ she manages one condition and the other conditions impact the management of the one condition?

A. The specialist has to manage all of the patient's chronic conditions to report CCM. The specialist may be the individual who is overseeing all care management and coordination. Of note, only one physician is allowed to bill and be paid for this service during any one calendar month.

Q. Can an E/M visit be billed at the same time as the CCM code?

A. Yes, but any clinical staff time on a day when the physician reports an E/M service may not be counted toward the care management service code. E/M services may be reported separately by the same physician (or other qualified heath care professional) during the same calendar month.

Q. Will the patient be required to pay co-pay each month, when the CCM service is reported?

A. Yes, the patient must indicate to the physician he/she wants chronic care management services, and is responsible for the co-insurance. It is the responsibility of the health care provider to notify the patient of the co-insurance and document consent for the service. Medicare has not yet indicated if signed consent is required each month or for a series of months. We will ask CMS for further guidance.

FINAL 2014 Compared to FINAL Jan to Mar 2015 Rates

Medicare Physician Fee Schedule(MPFS) Endoscopy/Bronchoscopy, Pulmonary Diagnostic Testing & Therapies, Sleep Medicine Testing, Pulmonary Rehabilitation/Respiratory Therapy and Thoracentesis/Chest Tubes December 23, 2014 MPFS File for January 1, 2015 & August 15, 2014 for October Release MPFS Files

			CY 2014 CF $35.8228	CY 2015 CF $35.7547	% Change	Dollar Change	CY 2014 CF $35.8228	CY 2015 CF $35.7547	% Change	Dollar Change
CPT/ HCPCS	Modifier	Short Description	2014 NF Allowable	2015 NF Allowable	NF Allowable	NF Allowable	2014 FAC Allowable	2015 FAC Allowable	FAC Allowable	FAC Allowable
31615		Visualization of windpipe	$186.28	$185.92	0%	($0.35)	$132.90	$132.65	0%	($0.25)
31620		Endobronchial us add-on	$290.88	$293.19	1%	$2.31	$69.50	$70.08	1%	$0.58
31622		Dx bronchoscope/wash	$316.32	$318.93	1%	$2.62	$151.53	$150.17	-1%	($1.36)
31623		Dx bronchoscope/brush	$334.58	$337.17	1%	$2.58	$151.53	$151.24	0%	($0.29)
31624		Dx bronchoscope/lavage	$314.88	$319.29	1%	$4.41	$152.61	$152.67	0%	$0.07
31625		Bronchoscopy w/biopsy(s)	$338.53	$339.31	0%	$0.79	$176.25	$175.91	0%	($0.34)
31626		Bronchoscopy w/markers	$449.93	$456.23	1%	$6.30	$213.15	$219.53	3%	$6.39
31627		Navigational bronchoscopy	$1,309.68	$1,434.84	10%	$125.15	$97.80	$100.47	3%	$2.67
31628		Bronchoscopy/lung bx each	$381.15	$379.00	-1%	($2.15)	$195.95	$195.94	0%	($0.01)
31629		Bronchoscopy/needle bx each	$599.67	$599.96	0%	$0.29	$211.00	$211.31	0%	$0.31
31630		Bronchoscopy dilate/fx repr	NA	NA	NA	NA	$207.77	$207.02	0%	($0.75)
31631		Bronchoscopy dilate w/stent	NA	NA	NA	NA	$237.86	$239.56	1%	$1.69
31632		Bronchoscopy/lung bx addl	$72.36	$72.58	0%	$0.22	$50.51	$50.41	0%	($0.10)
31633		Bronchoscopy/needle bx addl	$89.56	$89.74	0%	$0.19	$65.20	$65.43	0%	$0.23
31634		Bronch w/balloon occlusion	$1,886.43	$1,912.88	1%	$26.45	$207.06	$214.17	3%	$7.11
31635		Bronchoscopy w/fb removal	$352.14	$356.47	1%	$4.34	$194.52	$194.86	0%	$0.35
31636		Bronchoscopy bronch stents	NA	NA	NA	NA	$229.62	$229.19	0%	($0.44)
31637		Bronchoscopy stent add-on	NA	NA	NA	NA	$76.30	$76.52	0%	$0.21
31638		Bronchoscopy revise stent	NA	NA	NA	NA	$263.66	$262.44	0%	($1.22)
31640		Bronchoscopy w/tumor excise	NA	NA	NA	NA	$264.01	$263.15	0%	($0.86)
31641		Bronchoscopy treat blockage	NA	NA	NA	NA	$267.24	$266.01	0%	($1.22)
31643		Diag bronchoscope/catheter	NA	NA	NA	NA	$181.98	$182.35	0%	$0.37
31645		Bronchoscopy clear airways	$323.12	$329.66	2%	$6.54	$166.93	$166.62	0%	($0.32)
31646		Bronchoscopy reclear airway	$290.52	$296.41	2%	$5.88	$144.72	$144.45	0%	($0.28)
31647		Bronchial valve init insert	NA	NA	NA	NA	$227.83	$230.26	1%	$2.43
31648		Bronchial valve remov init	NA	NA	NA	NA	$218.16	$209.52	-4%	($8.64)
31649		Bronchial valve remov addl	$70.57	$70.08	-1%	($0.49)	$70.57	$70.08	-1%	($0.49)
31651		Bronchial valve addl insert	$82.03	$76.52	-7%	($5.52)	$82.03	$76.52	-7%	($5.52)
31660		Bronch thermoplsty 1 lobe	NA	NA	NA	NA	$217.80	$215.24	-1%	($2.56)
31661		Bronch thermoplsty 2/> lobes	NA	NA	NA	NA	$229.62	$225.25	-2%	($4.37)
32554		Aspirate pleura w/o imaging	$200.97	$204.16	2%	$3.19	$93.14	$92.25	-1%	($0.89)
32555		Aspirate pleura w/ imaging	$299.84	$293.55	-2%	($6.29)	$117.14	$116.92	0%	($0.22)
32556		Insert cath pleura w/o image	$542.00	$563.49	4%	$21.50	$128.60	$127.64	-1%	($0.96)
32557		Insert cath pleura w/ image	$577.82	$519.16	-10%	($58.66)	$171.59	$159.82	-7%	($11.77)
94002		Vent mgmt inpat init day	NA	NA	NA	NA	$94.57	$94.03	-1%	($0.54)
94003		Vent mgmt inpat subq day	NA	NA	NA	NA	$68.06	$67.93	0%	($0.13)
94010		Breathing capacity test	$36.18	$36.47	1%	$0.29	NA	NA	NA	NA

