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# Coding & Billing Quarterly

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## Letter from the Editor

Welcome to the February ATS Coding and Billing Quarterly. This issue covers new and revised codes for 2016 as well as important CMS clarifications of coding and reimbursement policy.

The good news is CMS has issued a clarification of the LDCT lung cancer screening benefit that makes it clear that any treating physicians (not just primary care physicians) can order LDCT lung cancer screening and provide the shared-decision making service! Members should know that that clarification was issued as a direct result of ATS advocacy on behalf of our members and the patients we serve.

For more information the CMS clarification and the source of the confusion, please see the LDCT Lung Cancer Screening article on page 12. That article also provides "nuts and bolts" information on how to correctly code, bill and document for the LDCT lung cancer screening benefit.

CMS also finalized policy to pay providers for advance care planning services. It appears that with time and patience, the medical community has outlasted the cries of Medicare "death panels" and CMS has finally adopted a policy that will allow physicians to work with their patients to develop end-of-life plans that respect the needs of patients and their families. This issue provides background on the correct use of the new code.

The final 2016 Physician payment rule also sees some reimbursement increases and decreases in pulmonary, critical care and sleep medicine services. This issue will lay out the winners and losers and provide some background information for the changes in the reimbursement rates. As always, we welcome your questions on coding, billing and regulatory compliance issues.

Sincerely,

Alan L. Plummer, MD  
Editor



## 2016 CMS PHYSICIAN PAYMENT RULE

Although CMS issued the final payment rules for both the Medicare Physician Fee Schedule (MPFS) and the Medicare Hospital Outpatient Prospective Payment System (HOPPS) in November of 2015, the payment calculations for both rules had many errors. The following two tables provide corrected information for both physician office payments and hospital outpatient payments.

### Medicare Physician Fee Schedule

Payments for pulmonary, critical care and sleep medicine saw only minor variation in the MPFS rule for 2016. Most of the payment changes were driven by system wide trends, such as across the board practice expense payment cuts, rather than factors specific to the individual service.

#### FINAL 2015 Compared to FINAL 2016 Rates

#### Medicare Physician Fee Schedule(MPFS) Endoscopy/Bronchoscopy, Pulmonary Diagnostic Testing & Therapies, Sleep Medicine Testing, Pulmonary Rehabilitation/Respiratory Therapy and Thoracentesis/Chest Tubes January 5, 2016 MPFS File for January 1, 2016 & October 2, 2015 for October 2015 Release MPFS Files

CPT/ HCPCS	Modifier	Short Description	CY 2015 CF \$35.9335 2015 NF Allowable	CY 2016 CF \$35.8043 2016 NF Allowable	% Change NF Allowable	Dollar Change NF Allowable	CY 2015 CF \$35.9335 2015 FAC Allowable	CY 2016 CF \$35.8043 2016 FAC Allowable	% Change FAC Allowable	Dollar Change FAC Allowable
31615		Visualization of windpipe	\$186.85	\$186.90	0%	\$0.04	\$133.31	\$132.83	0%	(\$0.48)
31620		Endobronchial us add-on	\$294.65	SEE 31652-31654	NA	NA	\$70.43	SEE 31652-31654	NA	NA
31622		Dx bronchoscope/wash	\$320.53	\$310.42	-3%	(\$10.10)	\$150.92	\$148.95	-1%	(\$1.97)
31623		Dx bronchoscope/brush	\$338.85	\$337.63	0%	(\$1.22)	\$152.00	\$151.09	-1%	(\$0.90)
31624		Dx bronchoscope/lavage	\$320.89	\$319.73	0%	(\$1.15)	\$153.44	\$152.53	-1%	(\$0.91)
31625		Bronchoscopy w/biopsy(s)	\$341.01	\$403.87	18%	\$62.86	\$176.79	\$174.72	-1%	(\$2.07)
31626		Bronchoscopy w/markers	\$458.51	\$926.97	102%	\$468.46	\$220.63	\$218.41	-1%	(\$2.23)
31627		Navigational bronchoscopy	\$1,442.01	\$1,438.97	0%	(\$3.04)	\$100.97	\$100.61	0%	(\$0.36)
31628		Bronchoscopy/lung bx each	\$380.90	\$425.36	12%	\$44.46	\$196.92	\$194.42	-1%	(\$2.50)
31629		Bronchoscopy/needle bx each	\$602.96	\$507.35	-16%	(\$95.62)	\$212.37	\$205.87	-3%	(\$6.49)
31630		Bronchoscopy dilate/fx repr	NA	NA	NA	NA	\$208.05	\$206.95	-1%	(\$1.11)
31631		Bronchoscopy dilate w/stent	NA	NA	NA	NA	\$240.75	\$238.10	-1%	(\$2.66)
31632		Bronchoscopy/lung bx addl	\$72.95	\$76.26	5%	\$3.32	\$50.67	\$50.84	0%	\$0.18
31633		Bronchoscopy/needle bx addl	\$90.19	\$94.17	4%	\$3.97	\$65.76	\$65.52	0%	(\$0.24)
31634		Bronch w/balloon occlusion	\$1,922.44	\$1,894.41	-1%	(\$28.04)	\$215.24	\$213.39	-1%	(\$1.85)
31635		Bronchoscopy w/fb removal	\$358.26	\$355.89	-1%	(\$2.36)	\$195.84	\$194.78	-1%	(\$1.06)
31636		Bronchoscopy bronch stents	NA	NA	NA	NA	\$230.33	\$229.15	-1%	(\$1.19)
31637		Bronchoscopy stent add-on	NA	NA	NA	NA	\$76.90	\$76.62	0%	(\$0.28)
31638		Bronchoscopy revise stent	NA	NA	NA	NA	\$263.75	\$261.73	-1%	(\$2.02)
31640		Bronchoscopy w/tumor excise	NA	NA	NA	NA	\$264.47	\$263.16	0%	(\$1.31)
31641		Bronchoscopy treat blockage	NA	NA	NA	NA	\$267.35	\$266.74	0%	(\$0.60)
31643		Diag bronchoscope/catheter	NA	NA	NA	NA	\$183.26	\$182.60	0%	(\$0.66)
31645		Bronchoscopy clear airways	\$331.31	\$330.12	0%	(\$1.19)	\$167.45	\$166.49	-1%	(\$0.96)
31646		Bronchoscopy reclear airway	\$297.89	\$296.10	-1%	(\$1.79)	\$145.17	\$143.93	-1%	(\$1.24)
31647		Bronchial valve init insert	NA	NA	NA	NA	\$231.41	\$228.79	-1%	(\$2.62)
31648		Bronchial valve remov init	NA	NA	NA	NA	\$210.57	\$211.60	0%	\$1.03
31649		Bronchial valve remov addl	\$70.43	\$71.97	2%	\$1.54	\$70.43	\$71.97	2%	\$1.54
31651		Bronchial valve addl insert	\$76.90	\$81.99	7%	\$5.09	\$76.90	\$81.99	7%	\$5.09
•31652		Bronch ebus samplng 1/2 node	See 31620	\$920.53	NA	NA	See 31620	\$241.68	NA	NA
•31653		Bronch ebus samplng 3/> node	See 31620	\$978.53	NA	NA	See 31620	\$266.74	NA	NA

