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Letter from the Editor

Happy New Year! The New Year will bring important changes to practitioners of pulmonary, critical care and sleep medicine, particularly in the Medicare program. Physicians who hope to avoid future cuts in Medicare reimbursement will have to start reporting on a mix of quality measures under CMS new quality measure program – the Merit-based Incentive Payment System or MIPS. This issue of ATS Coding and Billing Quarterly will walk you through the new policy and identify quality measures that are likely to be most relevant to ATS members.

This issue also outlines the significant change in how physician will report and be reimbursed for moderate or conscious sedation. While the change in CMS policy impact all providers, this edition discusses its impacts pulmonary providers. This issue also covers new ICD-10 diagnosis and procedure codes of interest to ATS members.

As always, if you have questions on correct coding billing or regulatory compliance matters, you can send us your question at codingquestions@thoracic.org.

Sincerely,

Alan L. Plummer, MD
Editor



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CMS MAKE MAJOR CHANGE IN HOW IT REIMBURSES MODERATE/ CONSCIOUS SEDATION

A major change in coding for bronchoscopy occurs on January 1, 2017, as moderate (conscious) sedation becomes separately identified from the work relative value units (wRVUs) for the bronchoscopy codes. While traditionally the bronchoscopist provided moderate sedation, in recent clinical practice other individuals often provide the sedation. The Centers for Medicare/Medicaid Services (CMS) mandated refinement of separate Current Procedural Terminology (CPT) codes to account for the work of moderate procedural sedation. In the final rule published in November 2016, CMS removed 0.25 wRVUs from many of the bronchoscopy codes to account for the work of moderate sedation. Therefore, to be reimbursed appropriately, one needs to include a moderate sedation CPT code for bronchoscopy procedure where this is done.”.

Use CPT codes **99151** and **99155** for patients younger than 5 years. For a patient 5 years or older, when the bronchoscopist provides moderate sedation, report CPT code **99152** for the initial 15 minutes and **99153** for subsequent time in 15 minute increments. For a patient 5 years or older, when a provider other than the bronchoscopist provides moderate sedation, use CPT code **99156** for the initial 15 minutes and **99157** for subsequent time in 15 minute increments. Utilize CPT codes **99156** and **99157** only when a second provider (other than the bronchoscopist) performs moderate sedation in the facility setting (e.g., hospital, outpatient hospital/ ambulatory surgery center, skilled nursing facility). When the second provider performs these services in the non-facility setting (e.g., physician office, freestanding imaging center), do not report codes **99155**, **99156**, or **99157**. Moderate sedation does not include minimal sedation (anxiolysis), deep sedation, or monitored anesthesia care (00100-01999), all typically provided by anesthesiologists.

Do not use a moderate sedation code (**99151-2** or **99155-6**) if providing less than 10 minutes of moderate sedation. As with other time-based codes, use the subsequent codes **99153** and **99157** when moderate sedation last 8 minutes or longer than the initial 15 minutes. The time for moderate sedation begins with the administration of the sedating agent, and concludes when the continuous face-to-face presence of the bronchoscopist ends, after completion of the procedure. Intermittent, re-evaluation of the patient afterward is post-service work, and not included in the time for moderate sedation. For example, if the bronchoscopist provides moderate sedation for 25 minutes in a 65 year old man, report **99152** (for the initial 15 minutes) and **99153** (for the subsequent 10 minutes). If an individual other than the bronchoscopist provides moderate sedation for 41 minutes in a 57 year old woman, use **99156** (for the initial 15 minutes) and two units of **99157** (for the subsequent 26 minutes) (see Table 1).

If a bronchoscopist provides moderate sedation and reports the appropriate CPT codes after January 1, 2017, the 0.25 wRVU change will have no financial impact compared to 2016. However, if a second provider performs the moderate sedation, expect approximately an \$8.72 drop (national average) in reimbursement per procedure.