CPT/ HCPCS	Modifier	Short Description	CY 2014 CF $35.8228 2014 NF Allowable	CY 2015 CF $35.7547 2015 NF Allowable	% Change NF Allowable	Dollar Change NF Allowable	CY 2014 CF $35.8228 2014 FAC Allowable	CY 2015 CF $35.7547 2015 FAC Allowable	% Change FAC Allowable	Dollar Change FAC Allowable
94010	26	Breathing capacity test	$8.60	$8.58	0%	($0.02)	$8.60	$8.58	0%	($0.02)
94010	TC	Breathing capacity test	$27.58	$27.89	1%	$0.31	NA	NA	NA	NA
94011		Spirometry up to 2 yrs old	NA	NA	NA	NA	$103.89	$101.54	-2%	($2.34)
94012		Spirmtry w/brnchdil inf-2 yr	NA	NA	NA	NA	$162.64	$167.69	3%	$5.05
94013		Meas lung vol thru 2 yrs	NA	NA	NA	NA	$32.24	$31.46	-2%	($0.78)
94014		Patient recorded spirometry	$52.30	$56.49	8%	$4.19	NA	NA	NA	NA
94015		Patient recorded spirometry	$26.87	$30.75	14%	$3.88	NA	NA	NA	NA
94016		Review patient spirometry	$25.43	$25.74	1%	$0.31	$25.43	$25.74	1%	$0.31
94060		Evaluation of wheezing	$60.90	$61.50	1%	$0.60	NA	NA	NA	NA
94060	26	Evaluation of wheezing	$13.25	$13.23	0%	($0.03)	$13.25	$13.23	0%	($0.03)
94060	TC	Evaluation of wheezing	$47.64	$48.27	1%	$0.62	NA	NA	NA	NA
94070		Evaluation of wheezing	$60.18	$60.07	0%	($0.11)	NA	NA	NA	NA
94070	26	Evaluation of wheezing	$29.37	$28.96	-1%	($0.41)	$29.37	$28.96	-1%	($0.41)
94070	TC	Evaluation of wheezing	$30.81	$31.11	1%	$0.30	NA	NA	NA	NA
94150		Vital capacity test	$25.43	$25.74	1%	$0.31	NA	NA	NA	NA
94150	26	Vital capacity test	$3.94	$3.93	0%	($0.01)	$3.94	$3.93	0%	($0.01)
94150	TC	Vital capacity test	$21.49	$21.81	1%	$0.32	NA	NA	NA	NA
94200		Lung function test (MBC/MVV)	$24.72	$25.74	4%	$1.03	NA	NA	NA	NA
94200	26	Lung function test (MBC/MVV)	$5.73	$5.72	0%	($0.01)	$5.73	$5.72	0%	($0.01)
94200	TC	Lung function test (MBC/MVV)	$18.99	$20.02	5%	$1.04	NA	NA	NA	NA
94250		Expired gas collection	$26.51	$26.46	0%	($0.05)	NA	NA	NA	NA
94250	26	Expired gas collection	$5.73	$5.36	-6%	($0.37)	$5.73	$5.36	-6%	($0.37)
94250	TC	Expired gas collection	$20.78	$21.10	2%	$0.32	NA	NA	NA	NA
94375		Respiratory flow volume loop	$39.41	$39.69	1%	$0.28	NA	NA	NA	NA
94375	26	Respiratory flow volume loop	$15.05	$15.02	0%	($0.03)	$15.05	$15.02	0%	($0.03)
94375	TC	Respiratory flow volume loop	$24.36	$24.67	1%	$0.31	NA	NA	NA	NA
94400		CO2 breathing response curve	$56.24	$57.21	2%	$0.97	NA	NA	NA	NA
94400	26	CO2 breathing response curve	$19.70	$19.67	0%	($0.04)	$19.70	$19.67	0%	($0.04)
94400	TC	CO2 breathing response curve	$36.54	$37.54	3%	$1.00	NA	NA	NA	NA
94450		Hypoxia response curve	$68.42	$67.22	-2%	($1.20)	NA	NA	NA	NA
94450	26	Hypoxia response curve	$20.06	$19.67	-2%	($0.40)	$20.06	$19.67	-2%	($0.40)
94450	TC	Hypoxia response curve	$48.36	$47.55	-2%	($0.81)	NA	NA	NA	NA
94452		Hast w/report	$58.03	$58.28	0%	$0.25	NA	NA	NA	NA
94452	26	Hast w/report	$14.69	$14.66	0%	($0.03)	$14.69	$14.66	0%	($0.03)
94452	TC	Hast w/report	$43.35	$43.62	1%	$0.28	NA	NA	NA	NA
94453		Hast w/oxygen titrate	$80.60	$80.81	0%	$0.20	NA	NA	NA	NA
94453	26	Hast w/oxygen titrate	$18.99	$19.31	2%	$0.32	$18.99	$19.31	2%	$0.32
94453	TC	Hast w/oxygen titrate	$61.62	$61.50	0%	($0.12)	NA	NA	NA	NA
94610		Surfactant admin thru tube	NA	NA	NA	NA	$60.54	$57.21	-6%	($3.33)
94620		Pulmonary stress test/simple	$56.24	$56.49	0%	$0.25	NA	NA	NA	NA
94620	26	Pulmonary stress test/simple	$31.17	$30.75	-1%	($0.42)	$31.17	$30.75	-1%	($0.42)
94620	TC	Pulmonary stress test/simple	$25.08	$25.74	3%	$0.67	NA	NA	NA	NA
94621		Pulm stress test/complex	$164.78	$165.54	0%	$0.76	NA	NA	NA	NA
94621	26	Pulm stress test/complex	$70.21	$69.72	-1%	($0.49)	$70.21	$69.72	-1%	($0.49)
94621	TC	Pulm stress test/complex	$94.57	$95.82	1%	$1.25	NA	NA	NA	NA