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CPT/ HCPCS	Modifier	Short Description	CY 2015 CF \$35.9335	CY 2016 CF \$35.8043	% Change	Dollar Change	CY 2015 FAC \$35.9335	CY 2016 FAC \$35.8043	% Change	Dollar Change
			2015 NF Allowable	2016 NF Allowable	NF Allowable	NF Allowable	2015 FAC Allowable	2016 FAC Allowable	FAC Allowable	FAC Allowable
•31654		Bronch ebus ivntj perph les	See 31620	\$146.80	NA	NA	See 31620	\$69.82	NA	NA
31660		Bronch thermoplasty 1 lobe	NA	NA	NA	NA	\$216.32	\$216.62	0%	\$0.30
31661		Bronch thermoplasty 2/> lobes	NA	NA	NA	NA	\$226.38	\$227.36	0%	\$0.98
32554		Aspirate pleura w/o imaging	\$205.18	\$204.08	-1%	(\$1.10)	\$92.71	\$92.73	0%	\$0.02
32555		Aspirate pleura w/ imaging	\$295.01	\$295.39	0%	\$0.37	\$117.50	\$116.36	-1%	(\$1.14)
32556		Insert cath pleura w/o image	\$566.31	\$550.31	-3%	(\$16.00)	\$128.28	\$127.82	0%	(\$0.46)
32557		Insert cath pleura w/ image	\$521.75	\$525.61	1%	\$3.85	\$160.62	\$159.33	-1%	(\$1.29)
94002		Vent mgmt inpat init day	NA	NA	NA	NA	\$94.51	\$94.52	0%	\$0.02
94003		Vent mgmt inpat subq day	NA	NA	NA	NA	\$68.27	\$68.03	0%	(\$0.25)
94010		Breathing capacity test	\$36.65	\$36.52	0%	(\$0.13)	NA	NA	NA	NA
94010	26		\$8.62	\$8.59	0%	(\$0.03)	\$8.62	\$8.59	0%	(\$0.03)
94010	TC		\$28.03	\$27.93	0%	(\$0.10)	NA	NA	NA	NA
94011		Spirometry up to 2 yrs old	NA	NA	NA	NA	\$102.05	\$104.19	2%	\$2.14
94012		Spirimtry w/brnchdil inf-2 yr	NA	NA	NA	NA	\$168.53	\$159.33	-5%	(\$9.20)
94013		Meas lung vol thru 2 yrs	NA	NA	NA	NA	\$31.62	\$35.09	11%	\$3.47
94014		Patient recorded spirometry	\$56.77	\$56.93	0%	\$0.15	NA	NA	NA	NA
94015		Patient recorded spirometry	\$30.90	\$31.15	1%	\$0.25	NA	NA	NA	NA
94016		Review patient spirometry	\$25.87	\$25.78	0%	(\$0.09)	\$25.87	\$25.78	0%	(\$0.09)
94060		Evaluation of wheezing	\$61.81	\$61.58	0%	(\$0.22)	NA	NA	NA	NA
94060	26		\$13.30	\$13.25	0%	(\$0.05)	\$13.30	\$13.25	0%	(\$0.05)
94060	TC		\$48.51	\$48.34	0%	(\$0.17)	NA	NA	NA	NA
94070		Evaluation of wheezing	\$60.37	\$60.51	0%	\$0.14	NA	NA	NA	NA
94070	26		\$29.11	\$29.36	1%	\$0.25	\$29.11	\$29.36	1%	\$0.25
94070	TC		\$31.26	\$31.15	0%	(\$0.11)	NA	NA	NA	NA
94150		Vital capacity test	\$25.87	\$25.42	-2%	(\$0.45)	NA	NA	NA	NA
94150	26		\$3.95	\$3.94	0%	(\$0.01)	\$3.95	\$3.94	0%	(\$0.01)
94150	TC		\$21.92	\$21.48	-2%	(\$0.44)	NA	NA	NA	NA
94200		Lung function test (MBC/MVV)	\$25.87	\$25.42	-2%	(\$0.45)	NA	NA	NA	NA
94200	26		\$5.75	\$5.73	0%	(\$0.02)	\$5.75	\$5.73	0%	(\$0.02)
94200	TC		\$20.12	\$19.69	-2%	(\$0.43)	NA	NA	NA	NA
94250		Expired gas collection	\$26.59	\$26.50	0%	(\$0.10)	NA	NA	NA	NA
94250	26		\$5.39	\$5.37	0%	(\$0.02)	\$5.39	\$5.37	0%	(\$0.02)
94250	TC		\$21.20	\$21.12	0%	(\$0.08)	NA	NA	NA	NA
94375		Respiratory flow volume loop	\$39.89	\$39.74	0%	(\$0.14)	NA	NA	NA	NA
94375	26		\$15.09	\$15.04	0%	(\$0.05)	\$15.09	\$15.04	0%	(\$0.05)
94375	TC		\$24.79	\$24.70	0%	(\$0.09)	NA	NA	NA	NA
94400		CO2 breathing response curve	\$57.49	\$56.57	-2%	(\$0.92)	NA	NA	NA	NA
94400	26		\$19.76	\$20.05	1%	\$0.29	\$19.76	\$20.05	1%	\$0.29
94400	TC		\$37.73	\$36.52	-3%	(\$1.21)	NA	NA	NA	NA
94450		Hypoxia response curve	\$67.55	\$69.10	2%	\$1.55	NA	NA	NA	NA
94450	26		\$19.76	\$20.41	3%	\$0.65	\$19.76	\$20.41	3%	\$0.65
94450	TC		\$47.79	\$48.69	2%	\$0.90	NA	NA	NA	NA
94452		Hast w/report	\$58.57	\$58.36	0%	(\$0.21)	NA	NA	NA	NA
94452	26		\$14.73	\$14.68	0%	(\$0.05)	\$14.73	\$14.68	0%	(\$0.05)

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CPT/ HCPCS	Modifier	Short Description	CY 2015 CF \$35.9335	CY 2016 CF \$35.8043	% Change	Dollar Change	CY 2015 FAC \$35.9335	CY 2016 FAC \$35.8043	% Change	Dollar Change
			2015 NF Allowable	2016 NF Allowable	NF Allowable	NF Allowable	2015 FAC Allowable	2016 FAC Allowable	FAC Allowable	FAC Allowable
94452	TC		\$43.84	\$43.68	0%	(\$0.16)	NA	NA	NA	NA
94453		Hast w/oxygen titrate	\$81.21	\$80.92	0%	(\$0.29)	NA	NA	NA	NA
94453	26		\$19.40	\$19.33	0%	(\$0.07)	\$19.40	\$19.33	0%	(\$0.07)
94453	TC		\$61.81	\$61.58	0%	(\$0.22)	NA	NA	NA	NA
94610		Surfactant admin thru tube	NA	NA	NA	NA	\$57.49	\$60.51	5%	\$3.02
94620		Pulmonary stress test/simple	\$56.77	\$56.93	0%	\$0.15	NA	NA	NA	NA
94620	26		\$30.90	\$31.15	1%	\$0.25	\$30.90	\$31.15	1%	\$0.25
94620	TC		\$25.87	\$25.78	0%	(\$0.09)	NA	NA	NA	NA
94621		Pulm stress test/complex	\$166.37	\$165.42	-1%	(\$0.96)	NA	NA	NA	NA
94621	26		\$70.07	\$70.18	0%	\$0.11	\$70.07	\$70.18	0%	\$0.11
94621	TC		\$96.30	\$95.24	-1%	(\$1.06)	NA	NA	NA	NA
94640		Airway inhalation treatment	\$18.69	\$18.62	0%	(\$0.07)	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	\$44.20	\$44.40	0%	\$0.20	NA	NA	NA	NA
94645		Cbt each addl hour	\$14.01	\$14.32	2%	\$0.31	NA	NA	NA	NA
94660		Pos airway pressure cpap	\$63.60	\$64.09	1%	\$0.49	\$38.45	\$38.67	1%	\$0.22
94662		Neg press ventilation cnp	NA	NA	NA	NA	\$34.86	\$37.95	9%	\$3.10
94664		Evaluate pt use of inhaler	\$17.61	\$17.54	0%	(\$0.06)	NA	NA	NA	NA
94667		Chest wall manipulation	\$26.59	\$26.50	0%	(\$0.10)	NA	NA	NA	NA
94668		Chest wall manipulation	\$29.11	\$29.36	1%	\$0.25	NA	NA	NA	NA
94680		Exhaled air analysis o2	\$58.21	\$58.00	0%	(\$0.21)	NA	NA	NA	NA
94680	26		\$12.94	\$12.89	0%	(\$0.05)	\$12.94	\$12.89	0%	(\$0.05)
94680	TC		\$45.28	\$45.11	0%	(\$0.16)	NA	NA	NA	NA
94681		Exhaled air analysis o2/co2	\$54.26	\$53.35	-2%	(\$0.91)	NA	NA	NA	NA
94681	26		\$10.06	\$10.03	0%	(\$0.04)	\$10.06	\$10.03	0%	(\$0.04)
94681	TC		\$44.20	\$43.32	-2%	(\$0.88)	NA	NA	NA	NA
94690		Exhaled air analysis	\$50.31	\$50.48	0%	\$0.18	NA	NA	NA	NA
94690	26		\$3.95	\$3.94	0%	(\$0.01)	\$3.95	\$3.94	0%	(\$0.01)
94690	TC		\$46.35	\$46.55	0%	\$0.19	NA	NA	NA	NA
94726		Pulm funct tst plethysmograph	\$53.54	\$53.35	0%	(\$0.19)	NA	NA	NA	NA
94726	26		\$12.58	\$12.53	0%	(\$0.05)	\$12.58	\$12.53	0%	(\$0.05)
94726	TC		\$40.96	\$40.82	0%	(\$0.15)	NA	NA	NA	NA
94727		Pulm function test by gas	\$42.76	\$42.61	0%	(\$0.15)	NA	NA	NA	NA
94727	26		\$12.58	\$12.53	0%	(\$0.05)	\$12.58	\$12.53	0%	(\$0.05)
94727	TC		\$30.18	\$30.08	0%	(\$0.11)	NA	NA	NA	NA
94728		Pulm funct test oscillometry	\$39.89	\$40.82	2%	\$0.93	NA	NA	NA	NA
94728	26		\$12.58	\$12.89	2%	\$0.31	\$12.58	\$12.89	2%	\$0.31
94728	TC		\$27.31	\$27.93	2%	\$0.62	NA	NA	NA	NA
94729		Co/membrane diffuse capacity	\$55.34	\$55.14	0%	(\$0.20)	NA	NA	NA	NA
94729	26		\$9.34	\$9.31	0%	(\$0.03)	\$9.34	\$9.31	0%	(\$0.03)
94729	TC		\$45.99	\$45.83	0%	(\$0.17)	NA	NA	NA	NA
94750		Pulmonary compliance study	\$82.29	\$81.63	-1%	(\$0.65)	NA	NA	NA	NA
94750	26		\$11.50	\$11.46	0%	(\$0.04)	\$11.50	\$11.46	0%	(\$0.04)
94750	TC		\$70.79	\$70.18	-1%	(\$0.61)	NA	NA	NA	NA
94760		Measure blood oxygen level	\$3.23	\$3.22	0%	(\$0.01)	NA	NA	NA	NA

