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Coding & Billing Quarterly

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CODING UPDATES

Remote Critical Care Services

The January 2008 *CPT Assistant* reports the new tracking codes for Remote Critical Care Services, 0188T and 0189T. These codes were accepted by the CPT Editorial Panel in October 2007 and were released on January 1, 2008. They will be implemented on July 1, 2008, and published in *CPT 2009*.

CPT Code	Descriptor
0188T	Remote real-time interactive video-conferenced critical care, evaluation and management of the critically ill or critically injured patient, first 30-74 minutes
0189T	each additional 30 minutes (List separately, in addition to code for primary service)

Please note that CPT 0188T can be used only once per date, even if the time spent by the physician is not continuous. Remote critical care services of less than 30 minutes on a given date should not be reported. The physician must devote full attention to the patient during service. Like all CPT time-based codes, it is important to document in the patient's record time spent.

Physician Staff Office Time Add-on ZZZ Code

The January 2008 *CPT Assistant* also reports a new CMS temporary add-on code (G0332) for additional work for administration of immunoglobulin by physician office staff, which pays about \$75.

CPT Code	Descriptor
G0332	Services for intravenous infusion of immunoglobulin prior to administration (this service is to be billed in conjunction with administration of immunoglobulin)

Notes from the Editor

Welcome to the second issue of the *ATS Coding & Billing Quarterly*. As the publication has already generated a number of questions from readers on appropriate coding, we have launched a new question and answer section in this issue—so please keep the questions coming.

This issue also includes brief descriptions of the CPT/RUC process for developing codes and relative value units. The ATS is actively involved in the code development and valuation process, so if you have ideas on new or revised codes, please contact us so we can help bring them to fruition. The Society cannot be an effective advocate without the help of its members, so your active participation in AMA RUC surveys is vital.

The CMS's revised coverage policy for CPAP for obstructive sleep apnea (OSA) is also described in this issue. While we are still awaiting important policy implementation details that will likely be developed by durable medical equipment Medicare administrative contractors (DME MACs), the CMS's revised policy will have significant impacts on the access to CPAP treatment for OSA patients.

Sincerely,

Alan L. Plummer, MD

Chair, ATS Clinical Practice Committee



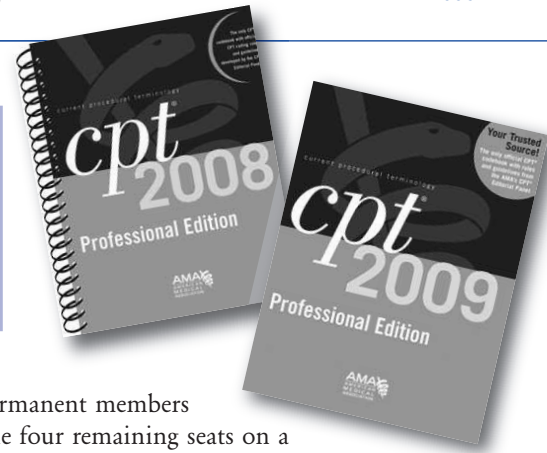
SCHEDULE A CODING & BILLING CONSULT AT ATS•2008

If you have a question related to coding, billing or regulatory compliance, ask the ATS! Diane Krier-Morrow, M.B.A., M.P.H., CCS-P, the Society's coding and billing consultant, will be onsite at the 2008 ATS International Conference in Toronto to answer members' questions on Sunday, May 18 and Monday, May 19 in the Center for Clinicians & Fellows. The ATS encourages members who will be attending the conference to schedule a free one-on-one consult by sending an e-mail to dkriermorr@aol.com.

Ms. Krier-Morrow is a nationally recognized expert in medical procedure coding and reimbursement. She has extensive experience with the American Medical Association's Current Procedural Terminology (CPT) for procedural codes and the AMA's RVS Update Committee (RUC), including practice expenses for Medicare reimbursement.



CPT 101



Current Procedural Terminology is the annually updated glossary of CPT codes. This listing of descriptive terms and associated codes was first developed by the American Medical Association in 1966 with the purpose of standardizing the vernacular used to document procedures in patients' medical records and in communications with insurance companies. Today, CPT provides a uniform language that describes diagnostic and therapeutic procedures. It is used by both federal (Medicare and Medicaid) and private payors to communicate work done by healthcare professionals.

There are three categories of CPT codes. Category I codes identify a service with a five digit code, inferring that the procedure is consistent with contemporary medical practice, is performed by a large number of physicians in multiple locations, has demonstrated efficacy and is supported by peer-reviewed U.S. research. Category II codes, designed to decrease the need for chart review and data abstraction, are used for performance measurement. Although they are not required for correct coding, some are part of the CMS's Physician Quality Reporting Initiative (PQRI).