			CY 2014 CF $35.8228	CY 2015 CF $35.7547	% Change	Dollar Change	CY 2014 CF $35.8228	CY 2015 CF $35.7547	% Change	Dollar Change
CPT/ HCPCS	Modifier	Short Description	2014 NF Allowable	2015 NF Allowable	NF Allowable	NF Allowable	2014 FAC Allowable	2015 FAC Allowable	FAC Allowable	FAC Allowable
94640		Airway inhalation treatment	$18.27	$18.59	2%	$0.32	NA	NA	NA	NA
94642		Aerosol inhalation treatment	$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00
94644		Cbt 1st hour	$44.06	$43.98	0%	($0.08)	NA	NA	NA	NA
94645		Cbt each addl hour	$14.33	$13.94	-3%	($0.38)	NA	NA	NA	NA
94660		Pos airway pressure cpap	$63.41	$63.29	0%	($0.12)	$38.33	$38.26	0%	($0.07)
94662		Neg press ventilation cnp	NA	NA	NA	NA	$40.84	$34.68	-15%	($6.16)
94664		Evaluate pt use of inhaler	$17.19	$17.52	2%	$0.32	NA	NA	NA	NA
94667		Chest wall manipulation	$25.43	$26.46	4%	$1.02	NA	NA	NA	NA
94668		Chest wall manipulation	$29.37	$28.96	-1%	($0.41)	NA	NA	NA	NA
94680		Exhaled air analysis o2	$58.03	$57.92	0%	($0.11)	NA	NA	NA	NA
94680	26	Exhaled air analysis o2	$12.90	$12.87	0%	($0.02)	$12.90	$12.87	0%	($0.02)
94680	TC	Exhaled air analysis o2	$45.14	$45.05	0%	($0.09)	NA	NA	NA	NA
94681		Exhaled air analysis o2/co2	$51.23	$53.99	5%	$2.76	NA	NA	NA	NA
94681	26	Exhaled air analysis o2/co2	$10.03	$10.01	0%	($0.02)	$10.03	$10.01	0%	($0.02)
94681	TC	Exhaled air analysis o2/co2	$41.20	$43.98	7%	$2.78	NA	NA	NA	NA
94690		Exhaled air analysis	$49.08	$50.06	2%	$0.98	NA	NA	NA	NA
94690	26	Exhaled air analysis	$3.94	$3.93	0%	($0.01)	$3.94	$3.93	0%	($0.01)
94690	TC	Exhaled air analysis	$45.14	$46.12	2%	$0.99	NA	NA	NA	NA
94726		Pulm funct tst plethysmograp	$53.38	$53.27	0%	($0.10)	NA	NA	NA	NA
94726	26	Pulm funct tst plethysmograp	$12.54	$12.51	0%	($0.02)	$12.54	$12.51	0%	($0.02)
94726	TC	Pulm funct tst plethysmograp	$40.84	$40.76	0%	($0.08)	NA	NA	NA	NA
94727		Pulm function test by gas	$42.27	$42.55	1%	$0.28	NA	NA	NA	NA
94727	26	Pulm function test by gas	$12.54	$12.51	0%	($0.02)	$12.54	$12.51	0%	($0.02)
94727	TC	Pulm function test by gas	$29.73	$30.03	1%	$0.30	NA	NA	NA	NA
94728		Pulm funct test oscillometry	$40.48	$39.69	-2%	($0.79)	NA	NA	NA	NA
94728	26	Pulm funct test oscillometry	$12.90	$12.51	-3%	($0.38)	$12.90	$12.51	-3%	($0.38)
94728	TC	Pulm funct test oscillometry	$27.58	$27.17	-1%	($0.41)	NA	NA	NA	NA
94729		Co/membane diffuse capacity	$54.45	$55.06	1%	$0.61	NA	NA	NA	NA
94729	26	Co/membane diffuse capacity	$9.31	$9.30	0%	($0.02)	$9.31	$9.30	0%	($0.02)
94729	TC	Co/membane diffuse capacity	$45.14	$45.77	1%	$0.63	NA	NA	NA	NA
94750		Pulmonary compliance study	$81.68	$81.88	0%	$0.20	NA	NA	NA	NA
94750	26	Pulmonary compliance study	$11.46	$11.44	0%	($0.02)	$11.46	$11.44	0%	($0.02)
94750	TC	Pulmonary compliance study	$70.21	$70.44	0%	$0.22	NA	NA	NA	NA
94760		Measure blood oxygen level	$3.22	$3.22	0%	($0.01)	NA	NA	NA	NA
94761		Measure blood oxygen level exercise	$5.02	$5.01	0%	($0.01)	NA	NA	NA	NA
94762		Measure blood oxygen level	$24.72	$24.67	0%	($0.05)	NA	NA	NA	NA
94770		Exhaled carbon dioxide test	NA	NA	NA	NA	$8.24	$7.51	-9%	($0.73)
94772		Breath recording infant	$0.00	$0.00	NA	$0.00	NA	NA	NA	NA
94772	26	Breath recording infant	$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00
94772	TC	Breath recording infant	$0.00	$0.00	NA	$0.00	NA	NA	NA	NA
94774		Ped home apnea rec compl	$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00
94775		Ped home apnea rec hk-up	$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00
94776		Ped home apnea rec downld	$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00
94777		Ped home apnea rec report	$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00