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CPT/ HCPCS	Modifier	Short Description	CY 2015	CY 2016	%	Dollar	CY 2015	CY 2016	%	Dollar
			CF \$35.9335	CF \$35.8043	Change	Change	CF \$35.9335	CF \$35.8043	Change	Change
			2015 NF Allowable	2016 NF Allowable	NF Allowable	NF Allowable	2015 FAC Allowable	2016 FAC Allowable	FAC Allowable	FAC Allowable
94761		Measure blood oxygen level exercise	\$5.03	\$5.01	0%	(\$0.02)	NA	NA	NA	NA
94762		Measure blood oxygen level	\$24.79	\$24.70	0%	(\$0.09)	NA	NA	NA	NA
94770		Exhaled carbon dioxide test	NA	NA	NA	NA	\$7.55	\$7.52	0%	(\$0.03)
94772		Breath recording infant	\$0.00	\$0.00	NA	\$0.00	NA	NA	NA	NA
94772	26		\$0.00	\$0.00	NA	\$0.00	\$0.00	\$0.00	NA	\$0.00
94772	TC		\$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
94780		Car seat/bed test 60 min	\$63.60	\$56.93	-10%	(\$6.67)	\$25.51	\$23.27	-9%	(\$2.24)
94781		Car seat/bed test + 30 min	\$23.36	\$23.27	0%	(\$0.08)	\$8.98	\$8.59	-4%	(\$0.39)
94799		Pulmonary service/procedure Unlisted	\$0.00	\$0.00	NA	\$0.00	NA	NA	NA	NA
94799	26		\$0.00	\$0.00	NA	\$0.00	\$0.00	\$0.00	NA	\$0.00
94799	TC		\$0.00	\$0.00	NA	\$0.00	NA	NA	NA	NA
95782		Polysom <6 yrs 4/> paramtrs	\$924.57	\$1,039.76	12%	\$115.19	NA	NA	NA	NA
95782	26		\$124.33	\$128.90	4%	\$4.57	\$124.33	\$128.90	4%	\$4.57
95782	TC		\$800.24	\$910.86	14%	\$110.62	NA	NA	NA	NA
95783		Polysom <6 yrs cpap/bilvl	\$1,261.27	\$1,089.88	-14%	(\$171.38)	NA	NA	NA	NA
95783	26		\$150.56	\$142.14	-6%	(\$8.42)	\$150.56	\$142.14	-6%	(\$8.42)
95783	TC		\$1,110.70	\$947.74	-15%	(\$162.96)	NA	NA	NA	NA
95800		Slp stdy unattended	\$182.18	\$180.45	-1%	(\$1.73)	NA	NA	NA	NA
95800	26		\$52.82	\$52.63	0%	(\$0.19)	\$52.82	\$52.63	0%	(\$0.19)
95800	TC		\$129.36	\$127.82	-1%	(\$1.54)	NA	NA	NA	NA
95801		Slp stdy unatnd w/anal	\$93.07	\$91.66	-2%	(\$1.41)	NA	NA	NA	NA
95801	26		\$50.31	\$50.13	0%	(\$0.18)	\$50.31	\$50.13	0%	(\$0.18)
95801	TC		\$42.76	\$41.53	-3%	(\$1.23)	NA	NA	NA	NA
95803		Actigraphy testing	\$143.37	\$143.22	0%	(\$0.16)	NA	NA	NA	NA
95803	26		\$43.84	\$44.40	1%	\$0.56	\$43.84	\$44.40	1%	\$0.56
95803	TC		\$99.54	\$98.82	-1%	(\$0.72)	NA	NA	NA	NA
95805		Multiple sleep latency test	\$424.73	\$432.87	2%	\$8.14	NA	NA	NA	NA
95805	26		\$60.01	\$60.15	0%	\$0.14	\$60.01	\$60.15	0%	\$0.14
95805	TC		\$364.73	\$372.72	2%	\$8.00	NA	NA	NA	NA
95806		Sleep study unatt & resp efft	\$170.32	\$170.43	0%	\$0.10	NA	NA	NA	NA
95806	26		\$61.81	\$61.94	0%	\$0.14	\$61.81	\$61.94	0%	\$0.14
95806	TC		\$108.52	\$108.49	0%	(\$0.03)	NA	NA	NA	NA
95807		Sleep study attended	\$474.32	\$484.43	2%	\$10.11	NA	NA	NA	NA
95807	26		\$62.88	\$63.37	1%	\$0.49	\$62.88	\$63.37	1%	\$0.49
95807	TC		\$411.44	\$421.06	2%	\$9.62	NA	NA	NA	NA
95808		Polysom any age 1-3> param	\$609.79	\$638.75	5%	\$28.96	NA	NA	NA	NA
95808	26		\$88.04	\$89.51	2%	\$1.47	\$88.04	\$89.51	2%	\$1.47
95808	TC		\$521.75	\$549.24	5%	\$27.48	NA	NA	NA	NA
95810		Polysom 6/> yrs 4/> param	\$628.84	\$631.23	0%	\$2.39	NA	NA	NA	NA
95810	26		\$123.61	\$123.88	0%	\$0.27	\$123.61	\$123.88	0%	\$0.27
95810	TC		\$505.23	\$507.35	0%	\$2.12	NA	NA	NA	NA