Table 1.		Moderate sedation performed by	
		Bronchoscopist	Second provider
Total intra-service time	Patient Age	Codes	Codes
Less than 10 minutes	Any age	Not reported separately	
15-22 minutes	< 5 years	99151	99155
	>5 years	99152	99156
23-37 minutes	< 5 years	99151 + 99153	99155 + 99157
	>5 years	99152 + 99153	99156 + 99157
38-52 minutes	< 5 years	99151 + 99153 x2	99155 + 99157 x2
	>5 years	99152 + 99153 x2	99156 + 99157 x2

MIPS

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 repealed the Sustainable Growth Rate (SGR) legislation for the physician fee schedule. The SGR will be replaced with MACRA and implemented through the Quality Payment Program (QPP). The goal of the QPP is to reward high quality patient care through two pathways: Advanced Alternative Payment Program (Advanced APM's) and the Merit-based Incentive Payment System (MIPS). This article will review the framework of the MIPS and how eligible members of the ATS can operate within its structure.

MIPS will consolidate components of three existing programs: the Physician Quality Reporting System (PQRS), the Physician Value-based Payment Modifier (VM), and the Medicare Electronic Record Incentive Program for Eligible Professionals (Meaningful Use or “MU”). Through MIPS, certain eligible clinicians will have their Medicare payments adjusted based on quality, cost, use of technology in patient care, and practice innovation. There are certain exclusions to participating in the QPP; clinicians participating in Medicare for the first time in 2017 are not eligible for the MIPS track of the QPP, nor are physicians who see fewer than 100 Medicare patients or who have less than \$30,000 in billed charges to Medicare patients. The first performance period opens January 1, 2017 and closes December 31, 2017. During 2017, clinicians record quality data and how technology supported their practice. In order to earn a positive payment adjustment under MIPS, the deadline to report this data is March 31, 2018. Afterwards, Medicare

provides feedback about performance, and performance based payment adjustments are made in 2019.

For the first year, there are multiple data reporting options within MIPS. The first option is to report nothing in 2017, which will result in a negative 4% payment adjustment in 2019. The second option is to report the minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity for any point in 2017), and have a 0% payment adjustment. The third option is to report 90 days of data during 2017 to earn a neutral or positive payment adjustment. Data collection must begin between January 1 and October 2, 2017. The fourth option is to report a full year of collected data and the clinician may earn a positive payment adjustment.

There will be four categories of collected data: Quality (replaces PQRS), Clinical Practice Improvement Activities (CPIA-New Category), Advancing Care information (ACI-replaces Medicare EHR Incentive/ "Meaningful Use"), and Cost (replaces the Value Based Modifier). The cost category will be calculated in 2017, but will not be used to determine payment. In 2018, the cost category will be included with the other domains to determine payment adjustment. Clinicians can report data either as an "individual" or as a "group". An individual is a single National Provider Identifier tied to a single Taxpayer Identification Number. An individual can send data for each of the MIPS categories through an electronic health record (EHR), registry, or a qualified clinical data registry, while Quality data can be sent through the routine Medicare claims process. A "group" is a set of clinicians sharing a common Tax Identification Number. Group level data can be sent for each of the MIPS categories through the CMS web interface, an EHR registry, or a qualified clinical data registry. To submit data through the CMS web interface, clinicians must register as a group by June 30, 2017. If the EHR is certified by the Office of the National Coordinator for Health Information Technology, then it should be ready to capture information for the MIPS Advancing Care Information (MU) category and certain measures for the Quality category.

In 2017, the overall MIPS performance score will be 60% Quality, 25% Advancing Care Information, and 15% Improvement Activities. Most MIPS participants reporting as individuals need to report up to six quality measures, including an outcome measure, for a minimum of 90 days in 2017. Groups using the web interface report 15 quality measures for a full year. To fulfill the required minimum measures for Advancing Care Information (MU), the EHR needs to comply with the following: security risk analysis, e-Prescribing, Provide Patient Access, Send Summary of Care, Request/Accept Summary of Care. For bonus credit, the EHR can report Public Health and Clinical Data Registry Reporting Measures. The EHR can also complete certain

activities in the CPIA performance category for bonus credit. Meeting the Improvement Activities measure requires most participants to attest that four improvement activities have been completed for a minimum of 90 days. Groups with 15 or fewer participants, clinicians in rural areas, or clinicians in health professional shortage areas can meet the Improvement Activities requirement by attesting completion of two activities for at least 90 days. Participants in certified medical homes, alternative payment models (APM) designated as medical homes, and other specific APM participants (i.e. Track One Shared Savings Program or the Oncology Care Model) automatically earn full credit for the Improvement Activities category. The Cost category will be calculated from claims.