CPT/ HCPCS	Modifier	Short Description	CY 2014 CF $35.8228 2014 NF Allowable	CY 2015 CF $35.7547 2015 NF Allowable	% Change NF Allowable	Dollar Change NF Allowable	CY 2014 CF $35.8228 2014 FAC Allowable	CY 2015 CF $35.7547 2015 FAC Allowable	% Change FAC Allowable	Dollar Change FAC Allowable
94780		Car seat/bed test 60 min	$51.94	$63.29	22%	$11.34	$23.28	$25.39	9%	$2.10
94781		Car seat/bed test + 30 min	$20.42	$23.24	14%	$2.82	$8.60	$8.94	4%	$0.34
94799		Pulmonary service/procedure Unlisted	$0.00	$0.00	NA	$0.00	NA	NA	NA	NA
94799	26	Pulmonary service/procedure Unlisted	$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00
94799	TC	Pulmonary service/procedure Unlisted	$0.00	$0.00	NA	$0.00	NA	NA	NA	NA
95782		Polysom <6 yrs 4/> paramtrs	$1,026.32	$919.97	-10%	($106.35)	NA	NA	NA	NA
95782	26	Polysom <6 yrs 4/> paramtrs	$132.54	$123.71	-7%	($8.83)	$132.54	$123.71	-7%	($8.83)
95782	TC	Polysom <6 yrs 4/> paramtrs	$893.78	$796.26	-11%	($97.52)	NA	NA	NA	NA
95783		Polysom <6 yrs cpap/bilvl	$1,094.03	$1,254.99	15%	$160.96	NA	NA	NA	NA
95783	26	Polysom <6 yrs cpap/bilvl	$144.37	$149.81	4%	$5.45	$144.37	$149.81	4%	$5.45
95783	TC	Polysom <6 yrs cpap/bilvl	$949.66	$1,105.18	16%	$155.52	NA	NA	NA	NA
95800		Slp stdy unattended	$179.47	$181.28	1%	$1.80	NA	NA	NA	NA
95800	26	Slp stdy unattended	$52.66	$52.56	0%	($0.10)	$52.66	$52.56	0%	($0.10)
95800	TC	Slp stdy unattended	$126.81	$128.72	2%	$1.90	NA	NA	NA	NA
95801		Slp stdy unatnd w/anal	$95.29	$92.60	-3%	($2.68)	NA	NA	NA	NA
95801	26	Slp stdy unatnd w/anal	$49.44	$50.06	1%	$0.62	$49.44	$50.06	1%	$0.62
95801	TC	Slp stdy unatnd w/anal	$45.85	$42.55	-7%	($3.31)	NA	NA	NA	NA
95803		Actigraphy testing	$151.17	$142.66	-6%	($8.51)	NA	NA	NA	NA
95803	26	Actigraphy testing	$44.06	$43.62	-1%	($0.44)	$44.06	$43.62	-1%	($0.44)
95803	TC	Actigraphy testing	$107.11	$99.04	-8%	($8.07)	NA	NA	NA	NA
95805		Multiple sleep latency test	$423.07	$422.62	0%	($0.45)	NA	NA	NA	NA
95805	26	Multiple sleep latency test	$60.18	$59.71	-1%	($0.47)	$60.18	$59.71	-1%	($0.47)
95805	TC	Multiple sleep latency test	$362.88	$362.91	0%	$0.03	NA	NA	NA	NA
95806		Sleep study unatt & resp efft	$173.02	$169.48	-2%	($3.55)	NA	NA	NA	NA
95806	26	Sleep study unatt & resp efft	$62.33	$61.50	-1%	($0.83)	$62.33	$61.50	-1%	($0.83)
95806	TC	Sleep study unatt & resp efft	$110.69	$107.98	-2%	($2.71)	NA	NA	NA	NA
95807		Sleep study attended	$476.44	$471.96	-1%	($4.48)	NA	NA	NA	NA
95807	26	Sleep study attended	$63.05	$62.57	-1%	($0.48)	$63.05	$62.57	-1%	($0.48)
95807	TC	Sleep study attended	$413.40	$409.39	-1%	($4.00)	NA	NA	NA	NA
95808		Polysom any age 1-3> param	$638.72	$606.76	-5%	($31.96)	NA	NA	NA	NA
95808	26	Polysom any age 1-3> param	$88.48	$87.60	-1%	($0.88)	$88.48	$87.60	-1%	($0.88)
95808	TC	Polysom any age 1-3> param	$550.24	$519.16	-6%	($31.08)	NA	NA	NA	NA
95810		Polysom 6/> yrs 4/> param	$621.17	$625.71	1%	$4.54	NA	NA	NA	NA
95810	26	Polysom 6/> yrs 4/> param	$123.95	$123.00	-1%	($0.95)	$123.95	$123.00	-1%	($0.95)
95810	TC	Polysom 6/> yrs 4/> param	$497.22	$502.71	1%	$5.49	NA	NA	NA	NA
95811		Polysom 6/>yrs cpap 4/> parm	$651.62	$657.17	1%	$5.55	NA	NA	NA	NA
95811	26	Polysom 6/>yrs cpap 4/> parm	$128.96	$127.64	-1%	($1.32)	$128.96	$127.64	-1%	($1.32)
95811	TC	Polysom 6/>yrs cpap 4/> parm	$522.65	$529.53	1%	$6.87	NA	NA	NA	NA
99291		Critical care first hour	$274.76	$277.81	1%	$3.05	$224.61	$226.33	1%	$1.72
99292		Critical care each add 30 min	$123.23	$123.71	0%	$0.48	$112.48	$112.98	0%	$0.50
99406		Behav chng smoking 3-10 min	$13.97	$14.30	2%	$0.33	$12.18	$12.51	3%	$0.33
99407		Behav chng smoking > 10 min	$27.58	$27.53	0%	($0.05)	$25.79	$25.74	0%	($0.05)
▲ 99487		Cmplx chron care w/o pt vsit	$0.00	$0.00	NA	NA	$0.00	$0.00	NA	NA
99488	Deleted 2015	Cmplx chron care w/ pt vsit	$185.20	$0.00	NA	NA	$152.61	$0.00	NA	NA