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CPT/ HCPCS	Modifier	Short Description	CY 2015	CY 2016	%	Dollar	CY 2015	CY 2016	%	Dollar
			CF \$35.9335	CF \$35.8043	Change	Change	CF \$35.9335	CF \$35.8043	Change	Change
			2015 NF Allowable	2016 NF Allowable	NF Allowable	NF Allowable	2015 FAC Allowable	2016 FAC Allowable	FAC Allowable	FAC Allowable
95811		Polysom 6/>yrs cpap 4/> parm	\$660.46	\$663.45	0%	\$3.00	NA	NA	NA	NA
95811	26		\$128.28	\$128.90	0%	\$0.61	\$128.28	\$128.90	0%	\$0.61
95811	TC		\$532.18	\$534.56	0%	\$2.38	NA	NA	NA	NA
99291		Critical care first hour	\$279.20	\$277.48	-1%	(\$1.72)	\$227.46	\$225.93	-1%	(\$1.53)
99292		Critical care each add 30 min	\$124.33	\$123.88	0%	(\$0.45)	\$113.55	\$113.14	0%	(\$0.41)
99406		Behav chng smoking 3-10 min	\$14.37	\$14.32	0%	(\$0.05)	\$12.58	\$12.53	0%	(\$0.05)
99407		Behav chng smoking > 10 min	\$27.67	\$27.93	1%	\$0.26	\$25.87	\$26.14	1%	\$0.27
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			NA	NA			NA	NA
99489		Cmplx chron care addl 30 min	\$0.00	\$0.00	NA	NA	\$0.00	\$0.00	NA	NA
99490		Chron care mgmt srvc 20 min	\$43.12	\$40.82	NA	NA	\$33.06	\$31.51	NA	NA
99495		Trans care mgmt 14 day disch	\$166.37	\$165.42	-1%	(\$0.96)	\$112.47	\$111.35	-1%	(\$1.12)
99496		Trans care mgmt 7 day disch	\$233.57	\$233.09	0%	(\$0.48)	\$162.06	\$161.12	-1%	(\$0.94)
99497		Advncd care plan 30 min	\$0.00	\$85.93	NA	NA	\$0.00	\$79.49	NA	NA
99498		Advncd care plan addl 30 min	\$0.00	\$74.83	NA	NA	\$0.00	\$74.47	NA	NA
G0237		Therapeutic procd strg endur	\$10.42	\$10.03	-4%	(\$0.40)	NA	NA	NA	NA
G0238		Oth resp proc, indiv	\$10.78	\$10.74	0%	(\$0.04)	NA	NA	NA	NA
G0239		Oth resp proc, group	\$13.30	\$13.25	0%	(\$0.05)	NA	NA	NA	NA
●G0296		Visit to determ LDCT elig	New in 2016	\$28.64	NA	NA	New in 2016	\$26.85	NA	NA
●G0297		LDCT for Lung CA screen	New in 2016	\$254.93	NA	NA	New in 2016	NA	NA	NA
●G0297	26		New in 2016	\$51.56	NA	NA	New in 2016	\$51.56	NA	NA
●G0297	TC		New in 2016	\$203.37	NA	NA	New in 2016	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	\$30.18	\$30.08	0%	(\$0.11)	\$14.01	\$13.96	0%	(\$0.05)
G0436		Tobacco-use counsel 3-10 min	\$14.37	\$14.68	2%	\$0.31	\$12.22	\$12.53	3%	\$0.31
G0463		Hospital outpt clinic visit	\$0.00	\$0.00	NA	\$0.00	\$0.00	\$0.00	NA	\$0.00

**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 2015 American Medical Association.

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

## Hospital Outpatient Prospective Payment System

HOPPS 2016 payments for pulmonary, critical care and sleep service saw significant variation from 2015 payment levels. The majority of the payment variation was driven by consolidation of Medicare Ambulatory Payment Classifications (APC) levels for outpatient services. The APC consolidation effort creates “winners” (example: **31626** – Bronchoscopy w/placement of markers +36%) and “losers” (example: **31646**- bronchoscopy, subsequent therapeutic aspiration of airways -64%) across many areas of pulmonary service including pulmonary function tests, bronchoscopic

procedures, ventilator management and sleep testing. The consolidation of APCs in the pulmonary community is a continuation of CMS’s efforts to decrease the number of APC levels across all physician specialties.

Reimbursement for pulmonary rehabilitation (**G0424** – pulmonary rehabilitation respiratory +7%) and respiratory therapy (**G0237** - Therapeutic procedure to increase strength or endurance of respiratory muscles, face to face, one on one, 15 minutes each - +74%) payments are both increased in 2016.

### FINAL 2015 Compared to FINAL 2016 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  
Updated October 1, 2015 HOPPS File (4Q 2015) & December 14, 2015 HOPPS File (1Q 2016)

CPT/ HCPCS	CMS Short Description Description	Status		APC		FINAL RULE CY 2015 Payment Rate	FINAL RULE CY 2016 Payment Rate	Dollar Change	Percent Change
		CY 2015	CY 2016	CY 2015	CY 2016				
31615	Visualization of windpipe	T	T	0252	5163	\$646.66	\$689.63	\$42.97	7%
31620	Endobronchial us add-on	N	D	N/A	NA	\$0.00	\$0.00	\$0.00	N/A
31622	Dx bronchoscope/wash	T	T	0076	5153	\$1,055.12	\$1,037.50	-\$17.62	-2%
31623	Dx bronchoscope/brush	T	T	0076	5153	\$1,055.12	\$1,037.50	-\$17.62	-2%
31624	Dx bronchoscope/lavage	T	T	0076	5153	\$1,055.12	\$1,037.50	-\$17.62	-2%
31625	Bronchoscopy w/biopsy(s)	T	T	0076	5153	\$1,055.12	\$1,037.50	-\$17.62	-2%
31626	Bronchoscopy w/markers	T	T	0415	5155	\$2,256.36	\$3,066.48	\$810.12	36%
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	5154	\$1,055.12	\$1,991.92	\$936.80	89%
31629	Bronchoscopy/needle bx each	T	T	0415	5154	\$2,256.36	\$1,991.92	-\$264.44	-12%
31630	Bronchoscopy dilate/fx repr	T	T	0415	5154	\$2,256.36	\$1,991.92	-\$264.44	-12%
31631	Bronchoscopy dilate w/stent	T	T	0415	5155	\$2,256.36	\$3,066.48	\$810.12	36%
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	5155	\$2,256.36	\$3,066.48	\$810.12	36%
31635	Bronchoscopy w/fb removal	T	T	0076	5153	\$1,055.12	\$1,037.50	-\$17.62	-2%
31636	Bronchoscopy bronch stents	T	T	0415	5155	\$2,256.36	\$3,066.48	\$810.12	36%
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	5155	\$2,256.36	\$3,066.48	\$810.12	36%
31640	Bronchoscopy w/tumor excise	T	T	0415	5154	\$2,256.36	\$1,991.92	-\$264.44	-12%
31641	Bronchoscopy treat blockage	T	T	0415	5154	\$2,256.36	\$1,991.92	-\$264.44	-12%
31643	Diag bronchoscope/catheter	T	T	0076	5153	\$1,055.12	\$1,037.50	-\$17.62	-2%
31645	Bronchoscopy clear airways	T	T	0076	5153	\$1,055.12	\$1,037.50	-\$17.62	-2%
31646	Bronchoscopy reclear airway	T	T	0076	5152	\$1,055.12	\$375.13	-\$679.99	-64%
31647	Bronchial valve init insert	T	T	0415	5155	\$2,256.36	\$3,066.48	\$810.12	36%