There are 271 Quality Measures. Clinicians should select up to six measures, including one outcome measure. 10 measures are applicable to Pulmonary, Critical Care, and Sleep Clinicians. They include: COPD-Long Acting Inhaled Bronchodilator Therapy, COPD-Spirometry Evaluation, Medication Management for People with Asthma, Optimal Asthma Control (outcome measure), Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections, Tobacco Use-screening and cessation intervention, Sleep Apnea-Assessment of Adherence to positive airway pressure therapy, Sleep Apnea-Assessment of Sleep Symptoms, Sleep Apnea-Positive Airway Pressure Therapy Prescribed, Sleep Apnea-Severity Assessment (AHI or RDI) at Initial Diagnosis. Optimal Asthma Control is the only outcome measure included in this list. The CMS website (<https://qpp.cms.gov/measures/quality>) contains an updated list of measures.

There are 92 Improvement Activities. Depending on work environment, most clinicians need to attest that four improvement activities have been completed. Some activities that are applicable to Pulmonary, Critical Care, and Sleep Clinicians include: care coordination agreements that promote improvements in patient tracking across settings; engagement of patients, family, and caregivers in developing a plan of care that is documented in the EHR; tobacco use-regular engagement in integrated prevention and treatment interventions that include screening and cessation for patient with behavioral or mental health conditions; use evidence based decision aid to support shared decision making (i.e. asthma action plan). Please see the list at qpp.cms.gov to see which Improvement Activities best suit your practice.

If a clinician does not enter an Advanced Alternative Payment Model, then one is likely entering the MIPS pathway. Between January 1 and October 2, 2017, begin collecting data for at least one quality measure and one improvement activity. This will avoid a 4% penalty in 2019. Data collection and quality reporting will be facilitated by working closely with an electronic health record vendor.

<https://qpp.cms.gov/>

ADVANCED ALTERNATIVE PAYMENT MODELS (APM)

APMs are models of care which provide incentive payments for high quality, cost-efficient value based care instead of the traditional fee for service (FFS) care. Advanced APMs are a subset of APMs which allow practices to earn a 5% incentive payment for participation. This incentive is determined by accepting some patient outcomes-related risk. Physicians and providers who participate in an APM and an Advanced APM are excluded from participating in the MIPS program. APMs may apply to a large population or to a specific medical condition or be episode based. To ensure that there is no negative payment adjustment in 2019, physicians have the option of choosing one of the MIPS options or joining an Advanced APM.

CMS has defined Alternative Payment Models in MACRA in several ways. These include the CMS Innovation Center Models, the Medicare Shared Savings Program, Medicare Health Care Quality Demonstration Program and other demonstration programs required by federal law. <https://innovation.cms.gov>

CMS currently describes an Advanced APM as an APM which meets all 3 of the following criteria

- Certified Electronic Health Record Technology (CEHRT) must be used
- Payment must be based on quality measures comparable to those in MIPS
- APM must bear the risk for monetary losses of more than a nominal amount or be a Medical Home Model expanded under section 1115A(c) of the Act.

CMS expects to expand the options for Advanced APMs and is exploring development of the Medicare Accountable Care Organization (ACO) Track 1 Plus (1+) as well as others in 2017-2018. The expanded options may translate to a greater participation in this pathway than first anticipated. The goal of CMS is to have at least 50% participation in APMs by 2018. It is expected that the participation in Advanced APMs will be 70,000-120,000 in 2017, and that this number may grow to 125,000-250,000 by the end of 2018. Presently there are no APMs or Advanced APMs that are specific to the Pulmonary or Sleep communities.