Category III codes are designed to aid data collection and to track the use of new and emerging technologies. In general, they do not meet the standards of a Category I code: they can be carrier-priced, but do not have a published relative value unit, as they are not referred to the RVS Update Committee.

Each year, the 17-member, AMA-sponsored CPT Editorial Panel edits and updates the current volume of *Current Procedural Terminology*. Members serve four-year terms. There are 11 physicians, who represent various medical specialties, two insurance companies, one hospital and one CMS representative. Seven physician seats are held permanently by specialty societies. Specialties

not represented by permanent members are eligible to hold the four remaining seats on a rotating basis. The panel meets in February, June and October.

Supporting the editorial panel is the CPT Advisory Committee, which includes both physicians nominated by national medical specialty organizations and representatives from other allied health professional societies. The committee advises the editorial panel on proposed code revisions and updates. Stephen Hoffmann, M.D., the ATS's CPT advisor, works closely with Steve Peters, M.D., who represents the American College of Chest Physicians.

The process of creating a new code usually begins when a specialty society, industry source, individual physician or CPT staff member makes a suggestion or reports a coverage issue or problem. Suggestions are submitted via CPT change proposal forms, which are then reviewed by AMA staff and distributed to AMA CPT advisors for comment.

If the proposed change receives support, it is first reviewed by two members of the Editorial Panel and then is discussed and voted upon at the panel's next meeting. Members of the panel can vote to add or revise the codes proposed, postpone further discussion until additional information is gathered or reject it outright. A code must be approved at the panel's February meeting to be ready for use the subsequent year.

If you have ideas for new codes or revisions of current codes, please e-mail Diane Krier-Morrow, the ATS's coding and billing consultant, at dkriermorr@aol.com. She will submit your suggestions to the ATS Clinical Practice Committee for review. The Clinical Practice Committee collaborates with the ACCP's Practice Management Committee on coding and reimbursement issues. ■



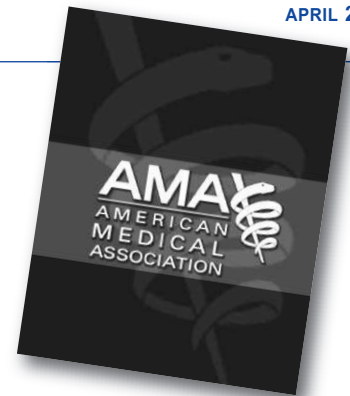
Q. Is there a new code for ventilation assistance and management? I have been using 94656 and 94657 for subsequent days.

A. If you reported 94656 or 94657 since January 1, 2007, you should have been denied payment. These codes were deleted in *CPT 2007*. Please review your accounts receivable. Check with insurers on how far back you can resubmit claims processed in error.

New codes for ventilator management, effective January 1, 2007, are:

CPT Code	Descriptor
94002	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day
94003	hospital inpatient/observation, each subsequent day
94004	nursing facility, per day
94005	Home ventilator management (within a calendar month, 30 minutes or more)

RUC 101



The ATS and other national medical societies have supported the AMA/Specialty Society Relative Value Scale (RVS) Update Committee (RUC) since it first met to review codes in May 1992. Alan Plummer, M.D., has served as the ATS's advisor to the RUC since its inception, while Scott Manaker, M.D., represents the ACCP. Burt Lesnick, M.D., was recently appointed as the ACCP's alternate RUC advisor.

The RUC comprises 29 members, including 20 specialties with permanent seats, two rotating seats for internal medicine specialties and one rotating seat for non-internal medicine specialties. The following specialties hold permanent seats:

- | | |
|-----------------------|---------------------|
| Anesthesia | Ophthalmology |
| Cardiology | Orthopaedic Surgery |
| Dermatology | Otolaryngology |
| Emergency Medicine | Pathology |
| Family Medicine | Pediatrics |
| General Surgery | Plastic Surgery |
| Internal Medicine | Psychiatry |
| Neurology | Radiology |
| Neurosurgery | Thoracic Surgery |
| Obstetrics/Gynecology | Urology |

The pulmonary community is eligible to hold one of the two rotating internal medicine seats currently filled by gastroenterology and geriatric medicine, that are up for election every two years. Many specialty societies have expressed concern that the specialties represented by permanent AMA RUC members do not accurately reflect the mix of physicians serving Medicare beneficiaries. More than once, the RUC has rejected the pulmonary community's efforts to secure a permanent seat. It also recently rejected a proposal to add a fourth rotating seat.