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CPT/ HCPCS	CMS Short Description Description	Status		APC		FINAL RULE CY 2015 Payment Rate	FINAL RULE CY 2016 Payment Rate	Dollar Change	Percent Change
		CY 2015	CY 2016	CY 2015	CY 2016				
31648	Bronchial valve remov init	T	T	0415	5154	\$2,256.36	\$1,991.92	-\$264.44	-12%
31649	Bronchial valve remov addl	Q2	Q2	0076	5153	\$1,055.12	\$1,037.50	-\$17.62	-2%
31651	Bronchial valve addl insert	N	N	N/A	N/A	\$0.00	\$0.00	\$0.00	N/A
•31652	Bronch ebus sampling 1/2 node	N/A	T	N/A	5154	\$0.00	\$1,992.92	\$1,992.92	N/A
•31653	Bronch ebus sampling 3/> node	N/A	T	N/A	5154	\$0.00	\$1,992.92	\$1,992.92	N/A
•31654	Bronch ebus ivntj perph les	N/A	N	N/A	N/A	\$0.00	\$0.00	\$0.00	N/A
31660	Bronch thermoplasty 1 lobe	T	T	0415	5155	\$2,256.36	\$3,066.48	\$810.12	36%
31661	Bronch thermoplasty 2/> lobes	T	T	0415	5155	\$2,256.36	\$3,066.48	\$810.12	36%
32554	Aspirate pleura w/o imaging	T	T	0070	5391	\$489.35	\$482.83	-\$6.52	-1%
32555	Aspirate pleura w/ imaging	T	T	0070	5391	\$489.35	\$482.83	-\$6.52	-1%
32556	Insert cath pleura w/o image	T	T	0070	5392	\$489.35	\$1,207.75	\$718.40	147%
32557	Insert cath pleura w/ image	T	T	0070	5391	\$489.35	\$482.83	-\$6.52	-1%
94002	Vent mgmt inpat init day <small>Single Code (Single Code APC Assignment &amp; Rate)</small>	Q3	Q3	0079	5801	\$374.20	\$457.11	\$82.91	22%
94002	Vent mgmt inpat init day <small>Composite (Composite APC Assignment &amp; Rate)</small>	Q3	Q3	0617	5041	\$656.94	\$666.27	\$9.33	1%
94002	Vent mgmt inpat init day <small>Composite (Composite APC Assignment &amp; Rate)</small>	Q3	Q3	0618	5045	\$889.32	\$851.40	-\$37.92	-4%
94003	Vent mgmt inpat subq day <small>Single Code (Single Code APC Assignment &amp; Rate)</small>	Q3	Q3	0079	5801	\$374.20	\$457.11	\$82.91	22%
94003	Vent mgmt inpat subq day <small>Composite (Composite APC Assignment &amp; Rate)</small>	Q3	Q3	0617	5041	\$656.94	\$666.27	\$9.33	1%
94003	Vent mgmt inpat subq day <small>Composite (Composite APC Assignment &amp; Rate)</small>	Q3	Q3	0618	5045	\$889.32	\$851.40	-\$37.92	-4%
94010	Breathing capacity test	Q1	Q1	0367	5721	\$161.28	\$129.75	-\$31.53	-20%
94011	Spirometry up to 2 yrs old	Q1	Q1	0367	5721	\$161.28	\$129.75	-\$31.53	-20%
94012	Spirimtry w/brnchdil inf-2 yr	Q1	Q1	0367	5722	\$161.28	\$220.35	\$59.07	37%
94013	Meas lung vol thru 2 yrs	S	S	0369	5723	\$236.86	\$396.52	\$159.66	67%
94014	Patient recorded spirometry	Q1	Q1	0367	5734	\$161.28	\$91.18	-\$70.10	-43%
94015	Patient recorded spirometry	Q1	Q1	0367	5722	\$161.28	\$220.35	\$59.07	37%
94016	Review patient spirometry	A	A	N/A	N/A	\$0.00	\$0.00	\$0.00	N/A
94060	Evaluation of wheezing	S	S	0369	5722	\$236.86	\$220.35	-\$16.51	-7%
94070	Evaluation of wheezing	S	S	0369	5722	\$236.86	\$220.35	-\$16.51	-7%
94150	Vital capacity test	Q1	Q1	0367	5721	\$161.28	\$129.75	-\$31.53	-20%
94200	Lung function test (MBC/MVV)	Q1	Q1	0420	5734	\$131.75	\$91.18	-\$40.57	-31%
94250	Expired gas collection	Q1	Q1	0340	5733	\$52.37	\$55.94	\$3.57	7%
94375	Respiratory flow volume loop	Q1	Q1	0367	5722	\$161.28	\$220.35	\$59.07	37%
94400	CO2 breathing response curve	Q1	Q1	0367	5722	\$161.28	\$220.35	\$59.07	37%
94450	Hypoxia response curve	Q1	Q1	0367	5721	\$161.28	\$129.75	-\$31.53	-20%
94452	Hast w/report	Q1	Q1	0367	5734	\$161.28	\$91.18	-\$70.10	-43%
94453	Hast w/oxygen titrate	Q1	Q1	0367	5734	\$161.28	\$91.18	-\$70.10	-43%
94610	Surfactant admin thru tube	Q1	Q1	0077	5791	\$164.63	\$149.46	-\$15.17	-9%
94620	Pulmonary stress test/simple	Q1	Q1	0420	5734	\$131.75	\$91.18	-\$40.57	-31%

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CPT/ HCPCS	CMS Short Description Description	Status		APC		FINAL RULE CY 2015	FINAL RULE CY 2016	Dollar Change	Percent Change
		CY 2015	CY 2016	CY 2015	CY 2016	Payment Rate	Payment Rate		
94621	Pulm stress test/complex	S	S	0369	5722	\$236.86	\$220.35	-\$16.51	-7%
94640	Airway inhalation treatment	Q1	Q1	0077	5791	\$164.63	\$149.46	-\$15.17	-9%
94642	Aerosol inhalation treatment	Q1	Q1	0077	5791	\$164.63	\$149.46	-\$15.17	-9%
94644	Cbt 1st hour	Q1	Q1	0420	5734	\$131.75	\$91.18	-\$40.57	-31%
94645	Cbt each addl hour	N	N	N/A	N/A	\$0.00	\$0.00	\$0.00	N/A
94660	Pos airway pressure cpap <small>Single Code (Single Code APC Assignment &amp; Rate)</small>	Q3	Q1	0077	5791	\$164.63	\$149.46	-\$15.17	-9%
94660	Pos airway pressure cpap <small>Composite (Composite APC Assignment &amp; Rate)</small>	Q3	N/A	0617	N/A	\$656.94	\$0.00	-\$656.94	N/A
94660	Pos airway pressure cpap <small>Composite (Composite APC Assignment &amp; Rate)</small>	Q3	N/A	0618	N/A	\$889.32	\$0.00	-\$889.32	N/A
94662	Neg press ventilation cnp <small>Single Code (Single Code APC Assignment &amp; Rate)</small>	Q3	Q3	0079	5801	\$374.20	\$457.11	\$82.91	22%
94662	Neg press ventilation cnp <small>Composite (Composite APC Assignment &amp; Rate)</small>	Q3	Q3	0617	5041	\$656.94	\$666.27	\$9.33	1%
94662	Neg press ventilation cnp <small>Composite (Composite APC Assignment &amp; Rate)</small>	Q3	Q3	0618	5045	\$889.32	\$851.40	-\$37.92	-4%
94664	Evaluate pt use of inhaler	Q1	Q1	0077	5791	\$164.63	\$149.46	-\$15.17	-9%
94667	Chest wall manipulation	Q1	Q1	0077	5734	\$164.63	\$91.18	-\$73.45	-45%
94668	Chest wall manipulation	Q1	Q1	0340	5733	\$52.37	\$55.94	\$3.57	7%
94680	Exhaled air analysis o2	Q1	Q1	0367	5721	\$161.28	\$129.75	-\$31.53	-20%
94681	Exhaled air analysis o2/co2	Q1	Q1	0367	5722	\$161.28	\$220.35	\$59.07	37%
94690	Exhaled air analysis	Q1	Q1	0340	5732	\$52.37	\$30.51	-\$21.86	-42%
94726	Pulm funct tst plethysmograp	Q1	Q1	0367	5722	\$161.28	\$220.35	\$59.07	37%
94727	Pulm function test by gas	Q1	Q1	0367	5721	\$161.28	\$129.75	-\$31.53	-20%
94728	Pulm funct test oscillometry	Q1	Q1	0367	5722	\$161.28	\$220.35	\$59.07	37%
94729	Co/membrane diffuse capacity	N	N	N/A	N/A	\$0.00	\$0.00	\$0.00	N/A
94750	Pulmonary compliance study	Q1	Q1	0367	5721	\$161.28	\$129.75	-\$31.53	-20%
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	Measure blood oxygen level <small>Single Code (Single Code APC Assignment &amp; Rate)</small>	Q3	Q3	0097	5721	\$112.71	\$129.75	\$17.04	15%
94762	Measure blood oxygen level <small>Composite (Composite APC Assignment &amp; Rate)</small>	Q3	Q3	0617	5041	\$656.94	\$666.27	\$9.33	1%
94762	Measure blood oxygen level <small>Composite (Composite APC Assignment &amp; Rate)</small>	Q3	Q3	0618	5045	\$889.32	\$851.40	-\$37.92	-4%
94770	Exhaled carbon dioxide test	S	S	0369	5722	\$236.86	\$220.35	-\$16.51	-7%
94772	Breath recording infant	S	S	0369	5723	\$236.86	\$396.52	\$159.66	67%
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	5721	\$112.71	\$129.75	\$17.04	15%
94776	Ped home apnea rec downld	S	S	0097	5721	\$112.71	\$129.75	\$17.04	15%
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	Q1	Q1	0340	5732	\$52.37	\$30.51	-\$21.86	-42%
+ 94781	Car seat/bed test + 30 min	N	N	N/A	N/A	\$0.00	\$0.00	\$0.00	N/A