Eligible Clinicians (those who bill Medicare more than \$30,000 a year and provide care for more than 100 Medicare patients a year) who do not elect to submit data to MIPS may elect to join an Advanced APM. These clinicians can become Qualifying APM Participants (QP) and may earn a 5% incentive payment in 2019 for participation in an Advanced APM in 2017 if the following criteria are met. First 25% of the Medicare Part B payments must be through the Advanced APM or alternatively 20% of Medicare patients seen must be

through the Advanced APM. In addition, QP must report the required APM quality data back to the APM to receive the incentive payment. These percentages for Medicare payments and Medicare patients seen increase to 75% and 50% respectively by 2021. Clinicians must meet one of either criterion. In 2021, the threshold percentage may be met by non-Medicare payers as well.

CMS expects the following to be Advanced APMs for 2017. Follow the links to learn how to join the specific Advanced APM.

- [Comprehensive ESRD Care \(CEC\) - Two-Sided Risk](#)
- [Comprehensive Primary Care Plus \(CPC+\)](#)
- [Next Generation ACO Model](#)
- [Shared Savings Program - Track 2](#)
- [Shared Savings Program - Track 3](#)
- [Oncology Care Model \(OCM\) - Two-Sided Risk](#)

Other APMs are also being developed and the final list will be updated no later than January 1, 2017. The website will be updated as new options become available, as well as on an annual basis. <https://qpp.cms.gov>

To be considered eligible as part of an APM entity, an eligible clinician must be on an APM Participation List on at least one of the following snapshot dates, March 31, June 30 or August 31 of the Performance Period year. Alternatively, the eligible clinician must report under the standard MIPS methods as outlined in the MIPS section. The QP Performance Period for each payment year will be from January 1 – August 31st of the calendar year that is two years prior to the payment year.

QPs also benefit from participation in an Advanced APM by receiving higher physician fee schedule updates beginning in 2026. If QPs do not meet the payment or patient thresholds in the Performance Period, they may become a “Partial” Qualifying APM Participant and may still elect to participate in MIPS.

Summary and Looking Ahead

Alternative Payment Models are one of two possible tracks of the new Quality Payment Program. A 5% incentive payment may be earned in 2019 when participating in an Advanced APM in 2017. Review the APM options as well as the details of the MIPS track at <https://qpp.cms.gov> to decide which option is best for your individual practice and or group. CMS continues to elicit feedback and comments as well as provide the CMS Innovation Center for the development of new models.

ICD-10-CM UPDATE FOR 2017

On October 1, 2015, the world of coding changed abruptly to ICD-10-CM from ICD-9-CM. Fortunately, the physicians and the US medical world had a 2 year period during which to prepare for the coding change. Apparently,

this allowed the medical profession and coders to become familiar with the new system which increased the number of codes from around 13,000 codes in ICD-9-CM to over 68,000 new codes in ICD-10-CM! The number of reported problems to CMS concerning the use of ICD-10-CM have been virtually nil. That is good news!

Entering 2017, the new system has been in effect for 15 months. The “grace period” for using the new system lasted until October 1, 2016 and now CMS expects physicians to code at the highest level possible when using the ICD-10-CM codes in patient care. If this is not done, expect billing denials to increase.

One of the areas which will be emphasized in pulmonary, critical care and sleep patients is to include coding about current or past smoking in the billing. It will be important to code whether the patient is a current or past smoker. Coding for those patients who are current smokers can be quite complex, many codes requiring 6 characters (see Table 1). They include codes for cigarette smoking (**F17.210-F17.219**), chewing tobacco (**F17.220-F17.229**) or for the use of other tobacco products (**F17.290-F17.299**). They should be used in lieu of using **Z72.0**, tobacco use NOS (not otherwise specified) which is a non-specific code and may lead to a billing denial. For example, if the patient is a current tobacco smoker, a code from **F17.210-F17.209** should be used. If the patient smoked cigars or a pipe regularly, then one should use a code from **F17.290-F17.299**.