CPT/ HCPCS	Modifier	Short Description	CY 2014 CF $35.8228 2014 NF Allowable	CY 2015 CF $35.7547 2015 NF Allowable	% Change NF Allowable	Dollar Change NF Allowable	CY 2014 CF $35.8228 2014 FAC Allowable	CY 2015 CF $35.7547 2015 FAC Allowable	% Change FAC Allowable	Dollar Change FAC Allowable
▲ 99489		Complx chron care addl 30 min	$41.20	$0.00	NA	NA	$48.72	$0.00	NA	NA
• 99490		Chron care mgmt srvc 20 min	New in 2015	$42.91	NA	NA	NA	$32.89	NA	NA
99495		Trans care mgmt 14 day disch	$164.07	$165.54	1%	$1.48	$111.41	$111.91	0%	$0.50
99496		Trans care mgmt 7 day disch	$231.77	$232.41	0%	$0.63	$161.20	$161.25	0%	$0.05
99497		Advncd care plan 30 min	$0.00	$0.00			$0.00	$0.00		
99498		Advncd care plan addl 30 min	$0.00	$0.00			$0.00	$0.00		
G0237		Therapeutic procd strg endur	$10.03	$10.37	3%	$0.34	NA	NA	NA	NA
G0238		"Oth resp proc, indiv"	$10.75	$10.73	0%	($0.02)	NA	NA	NA	NA
G0239		"Oth resp proc, group "	$12.90	$13.23	3%	$0.33	NA	NA	NA	NA
G0379		Direct refer hospital observ	$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00
G0384		Lev 5 hosp type bed visit	$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00
G0390		Trauma respons w/hosp criti	$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00
G0398		Home sleep test/type 2 porta	$0.00	$0.00	NA	$0.00	NA	NA	NA	NA
G0398	26	Home sleep test/type 2 porta	$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00
G0398	TC	Home sleep test/type 2 porta	$0.00	$0.00	NA	$0.00	NA	NA	NA	NA
G0399		Home sleep test/type 3 porta	$0.00	$0.00	NA	$0.00	NA	NA	NA	NA
G0399	26	Home sleep test/type 3 porta	$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00
G0399	TC	Home sleep test/type 3 porta	$0.00	$0.00	NA	$0.00	NA	NA	NA	NA
G0424		Pulmonary rehab w exer	$30.45	$30.03	-1%	($0.42)	$14.69	$13.94	-5%	($0.74)
G0436		Tobacco-use counsel 3-10 min	$14.33	$14.30	0%	($0.03)	$12.18	$12.16	0%	($0.02)
G0463		Hospital outpt clinic visit	$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00

Disclaimer

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Note: ▲ 99487 Status B - Payment bundled into payment for other services

Table note: The final and interim final RVUs values listed in the table are set for 2015. However, the conversion factor of $35.7547 is for January 1, 2015 – March 31, 2015 only. The conversion factor for reminder of 2015 is unknown and is dependent on how Congress addresses the SGR fix.

FINAL 2014 Compared to Final 2015 Rates

Medicare Hospital Outpatient Prospective Payment System HOPPS (APC)
Endoscopy/Bronchoscopy, Pulmonary Diagnostic Testing & Therapies, Sleep Medicine Testing, Pulmonary Rehabilitation/Respiratory Therapy and Thoracentesis/Chest Tubes