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CPT/ HCPCS	CMS Short Description Description	Status		APC		FINAL RULE CY 2015 Payment Rate	FINAL RULE CY 2016 Payment Rate	Dollar Change	Percent Change
		CY 2015	CY 2016	CY 2015	CY 2016				
94799	Pulmonary service/procedure Unlisted	Q1	Q1	0367	5721	\$161.28	\$129.75	-\$31.53	-20%
# 95782	Polysom <6 yrs 4/> paramtrs	S	S	0435	5724	\$854.29	\$856.44	\$2.15	0%
# 95783	Polysom <6 yrs cpap/bilvl	S	S	0435	5724	\$854.29	\$856.44	\$2.15	0%
# 95800	Slp stdy unattended	S	S	0213	5721	\$176.63	\$129.75	-\$46.88	-27%
# 95801	Slp stdy unatnd w/anal	S	Q1	0213	5734	\$176.63	\$91.18	-\$85.45	-48%
95803	Actigraphy testing	Q1	Q1	0340	5734	\$52.37	\$91.18	\$38.81	74%
95805	Multiple sleep latency test	S	S	0435	5724	\$854.29	\$856.44	\$2.15	0%
95806	Sleep study unatt&resp efft	S	S	0213	5721	\$176.63	\$129.75	-\$46.88	-27%
95807	Sleep study attended	S	S	0209	5723	\$230.83	\$396.52	\$165.69	72%
95808	Polysom any age 1-3> param	S	S	0435	5724	\$854.29	\$856.44	\$2.15	0%
95810	Polysom 6/> yrs 4/> param	S	S	0435	5724	\$854.29	\$856.44	\$2.15	0%
95811	Polysom 6/>yrs cpap 4/> parm	S	S	0435	5724	\$854.29	\$856.44	\$2.15	0%
99291	Critical care first hour	Q3	J2	0617	5041	\$656.94	\$666.27	\$9.33	1%
Single Code	(Single Code APC Assignment & Rate)								
99291	Critical care first hour	Q3	J2	8009	8011	\$1,234.70	\$2,174.14	\$939.44	76%
Composite/ Comprehensive	(Composite/Comprehensive APC Assignment & Rate)								
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	5821	\$26.02	\$27.12	\$1.10	4%
99407	Behav chng smoking > 10 min	S	S	0031	5821	\$26.02	\$27.12	\$1.10	4%
99487	Cmplx chron care w/o pt vsit	N	N	N/A	N/A	\$0.00	\$0.00	\$0.00	N/A
99488	Cmplx chron care w/ pt vsit	D	N/A	CH D	N/A	Deleted Code	Deleted Code	N/A	N/A
Deleted 2015									
99489	Complx chron care addl30 min	N	N	N/A	N/A	\$0.00	\$0.00	\$0.00	N/A
99490	"Chron care mgmt srvc 20 min"	V	V	0631	5011	\$53.72	\$54.41	\$0.69	1%
99495	Trans care mgmt 14 day disch	V	V	0632	5012	\$106.27	\$102.12	-\$4.15	-4%
99496	Trans care mgmt 7 day disch	V	V	0632	5012	\$106.27	\$102.12	-\$4.15	-4%
99497	Advncd care plan 30 min	N	Q1	N/A	5011	\$0.00	\$54.41	\$54.41	N/A
99498	Advncd care plan addl 30 min	N	N	N/A	N/A	\$0.00	\$0.00	\$0.00	N/A
G0237	Therapeutic procd strg endur	Q1	Q1	0340	5734	\$52.37	\$91.18	\$38.81	74%
G0238	Oth resp proc, indiv	Q1	Q1	0340	5733	\$52.37	\$55.94	\$3.57	7%
G0239	Oth resp proc, group	Q1	Q1	0450	5732	\$29.24	\$30.51	\$1.27	4%
●G0296	Visit to determ LDCT elig	N/A	S	N/A	5822	\$0.00	\$69.65	\$69.65	N/A
●G0297	LDCT for Lung CA screen	N/A	S	N/A	5570	\$0.00	\$112.49	\$112.49	N/A
G0379	Direct refer hospital observ	Q3	J2	0633	5013	\$386.95	\$480.69	\$93.74	24%
Single Code	(Single Code APC Assignment & Rate)								
G0379	Direct refer hospital observ	Q3	J2	8009	8011	\$1,234.70	\$2,174.14	\$939.44	76%
Composite/ Comprehensive	(Composite/Comprehensive APC Assignment & Rate)								
G0384	Lev 5 hosp type bed visit	Q3	J2	0630	5035	\$304.38	\$315.88	\$11.50	4%
Single Code	(Single Code APC Assignment & Rate)								
G0384	Lev 5 hosp type bed visit	Q3	J2	8009	8011	\$1,234.70	\$2,174.14	\$939.44	76%
Composite/ Comprehensive	(Composite/Comprehensive APC Assignment & Rate)								
G0390	Trauma respons w/hosp criti	S	S	0618	5045	\$889.32	\$851.40	-\$37.92	-4%

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CPT/ HCPCS	CMS Short Description Description	Status		APC		FINAL RULE CY 2015	FINAL RULE CY 2016	Dollar Change	Percent Change
		CY 2015	CY 2016	CY 2015	CY 2016	Payment Rate	Payment Rate		
G0398	Home sleep test/type 2 porta	S	S	0213	5721	\$176.63	\$129.75	-\$46.88	-27%
G0399	Home sleep test/type 3 porta	S	S	0213	5721	\$176.63	\$129.75	-\$46.88	-27%
G0424	Pulmonary rehab w exer	Q1	Q1	0340	5733	\$52.37	\$55.94	\$3.57	7%
G0436	Tobacco-use counsel 3-10 min	S	S	0031	5821	\$26.02	\$27.12	\$1.10	4%
G0463	Hospital outpt clinic visit	Q3	J2	0634	5012	\$96.25	\$102.12	\$5.87	6%
Single Code	(Single Code APC Assignment & Rate)								
G0463	Hospital outpt clinic visit	Q3	J2	8009	8011	\$1,234.70	\$2,174.14	\$939.44	76%
Composite/ Comprehensive	(Composite/Comprehensive APC Assignment & Rate)								
Composite	Critical Care	S	S	0617	5041	\$656.94	\$666.27	\$9.33	1%
Composite	Trauma Response with Critical Care	S	S	0618	5045	\$889.32	\$851.40	-\$37.92	-4%
Composite	Extended Assessment & Management Composite V	N/A	N/A	8009	N/A	\$1,234.70	\$0.00	-\$1,234.70	-100%
C-APC	Comprehensive Observation Services	N/A	J2	N/A	8011	\$0.00	\$2,174.14	\$2,174.14	N/A

**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 new or composite/comprehensive APC indicates that the APC assignment or configuration of the composite APC has been changed for CY 2016.

**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.

## PULMONARY PHYSICIANS CAN ORDER LUNG CANCER SCREENING/PROVIDE SHARED DECISION-MAKING SERVICE

After compelling arguments by ATS and sister organizations, the Centers for Medicare and Medicaid Services Coverage and Analysis Group issued a clarification this week regarding which physicians can order lung cancer screening and provide the shared decision-making visit.

In its clarification statement, CMS states, “Based on the NCD and applicable regulations, the physician or non-physician practitioner who furnishes the shared-decision making visit and orders the LDCT must be treating the beneficiary and use the results in the management of the beneficiary’s specific medical problem to ensure improved health outcomes.”