If the patient has a past history of smoking, then code **Z87.891** (History of tobacco dependence) should be used. Note that tobacco use has been changed to tobacco dependence in this code. Remember to use the smoking and past history of smoking codes when referring a patient for lung cancer screening using low dose CT (LDCT) or when billing for a patient with a J-code diagnosis.

If the patient has had an occupational exposure to environmental tobacco smoke, then use code **Z57.31**. If the patient has had exposure to passive smoke at home, whether acute or chronic, use **Z77.22**. For example, if a non-smoking patient has lived with a spouse who smoked in the home or lived in a household in which smoking occurred, then you should code **Z77.22**.

There have been only a few changes to the pulmonary, critical care and sleep ICD-10-CM codes in 2017. Overall there were over 2,000 changes to ICD-10-CM for 2017! We were spared this year! The ICD Coordination and Maintenance Committee which decides on coding changes to ICD-10-CM meets in March and September of each year to decide on new codes and changes in the old codes which will go into effect October 1 of the current year. This process was suspended in past years until ICD-10-CM went into effect October 1, 2015.

There have been minor wording changes to codes **J95.83**, **J95.830**, **J95.831** which now deal with postprocedural

Table 1: Current Smoker Codes	
F17 Nicotine dependence	
F17.2 Nicotine dependence	
F17.20 Nicotine dependence, unspecified	
F17.200	..... uncomplicated
F17.201	..... in remission
F17.203 Nicotine dependence unspecified, with withdrawal	
F17.208	..... with other nicotine-induced disorders
F17.209	..... with unspecified nicotine-induced disorders
F17.21 Nicotine dependence, cigarettes	
F17.210	..... uncomplicated
F17.211	..... in remission
F17.213	..... with withdrawal
F17.218	..... with other nicotine-induced disorders
F17.219	..... with unspecified nicotine-induced disorders
F17.22 Nicotine dependence, chewing tobacco	
F17.220	..... uncomplicated
F17.221	..... in remission
F17.223	..... with withdrawal
F17.228	..... with other nicotine-induced disorders
F17.229	..... with unspecified nicotine-induced disorders
F17.29 Nicotine dependence, other tobacco product	
F17.290	..... uncomplicated
F17.291	..... in remission
F17.293	..... with withdrawal
F17.298	..... with other nicotine-induced disorders
F17.299	..... with unspecified nicotine-induced disorders

hemorrhage only. Postprocedural hematomas and seromas have been split out from these codes to become new codes **J95.86**, **J95.860** and **J95.861** for postprocedural hematomas and **J95.862** and **J95.863** for postprocedural seromas.

The diseases of the mediastinum have had a few coding changes. There is a new code, **J98.51** for mediastinitis (code first underlying condition, if applicable, such as postoperative

mediastinitis [T81.-]). Fibrosis, hernia and retraction of mediastinum have been moved from underneath **J98.5** (Diseases of the mediastinum, not elsewhere classified) to underneath a new code, **J98.59** (Other diseases of mediastinum, not elsewhere classified).

References: www.cms.gov/Medicare/Coding/ICD10/2017-ICD-10-and-GEMs.html
www.cdc.gov/nchs/icd/icd10cm.htm
www.ICD10Data.com

CMS AND PULMONARY REHABILITATION

In November, CMS issued the final rule for the Hospital Outpatient Prospective Payment System. As many people in the pulmonary rehabilitation community already know, the final rule includes significant (and unexpected) cuts in reimbursement for respiratory therapy/pulmonary rehabilitation codes. Below is a chart that shows current payment, payment levels listed in the proposed HOPPS rule and what came out in the final rule.

What Happened?

CMS changed the status indicator for the code from “Q1” status to “S” status. Q status means it is a bundled service including all services/supplies related to providing the service and would only be paid, if no other major service is provided on that day. “S” status means it is an unbundled service that can be billed and is separately payable regardless if other major services are on that claim. To clarify, when it was Q1 status the payment for pulmonary rehab, supplemental oxygen, six minute walk test, labs, etc were all part of one payment. With S status, it will always be separately paid, as would any other status S code like smoking cessation, and is not automatically packaged if another major service(s) is on that claim.