CPT/ HCPCS	CMS Short Description Description	Status		APC		FINAL RULE CY 2014 Payment Rate	FINAL RULE CY 2015 Payment Rate	Dollar Change	Percent Change
		CY 2014	CY 2015	CY 2014	CY 2015				
31615	Visualization of windpipe	T	T	0252	0252	$545.14	$646.66	$101.52	19%
31620	Endobronchial us add-on	N	N	N/A	N/A	$0.00	$0.00	$0.00	N/A
31622	Dx bronchoscope/wash	T	T	0076	0076	$951.62	"$1,055.12"	$103.50	11%
31623	Dx bronchoscope/brush	T	T	0076	0076	$951.62	"$1,055.12"	$103.50	11%
31624	Dx bronchoscope/lavage	T	T	0076	0076	$951.62	"$1,055.12"	$103.50	11%
31625	Bronchoscopy w/biopsy(s)	T	T	0076	0076	$951.62	"$1,055.12"	$103.50	11%
31626	Bronchoscopy w/markers	T	T	0415	0415	"$2,000.39"	"$2,256.36"	$255.97	13%
31627	Navigational bronchoscopy	N	N	N/A	N/A	$0.00	$0.00	$0.00	N/A
31628	Bronchoscopy/lung bx each	T	T	0076	0076	$951.62	"$1,055.12"	$103.50	11%
31629	Bronchoscopy/needle bx each	T	T	0415	0415	"$2,000.39"	"$2,256.36"	$255.97	13%
31630	Bronchoscopy dilate/fx repr	T	T	0415	0415	"$2,000.39"	"$2,256.36"	$255.97	13%
31631	Bronchoscopy dilate w/stent	T	T	0415	0415	"$2,000.39"	"$2,256.36"	$255.97	13%
31632	Bronchoscopy/lung bx addl	N	N	N/A	N/A	$0.00	$0.00	$0.00	N/A
31633	Bronchoscopy/needle bx addl	N	N	N/A	N/A	$0.00	$0.00	$0.00	N/A
31634	Bronch w/balloon occlusion	T	T	0415	0415	"$2,000.39"	"$2,256.36"	$255.97	13%
31635	Bronchoscopy w/fb removal	T	T	0076	0076	$951.62	"$1,055.12"	$103.50	11%
31636	Bronchoscopy bronch stents	T	T	0415	0415	"$2,000.39"	"$2,256.36"	$255.97	13%
31637	Bronchoscopy stent add-on	N	N	N/A	N/A	$0.00	$0.00	$0.00	N/A
31638	Bronchoscopy revise stent	T	T	0415	0415	"$2,000.39"	"$2,256.36"	$255.97	13%
31640	Bronchoscopy w/tumor excise	T	T	0415	0415	"$2,000.39"	"$2,256.36"	$255.97	13%
31641	Bronchoscopy treat blockage	T	T	0415	0415	"$2,000.39"	"$2,256.36"	$255.97	13%
31643	Diag bronchoscope/catheter	T	T	0076	0076	$951.62	"$1,055.12"	$103.50	11%
31645	Bronchoscopy clear airways	T	T	0076	0076	$951.62	"$1,055.12"	$103.50	11%
31646	Bronchoscopy reclear airway	T	T	0076	0076	$951.62	"$1,055.12"	$103.50	11%
31647	Bronchial valve init insert	T	T	0415	0415	"$2,000.39"	"$2,256.36"	$255.97	13%
31648	Bronchial valve remov init	T	T	0415	0415	"$2,000.39"	"$2,256.36"	$255.97	13%
31649	Bronchial valve remov addl	Q2	Q2	0076	0076	$951.62	"$1,055.12"	$103.50	11%
31651	Bronchial valve addl insert	N	N	N/A	N/A	$0.00	$0.00	$0.00	N/A
31660	Bronch thermoplsty 1 lobe	T	T	0415	0415	"$2,000.39"	"$2,256.36"	$255.97	13%
31661	Bronch thermoplsty 2/> lobes	T	T	0415	0415	"$2,000.39"	"$2,256.36"	$255.97	13%
32554	Aspirate pleura w/o imaging	T	T	0070	0070	$485.19	$489.35	$4.16	1%
32555	Aspirate pleura w/ imaging	T	T	0070	0070	$485.19	$489.35	$4.16	1%
32556	Insert cath pleura w/o image	T	T	0070	0070	$485.19	$489.35	$4.16	1%
32557	Insert cath pleura w/ image	T	T	0070	0070	$485.19	$489.35	$4.16	1%
94002 Single Code	Vent mgmt inpat init day (Single Code APC Assignment & Rate)	Q3	Q3	0079	0079	$349.21	$374.20	$24.99	7%
94002 Composite	Vent mgmt inpat init day (Composite APC Assignment & Rate)	Q3	Q3	0617	0617	$634.94	$656.94	$22.00	3%
94002 Composite	Vent mgmt inpat init day (Composite APC Assignment & Rate)	Q3	Q3	0618	0618	$961.51	$889.32	-$72.19	-8%