This clarification of its earlier statement is final assurance that pulmonary providers and other specialists can order lung cancer screening and provide the shared-decision making visit, provided all other CMS requirements are met.

The ATS is pleased that CMS has issued this clarification in a timely manner and the ATS believes this clarification puts to rest questions about which physicians and non-physician providers can order lung cancer screening and provide the shared decision making service.

The confusion stemmed from the publication of a recent Medicare Learning Network Matter (MLN) (<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9246.pdf>) article that states only primary care providers can order shared decision making visits and only primary care physicians can provide shared decision making visits. The MLN article is in essence an “educational” summary article of the Notice of Coverage Determination (NCD) document (<https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=274>) issued by CMS that states LDCT scans are a covered Medicare service and what the conditions of coverage are. The official CMS policy is contained in the NCD document. As the ATS pointed out in our communications to CMS that resulted in the clarification policy, there is nothing in the NCD document that expressly limits or implies limiting the service to primary care providers. Further the U.S. Preventative Services Taskforce report (<http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/lung-cancerscreening>) on LDCT screening, on which CMS based its NCD document, does not limit the service to primary care providers, and in fact recognizes patients will be referred for screening from non-primary care providers.

Additionally, the ATS reached out to a number of directors of Medicare Administrative Contractors (MAC), the entities actually responsible for reviewing, processing and paying Medicare claims, and the MAC directors have reported that there are no plans to limit payment for this service to primary care physicians. The MAC directors further note that, assuming proper coding and documentation, they plan to pay claims for the shared decision making visits from all physician providers (including specialists).

In summary, while the MLN article has created some confusion and has not yet been retracted or corrected, the clarification policy provides ample guidance from CMS that all physicians are able to order lung cancer screening and provide the shared decision making service, provided all other CMS criteria are met.

### LDCT Lung Cancer Screening - Important ICD-10-CM Coding Issue

And if the confusion surrounding what type of providers wasn’t enough, there is also a LDCT screening coding problem involving ICD-10-CM codes. Medicare will deny **G0296** (Counseling visit to discuss need for lung cancer screening (LDCT) using low dose CT scan (service is for eligibility determination and shared decision making) and **G0297** (Low dose CT scan (LDCT) for lung cancer screening) for claims that do not contain the ICD 9 CM code **V15.82** (History of tobacco use) for claims with dates of service February 5, 2015 to September 30, 2015 and ICD-10-CM code **Z87.891** (Personal history of nicotine dependence) for claims with dates of service on or after October 1, 2015. This leaves a gap for coding our patients that are current smokers. We have been in contact with CMS and understand they have plans to add ICD-10 code **F17.2**- (Nicotine dependence) in the future. However, for those patients who are current smokers, those claims will need to be held, as contractors do not currently have instructions and these claims will be denied.

### How to Use the New LDCT Lung Cancer Screening Codes

The code to use for a SDM visit is **G0296** (counseling visit to discuss need for lung cancer screening [LDCT]). This is a 15 minute code with reimbursement of \$69.65 in the hospital out-patient setting and \$28.64 in a physician’s office. It can be billed on the same day as an E/M visit, provided medical necessity is met. If this occurs, it should be billed with a 25 modifier added to the E/M service. The time to perform the

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E/M service is exclusive of the time to perform the SDM. Since this is a preventive service benefit, no patient copays are applicable. Remember to affix **Z87.891** (Personal history of nicotine dependence) to the bill and hold the bill, if the patient is currently smoking (see above). Use code **G0297** (Low dose CT scan [LDCT]) when the CT scan is ordered. Remember to add **Z89.891** to the order sheet (see above). The reimbursement for **G0297** is \$112.49 in the hospital outpatient setting and \$254.93 in a physician's office. For

additional information on how to use the new codes for LDCT lung cancer screening appropriately, please visit the ATS website (<https://www.thoracic.org/professionals/clinicalresources/resources-for-practices/ats-coding-billing-issues/atscoding-billing-webinars/index.php>) and listen to the webinar on eligibility, documentation and coding requirements for the new LDCT lung cancer screening benefit.

## “INCIDENT-TO” SERVICES

The Centers for Medicare & Medicaid Services (CMS) has amended its incident-to regulations to clarify that the physician or other practitioner who bills for incident-to services must be the same person who directly supervised the ancillary personnel who provided the services. The direct supervision requirement for incident-to services has not changed – the physician must be present in the office suite (but not the exam room) and immediately available to furnish assistance and direction throughout the performance of the service.

This does not mean that the billing/supervising physician also has to be the one who initiated the original care plan or service upon which the incident-to service is based. Under the clarified regulations, scenarios like the following are acceptable: Dr. A treats Mrs. Jones on Monday, initiating a plan of care and asking her to return in one week for follow-up with the nurse. If Dr. A is on vacation when the patient returns and his partner, Dr. B, directly supervises the nurse visit, Dr. B must bill for the service under his own provider number, according to the amended regulations.

When incident-to services are provided, practices will need to decide which physician qualifies as the supervising physician. Although claims don't identify that services were provided incident to a physician's care, medical record documentation should clearly name the supervising physician.

Note that services and supplies provided incident to transitional care management (**99495, 99496**) and chronic care management services (**99487, 99489**) remain an exception to the direct supervision requirement. These can continue to be provided under the general supervision of the physician (or other practitioner). General supervision means the service is furnished under the physician's overall direction and control, but the physician's presence in the office suite is not required.

CMS also amended its regulations to clarify that ancillary personnel are prohibited from providing incident-to services if they have been excluded from Medicare, Medicaid, or any

other federally funded health care programs by the Office of Inspector General or have had their Medicare enrollment revoked for any reason. Such individuals are technically prohibited from providing services to Medicare beneficiaries, but CMS makes it explicit in this case.

## 2016: NEW EBUS CPT CODES

ATS members should be aware that 2016 brings a change in Endobronchial Ultrasound (EBUS) Current Procedural Terminology (CPT®) coding in 2016. The changes better reflect the current technology and differentiate between convex and radial probe ultrasound. The add-on code **31620** will be eliminated and replaced by 3 distinct codes, **31652**, **31653** and **31654**. **31652** should be used when a convex probe EBUS scope is utilized for sampling 2 or fewer hilar or mediastinal stations or structures. Similarly, **31653** is used when 3 or more hilar or mediastinal stations or structures are sampled. Note that the code chosen depends upon the number of stations or structures sampled and **31652** and **31653** may not be used together. Also, the stations or structures sampled now coincide with the appropriate anatomic locations. **31652** and **31653**

incorporate sampling so that **31629** and **31633** (transbronchial needle aspiration at the initial or additional stations) cannot be used with these codes. **31654** is used when a radial probe EBUS is employed to image peripheral lesions for access and sampling. It is an add-on code to be used with other bronchoscopy codes (**31622-26**, **31628**, **31629**, **31640**, **31643**, **31645-46**) but does not include sampling. It is appropriate to use **31629** and other sampling codes with **31654** even if mediastinal/hilar sampling occurred (codes **31652** or **31653**). The distinction is the use of a different form during the same session of EBUS for peripheral sampling. The multiple endoscopy rule applies to all bronchoscopic procedures during the session with modifiers used if appropriate.

## ADVANCE CARE PLANNING AVAILABLE TO MEDICARE BENEFICIARIES IN 2016

The ATS is pleased that CMS has finally agreed to reimburse physicians for discussing advance care planning with Medicare beneficiaries. The ATS has long advocated for CMS to recognize the value of and pay for this important service. Prior to January 2016, neither physicians nor beneficiaries could seek reimbursement from Medicare for advance care planning, if those discussions were the sole purpose of the visit. ATS as part of 66 organizations representing patients, healthcare professionals, caregivers, and many other stakeholders endorsed a letter asking Secretary of Health and Human Services Sylvia Mathews Burwell to recognize Advance Care Planning (ACP) as an essential element of high-quality care that supports patients in aligning their future care with what is most important to them through ongoing conversations with their healthcare professionals. ACP leads to better care, higher patient and family satisfaction, fewer unwanted hospitalizations, and lower rates of caregiver distress, depression, and lost productivity, according to recent studies. The 2004 IOM report, "Dying in America," also cited payment for ACP as one five key recommendations for improving care quality and honoring individual wishes and expectations.