G-Code	Short Descriptor	2016 Final Payment	2017 Proposed Payment	2017 Final Payment
G0237	Therapeutic procd strg endur	\$91.18	\$265.56	\$28.37
G0238	Oth resp proc, indiv	\$55.94	\$161.29	\$28.37
G0239	Oth resp proc, indiv	\$30.51	\$95.66	\$28.37
G0424	Pulmonary rehab w exer	\$55.94	\$161.29	\$54.53

Why did this happen?

During the public comment process, CMS received a comment from the Provider Round Table – an organization representing 14 health systems with hospital facilities in 35 states - saying that Medicare law required pulmonary rehab to be separately paid, therefore S status indicator. For reasons we do not fully understand, CMS found the comments compelling and switched the indicator status based on the Provider Roundtable comments.

How bad is this?

The ATS hired a consultant to run some Medicare reimbursement scenarios for the ATS under different rules for pulmonary rehabilitation. For the purposes of this analysis, pulmonary rehabilitation includes codes **G0424** and **G0237**, **G0238** and **G0239** reimbursements. Not surprisingly, compared to the 2017 proposed rule reimbursement rates, the final rule represents about a projected -33% or \$21.5 million cut in total CMS reimbursement for pulmonary rehabilitation. Even when factoring in the S status indicator ensuring payment for each time the code is submitted (compared to being paid only once per claim using the “Q1” status indicator), total payments came out lower comparing the CMS proposed rule reimbursements to the CMS final rule reimbursements.

However, comparing the final rule reimbursements for pulmonary rehabilitation to 2015 Medicare actual reimbursements (the most recent year we have data for) for pulmonary rehabilitation payments, to projected 2017 pulmonary rehabilitation payments under the final rule, we are expecting to see \$11.0 million increase in total Medicare reimbursements versus 2015. So total reimbursements are projected to continue increase. Please note, there will be significant program variation, based on the mix of submitted codes (**G0424**, **G0237**, **G0238** and **G0239**) and on whether programs submit claims for each encounter or a single claim for multiple encounters.

What is Next?

The ATS and several sister organizations recently met with CMS staff to discuss our concerns on reimbursement and policy volatility created by CMS rapidly evolving pulmonary rehabilitation policies. While no concrete results came from that meeting, CMS seemed open to a number of policy suggestions offered by the ATS and our sister societies that will address reimbursements and program volatility. The ATS will continue to push CMS to adopt more rational policy on Medicare coverage and reimbursement for pulmonary rehabilitation.

Q&A

Moderate Sedation and ECGs

Q. Other than bronchoscopy, are there any common pulmonary procedures that have included moderate sedation in the past for which I must now bill separately? Similarly, in what other situations can I bill for moderate sedation?

A. Allowing for the same time and supervision of moderate sedation rules discussed already, yes there are. Codes that were in the AMA CPT manual in appendix G (“G codes”), are now indicated with a triangle next to the code.

Examples include:

32405 Biopsy, lung or mediastinum, percutaneous needle

32550 Insertion of indwelling tunneled pleural catheter with cuff

32551 Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure)

32553 Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple

If moderate sedation is used in the performance of other procedures not previously listed in Appendix G, CPT codes **99151-99157** may be used according to the specified rules.

Examples include:

32556 chest tube (catheter) over a wire without image guidance

32557 chest tube (catheter) over wire with image guidance.

Note: Administration of pain medications alone for a procedure is not separately billable

Q. I see that a separate provider can bill for moderate sedation. What if that separate provider is my colleague and bills under the same tax id? Can I bill for her work and how would this be structured?

A. If the second provider is of the same group, the moderate sedation should be charged on a bill prepared by the bronchoscopist (one bill per practice).

Q. Who qualifies as a second provider for moderate sedation? Must the second provider be another bronchoscopist?

A. Specifically for moderate sedation, the second provider may be an anesthesiologist, CRNA, pulmonologist, another qualified physician, APN or PA and, if in another practice, submits his or her bill separately.