CPT/ HCPCS	CMS Short Description Description	Status CY 2014	Status CY 2015	APC CY 2014	APC CY 2015	FINAL RULE CY 2014 Payment Rate	FINAL RULE CY 2015 Payment Rate	Dollar Change	Percent Change
94003 Single Code	Vent mgmt inpat subq day (Single Code APC Assignment & Rate)	Q3	Q3	0079	0079	$349.21	$374.20	$24.99	7%
94003 Composite	Vent mgmt inpat subq day (Composite APC Assignment & Rate)	Q3	Q3	0617	0617	$634.94	$656.94	$22.00	3%
94003 Composite	Vent mgmt inpat subq day (Composite APC Assignment & Rate)	Q3	Q3	0618	0618	$961.51	$889.32	-$72.19	-8%
94010	Breathing capacity test	X	Q1	0368	0367	$88.74	$161.28	$72.54	82%
94011	Spirometry up to 2 yrs old	X	Q1	0367	0367	$57.37	$161.28	$103.91	181%
94012	Spirmtry w/brnchdil inf-2 yr	X	Q1	0368	0367	$88.74	$161.28	$72.54	82%
94013	Meas lung vol thru 2 yrs	X	S	0369	0369	$243.71	$236.86	-$6.85	-3%
94014	Patient recorded spirometry	X	Q1	0368	0367	$88.74	$161.28	$72.54	82%
94015	Patient recorded spirometry	X	Q1	0368	0367	$88.74	$161.28	$72.54	82%
94016	Review patient spirometry	A	A	N/A	N/A	$0.00	$0.00	$0.00	N/A
94060	Evaluation of wheezing	S	S	0078	0369	$135.40	$236.86	$101.46	75%
94070	Evaluation of wheezing	X	S	0369	0369	$243.71	$236.86	-$6.85	-3%
94150	Vital capacity test	X	Q1	0367	0367	$57.37	$161.28	$103.91	181%
94200	Lung function test (MBC/MVV)	X	Q1	0367	0420	$57.37	$131.75	$74.38	130%
94250	Expired gas collection	X	Q1	0367	0340	$57.37	$52.37	-$5.00	-9
94375	Respiratory flow volume loop	X	Q1	0368	0367	$88.74	$161.28	$72.54	82%
94400	CO2 breathing response curve	X	Q1	0368	0367	$88.74	$161.28	$72.54	82%
94450	Hypoxia response curve	X	Q1	0368	0367	$88.74	$161.28	$72.54	82%
94452	Hast w/report	X	Q1	0368	0367	$88.74	$161.28	$72.54	82%
94453	Hast w/oxygen titrate	X	Q1	0368	0367	$88.74	$161.28	$72.54	82%
94610	Surfactant admin thru tube	S	Q1	0102	0077	$78.19	$164.63	$86.44	111%
94620	Pulmonary stress test/simple	X	Q1	0368	0420	$88.74	$131.75	$43.01	48%
94621	Pulm stress test/complex	X	S	0369	0369	$243.71	$236.86	-$6.85	-3%
94640	Airway inhalation treatment	S	Q1	0102	0077	$78.19	$164.63	$86.44	111%
94642	Aerosol inhalation treatment	S	Q1	0078	0077	$135.40	$164.63	$29.23	22%
94644	Cbt 1st hour	X	Q1	0420	0420	$98.25	$131.75	$33.50	34%
94645	Cbt each addl hour	N	N	N/A	N/A	$0.00	$0.00	$0.00	N/A
94660 Single Code	Pos airway pressure cpap (Single Code APC Assignment & Rate)	Q3	Q3	0102	0077	$78.19	$164.63	$86.44	111%
94660 Composite	Pos airway pressure cpap (Composite APC Assignment & Rate)	Q3	Q3	0617	0617	$634.94	$656.94	$22.00	3%
94660 Composite	Pos airway pressure cpap (Composite APC Assignment & Rate)	Q3	Q3	0618	0618	$961.51	$889.32	-$72.19	-8%
94662 Single Code	Neg press ventilation cnp (Single Code APC Assignment & Rate)	Q3	Q3	0079	0079	$349.21	$374.20	$24.99	7%
94662 Composite	Neg press ventilation cnp (Composite APC Assignment & Rate)	Q3	Q3	0617	0617	$634.94	$656.94	$22.00	3%
94662 Composite	Neg press ventilation cnp (Composite APC Assignment & Rate)	Q3	Q3	0618	0618	$961.51	$889.32	-$72.19	-8%
94664	Evaluate pt use of inhaler	S	Q1	0102	0077	$78.19	$164.63	$86.44	111%
94667	Chest wall manipulation	S	Q1	0102	0077	$78.19	$164.63	$86.44	111%
94668	Chest wall manipulation	S	Q1	0077	0340	$39.35	$52.37	$13.02	33%
94680	Exhaled air analysis o2	X	Q1	0368	0367	$88.74	$161.28	$72.54	82%
94681	Exhaled air analysis o2/co2	X	Q1	0369	0367	$243.71	$161.28	-$82.43	-34%
94690	Exhaled air analysis	X	Q1	0035	0340	$22.11	$52.37	$30.26	137%
94726	Pulm funct tst plethysmograp	X	Q1	0368	0367	$88.74	$161.28	$72.54	82%

CPT/ HCPCS	CMS Short Description Description	Status CY 2014	Status CY 2015	APC CY 2014	APC CY 2015	FINAL RULE CY 2014 Payment Rate	FINAL RULE CY 2015 Payment Rate	Dollar Change	Percent Change	
94727	Pulm function test by gas	X	Q1	0368	0367	$88.74	$161.28	$72.54	82%	
94728	Pulm funct test oscillometry	X	Q1	0368	0367	$88.74	$161.28	$72.54	82%	
94729	Co/membane diffuse capacity	N	N	N/A	N/A	$0.00	$0.00	$0.00	N/A	
94750	Pulmonary compliance study	X	Q1	0367	0367	$57.37	$161.28	$103.91	181%	
94760	Measure blood oxygen level	N	N	N/A	N/A	$0.00	$0.00	$0.00	N/A	
94761	Measure blood oxygen level	N	N	N/A	N/A	$0.00	$0.00	$0.00	N/A	
94762 Code	Measure blood oxygen level (Single Code APC Assignment & Rate)	Q3	Q3	0096	0097	$131.06	$112.71	-$18.35	-14%	Single
94762 Composite	Measure blood oxygen level (Composite APC Assignment & Rate)	Q3	Q3	0617	0617	$634.94	$656.94	$22.00	3%	
94762 Composite	Measure blood oxygen level (Composite APC Assignment & Rate)	Q3	Q3	0618	0618	$961.51	$889.32	-$72.19	-8%	
94770	Exhaled carbon dioxide test	X	S	0369	0369	$243.71	$236.86	-$6.85	-3%	
94772	Breath recording infant	X	S	0369	0369	$243.71	$236.86	-$6.85	-3%	
94774	Ped home apnea rec compl	B	B	N/A	N/A	$0.00	$0.00	$0.00	N/A	
94775	Ped home apnea rec hk-up	S	S	0097	0097	$70.18	$112.71	$42.53	61%	
94776	Ped home apnea rec downld	S	S	0097	0097	$70.18	$112.71	$42.53	61%	
94777	Ped home apnea rec report	B	B	N/A	N/A	$0.00	$0.00	$0.00	N/A	
94780	Car seat/bed test 60 min	X	Q1	0340	0340	$53.44	$52.37	-$1.07	-2%	
+ 94781	Car seat/bed test + 30 min	N	N	N/A	N/A	$0.00	$0.00	$0.00	N/A	
94799	Pulmonary service/procedure Unlisted	X	Q1	0367	0367	$57.37	$161.28	$103.91	181%	
# 95782	Polysom <6 yrs 4/> paramtrs	S	S	0209	0435	$440.12	$854.29	$414.17	94%	
# 95783	Polysom <6 yrs cpap/bilvl	S	S	0209	0435	$440.12	$854.29	$414.17	94%	
# 95800	Slp stdy unattended	S	S	0213	0213	$181.60	$176.63	-$4.97	-3%	
# 95801	Slp stdy unatnd w/anal	S	S	0213	0213	$181.60	$176.63	-$4.97	-3%	
95803	Actigraphy testing	X	Q1	0340	0340	$53.44	$52.37	-$1.07	-2%	
95805	Multiple sleep latency test	S	S	0435	0435	$862.51	$854.29	-$8.22	-1%	
95806	Sleep study unatt&resp efft	S	S	0213	0213	$181.60	$176.63	-$4.97	-3%	
95807	Sleep study attended	S	S	0209	0209	$440.12	$230.83	-$209.29	-48%	
95808	Polysom any age 1-3> param	S	S	0435	0435	$862.51	$854.29	-$8.22	-1%	
95810	Polysom 6/> yrs 4/> param	S	S	0435	0435	$862.51	$854.29	-$8.22	-1%	
95811	Polysom 6/>yrs cpap 4/> parm	S	S	0435	0435	$862.51	$854.29	-$8.22	-1%	
99291 Single Code	Critical care first hour (Single Code APC Assignment & Rate)	Q3	Q3	0617	0617	$634.94	$656.94	$22.00	3%	
99291 Composite	Critical care first hour (Composite APC Assignment & Rate)	Q3	Q3	8009	8009	"$1,198.91"	"$1,234.70"	$35.79	3%	
99292	Critical care each add 30 min	N	N	N/A	N/A	$0.00	$0.00	$0.00	N/A	
99406	Behav chng smoking 3-10 min	S	S	0031	0031	$23.92	$26.02	$2.10	9%	
99407	Behav chng smoking > 10 min	S	S	0031	0031	$23.92	$26.02	$2.10	9%	
_99487	Cmplx chron care w/o pt vsit	N	N	N/A	N/A	$0.00	$0.00	$0.00	N/A	
99488 Deleted 2015	Cmplx chron care w/ pt vsit	N	D	N/A	CH D	$0.00	Deleted Code	N/A	N/A	
99489	Complx chron care addl30 min	N	N	N/A	N/A	$0.00	$0.00	$0.00	N/A	
99495	Trans care mgmt 14 day disch	V	V	0632	0632	$96.53	$106.27	$9.74	10%	
99496	Trans care mgmt 7 day disch	V	V	0632	0632	$96.53	$106.27	$9.74	10%	
_99490	Chron care mgmt srvc 20 min	N/A	V	N/A	0631	N/A	$53.72	N/A	N/A	
_99497	Advncd care plan 30 min	N/A	N	N/A	N/A	$0.00	$0.00	$0.00	N/A	
_99498	Advncd care plan addl 30 min	N/A	N	N/A	N/A	$0.00	$0.00	$0.00	N/A	