As a result of the stakeholder efforts, the Centers for Medicare and Medicaid Services (CMS) will begin covering ACP—discussions that physicians and other health professionals have with their patients regarding end-of-life care and patient preferences—as a separate and billable service. The following FAQs provide information on Medicare's policies in end-of-life care and advance care planning.

CPT® Code	Description
<b>99497</b>	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
<b>+99498</b>	each additional 30 minutes (list separately in addition to code for primary procedure)

CPT®	MPFS 2016 National Rate	HOPPS 2016 National Rate
<b>99497</b>	\$85.99 Non-Facility	\$54.41 APC Group 5011
	\$79.54 Facility	Status "Q1"
<b>+99498</b>	\$74.88 Non-Facility	Status "N"
	\$74.52 Facility	Packaged into Procedure

Status N description, Items and Services Packaged into APC Rates  
Paid under OPPS; payment is packaged into payment for other services. Therefore there is no separate APC payment.  
Status Q1 description, STV-Packaged Codes  
Paid under OPPS; Addendum B displays APC assignments when services are separately payable.  
(1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "S," "T," or "V."  
(2) In other circumstances, payment is made through a separate APC payment.

## Q&A

### Advance Care Planning

**Q.** What is “advance care planning” and does Medicare cover it?

**A.** Advance care planning involves multiple steps designed to help individuals a) learn about the health care options that are available for end-of-life care; b) determine which types of care best fit their personal wishes; and c) share their wishes with family, friends, and their physicians. In some cases, patients who have already considered their options may need only one advance care planning conversation with their physician. However, experts state that frequently, beneficiaries may require a series of conversations with their physician or other health professionals to understand and define their end-of-life wishes clearly.

Starting January 1, 2016, Medicare will cover ACP as a separate service provided by physicians and other health professionals (such as nurse practitioners) who bill Medicare using the physician fee schedule. Medicare will cover ACP provided in medical offices and facility settings, including hospitals.

**Q.** Are the advance care planning services CPT® codes retroactive for use to the date CPT® established them?

**A.** No. CPT® established two new codes in 2015 to describe advance care planning services. However Medicare did not allow separate payment for these codes for claims with dates of service in 2015, as CMS stated, these services were bundled as part of an E/M visit. As noted above, CMS changed the policy and providers may begin billing for these services for dates on or after January 1, 2016 with the following CPT® code **99497** and or **99498**.

**Q.** Are the legal forms required to be completed and signed in order to bill the advance care planning services CPT® codes?

**A.** No, you can use these ACP CPT® codes to report the face-to-face service, with or without completing the relevant legal forms. CPT® describes an advance directive as

“a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time.” Some examples of these forms are a health care proxy, durable power of attorney for health care, living will, and medical orders for life-sustaining treatment.

**Q.** What is Medicare paying for advance care services in 2016?

**A.** CMS has assigned a total of 2.40 relative value units (RVUs) to **99497** and 2.09 RVUs to **99498** in the non-facility setting (e.g., physician office), which translates to \$85.99 and \$74.88, respectively, using the 2016 Medicare conversion factor (unadjusted for geography, sequestration, and any applicable Medicare payment adjustments). In the Hospital outpatient setting CMS has assigned CPT® **99497** to APC group 5011 with a national payment rate \$54.41 and CPT® **99498** a status indicator of “N” consistent with the add-on code policy as the payment for the add-on code is considered packaged into the primary procedure **99497**. Providers in the hospital setting should report the add-on code for appropriate coding and for capturing appropriate volumes and costs of these services, even if there is no current separate payment as information is used for future hospital rate setting. Payment in general may still depend on local coverage determinations by the Medicare Administrative Contractors (MAC), as medically appropriate ICD-10-CM codes and frequency limits would be at the discretion of the MACs.

**Q.** Can I bill both an E/M visit and advance care planning on the same date of service?

**A.** Yes, CMS offers the following example of how a physician might provide and bill for advance care planning. A physician sees a 68-year-old male with heart failure and diabetes who takes multiple medications. She provides evaluation and management (E/M) of these two diseases, including adjusting medications

as appropriate. In addition to discussing the patient’s short-term treatment options, the physician learns of the patient’s interest in discussing long-term treatment options and planning. The patient inquires about the possibility of a heart transplant if his congestive heart failure worsens. The physician and patient also discuss advance care planning for care and treatment if he suffers a health event that adversely affects his decision-making capacity.

In this example, the physician would report a standard E/M code and one or both of the advanced care planning codes, depending on the duration of the service. The physician would NOT count the time spent on the E/M portion of the visit toward the time used to code **99497** and **99498**. Per CPT®, no active management of the problem or problems is undertaken during the time period for which these two codes are reported.

Note that the advance care planning service described in the example above would not necessarily have to occur on the same day as an E/M service. It can be billed as a stand-alone service. A 25 modifier does not need to be appended to the E/M service.

**Q.** Can I bill advance care planning on the same date of service as critical care services?

**A.** No. CPT® makes clear in exclusionary parentheticals that advance care services would not be billable on the same date as any adult or pediatric critical care services. CPT provided the following list of codes that may not be billed with ACP services. Those CPT services are **99291, 99292, 99468, 99469, 99471, 99472, 99475, 99476, 99477, 99478, 99479, and 99480**.

**Q.** Can I bill advance care planning on the same date of service as inpatient care services?

**A.** Yes. ACP during an inpatient hospital visit is not excluded. Again, the physician would NOT count the time spent on the E/M portion of the visit toward the time used to code **99497** and **99498**. A 25 modifier does not need to be appended to the E/M service.

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## Q&A (cont'd)

**Q.** Are the advance care planning services subject to a co-payment, deductible or co-insurance?

**A.** In general, as with most other physician services, beneficiaries are subject to cost sharing for ACP provided by their physician or health professional, (e.g., co-payment, co-insurance, deductible). However, if Medicare beneficiaries desire ACP during their annual wellness visit, physicians and other health professionals may provide it during that visit and bill Medicare separately for it. However, beneficiaries will not have any cost sharing liability for advance care planning provided in conjunction with their annual wellness visits.

**Q.** Can we bill for ACP that takes 16 minutes?

**A.** Yes. The CPT® time rule applies for any service in the CPT manual that does not have a parenthetical that states otherwise. In this case, providers would follow the CPT time rule convention that states, “A unit of time is attained when the mid-point is passed.” We would like to point out that ACP services should not be rushed. Therefore, while CPT would allow coding at 16 minutes, we anticipate many

of these services will take closer to the 30 minutes or more.

**Q.** Can more than one provider or specialist(s) provide advance care planning in any given year(s), what are the frequency limitations?

**A.** We are currently not aware of any national or local frequency limitations by any of the National Correct Coding Initiative or Medically Unlikely Edits. Medicare Administrative Contractors (MACs) have the authority to place frequency limits, therefore we suggest that you check with your local payers and MACs.

More information on the Advance Care Planning service can be found at the CMS website (<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-10-30.html>).

### **LDCT Lung Cancer Screening**

**Q.** How does the CMS clarification statement on LDCT screening programs apply to “stand-alone” screening programs in which the shared decision making visit team is part of the Radiology practice?

**A.** Such programs should be allowed under the CMS clarification provided the results

of the services offered by the program are used in the management of the Medicare beneficiaries care. A shared-decision making visit followed by a proper communication of results and recommendations should meet the CMS criteria.

**Q.** CMS has issued a clarification statement to clarify which physicians can order screening and provide a shared decision making service, however the MLN Matters article is still in circulation. How should ATS members use this clarification statement from CMS to assure compliance officers that all physicians are able to participate in the lung cancer screening benefit?

**A.** While the clarification issued by CMS should provide ample assurance that all physicians can participate in the LDCT lung cancer screening benefit, we understand that until the MLN Matters article is retracted or corrected, many compliance offices will be reticent to move forward. The ATS has contacted CMS to request a retraction or correction of the MLN Matters article.