CPT/ HCPCS	CMS Short Description Description	Status CY 2014	Status CY 2015	APC CY 2014	APC CY 2015	FINAL RULE CY 2014 Payment Rate	FINAL RULE CY 2015 Payment Rate	Dollar Change	Percent Change
G0237	Therapeutic procd strg endur	S	Q1	0077	0340	$39.35	$52.37	$13.02	33%
G0238	"Oth resp proc, indiv"	S	Q1	0077	0340	$39.35	$52.37	$13.02	33%
G0239	"Oth resp proc, group"	S	Q1	0077	0450	$39.35	$29.24	-$10.11	-26%
G0379 Single Code	Direct refer hospital observ (Single Code APC Assignment & Rate)	Q3	Q3	0633	0633	$327.85	$386.95	$59.10	18%
G0379 Composite	Direct refer hospital observ (Composite APC Assignment & Rate)	Q3	Q3	8009	8009	"$1,198.91"	"$1,234.70"	$35.79	3%
G0384 Single Code	Lev 5 hosp type bed visit (Single Code APC Assignment & Rate)	Q3	Q3	0630	0630	$312.43	$304.38	-$8.05	-3%
G0384 Composite	Lev 5 hosp type bed visit (Composite APC Assignment & Rate)	Q3	Q3	8009	8009	"$1,198.91"	"$1,234.70"	$35.79	3%
G0390	Trauma respons w/hosp criti	S	S	0618	0618	$961.51	$889.32	-$72.19	-8%
G0398	Home sleep test/type 2 porta	S	S	0213	0213	$181.60	$176.63	-$4.97	-3%
G0399	Home sleep test/type 3 porta	S	S	0213	0213	$181.60	$176.63	-$4.97	-3%
G0424	Pulmonary rehab w exer	S	Q1	0077	0340	$39.35	$52.37	$13.02	33%
G0436	Tobacco-use counsel 3-10 min	S	S	0031	0031	$23.92	$26.02	$2.10	9%
G0463 Single Code	Hospital outpt clinic visit (Single Code APC Assignment & Rate)	Q3	Q3	0634	0634	$92.53	$96.25	$3.72	4%
G0463 Composite	Hospital outpt clinic visit (Composite APC Assignment & Rate)	Q3	Q3	8009	8009	"$1,198.91"	"$1,234.70"	$35.79	3%
Composite	Critical Care	S	S	0617	0617	$634.94	$656.94	$22.00	3%
Composite	Trauma Response with Critical Care	S	S	0618	0618	$961.51	$889.32	-$72.19	-8%
Composite	Extended Assessment & Management Composite	V	V	8009	8009	"$1,198.91"	"$1,234.70"	$35.79	3%

Definitions: Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is typically reported with multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, a single payment is made for all of the codes as a whole, rather than paying each code individually. The grouping process is described in the CMS Internet-Only Manual (IOM) Pub. 100-04, Chapter 4, Section 10.2.1 Use of the comment indicator "CH" in association with a composite APC indicates that the configuration of the composite APC has been changed for CY 2015.

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