Since 1992, Medicare has reimbursed physician services on a resource-based relative value scale (RBRVS). There are three components to resource costs: physician work, practice expense and professional liability (malpractice) insurance. The physician work component accounts for about 52 percent of the total relative value for each service provided. Physician work is proxy for the time, technical skill, effort, stress and risk involved in a physician service. Data on physician work is collected by specialty societies through surveys. It follows that broad and accurate participation in these surveys is essential to establish fair physician work values for CPT codes.

Practice expense accounts for 44 percent of total relative value for physician services. In 2002, the RUC completed a four-year project aimed at converting practice expenses to resource-based values. Practice expenses include three components: clinical labor, medical supplies and medical equipment.

The professional liability insurance (PLI) component is about 4 percent of the total value for each service. In 2000, the CMS implemented resource-based PLI relative value units. Thus, all components of each RUC-evaluated code are now resource-based.

By law, Medicare is required to review the overall relativity of its physician fee schedule every five years. During this review, codes that are either over-valued or under-valued are evaluated for potential revision.

The ATS, working closely with the ACCP, has played an active role in helping establish fair relative values for CPT codes used by pulmonary, critical care and sleep physicians. In Medicare's last Five-Year review finalized in 2007, the Society worked to secure significant work value increases across evaluation and management codes, including increases to critical care codes 99291 and 99292. ■

THE PROCEDURE

A physician performs a thoracentesis using a thoracentesis kit, which has a catheter on top of a needle, well-behind the needle tip. This is inserted over a rib. Once pleural space is entered, the catheter is advanced into the pleural space and then the needle is withdrawn. The pleural fluid is then withdrawn by using a stopcock and tubing leading to a collection bag or by using a vacuum bottle. Once all fluid is removed, the catheter is withdrawn. The pleural fluid is sent for culture, cell count, chemistries and cytology or other studies as dictated by the clinical condition of the patient.

Q. What code would you use? What is the difference between codes 32421 and 32422 if you don't use a water seal?

A. You report 32422 in this example, regardless of whether or not a water seal is used. The only time a water seal would be used is if the patient had a pneumothorax and the catheter inserted into the pleural space was connected to a tube leading to a water seal (to prevent air returning to the pleural space). Code 32421 is used when a needle only is used to access the pleural space to drain the fluid.

Q. Regarding the chemical pleurodesis code (32560)—does the code differ when you instill a fibrinolytic agent to treat an empyema? Is it 32560 or something else?

A. Instillation of a fibrinolytic agent is called fibrinolysis. There is no code for pleurolysis, so you would have to use 32999, the unlisted code for the lungs and pleura, to code for the procedure. You would also need to submit a detailed description of the procedure with the bill.

CMS Issues Final Policy on CPAP Devices



In March, the Centers for Medicare and Medicaid Services (CMS) issued the final Notice of Coverage Determination for continuous positive airway pressure (CPAP) devices for the treatment of obstructive sleep apnea (OSA).

The final CMS policy closely followed the proposed notice of coverage determination issued earlier this year, which proposed two major changes in CMS coverage for CPAP. The first major component of the decision was to cover CPAP for an initial 12 week period. Coverage beyond 12 weeks is “covered for those beneficiaries diagnosed with OSA whose OSA improved as a result of CPAP during this 12 week period.”

The second major component of the CMS policy is to broaden diagnosis of OSA to include unattended monitoring devices. Previously, CMS policy had limited OSA diagnosis to facility-based polysomnography tests.

While it will take some time for local durable medical equipment Medicare administrative contractors (DME MACs) to implement, the final policy will likely have significant impacts on patient access to CPAP therapy for OSA. What constitutes “improved” is not explained in the decision memo and will likely be further fleshed out in local coverage policies developed by DME MACs. The ATS will work with the CMS and DME MACs to help establish reasonable standards to evaluate improvements in OSA.

Decision Summary

Coverage of CPAP is initially limited to a 12 week period for beneficiaries diagnosed with OSA as subsequently described. CPAP is subsequently covered for those beneficiaries diagnosed with OSA whose OSA improved as a result of CPAP during this 12 week period.

CPAP for adults is covered when diagnosed using a clinical evaluation and a positive:

1. polysomnography (PSG) performed in a sleep laboratory; or
2. unattended home sleep monitoring device of Type II; or
3. unattended home sleep monitoring device of Type III; or
4. unattended home sleep monitoring device of Type IV, measuring at least three channels.

CMS policy requires that, in general, diagnostic tests that are not ordered by the beneficiary’s treating physician are not considered reasonable and necessary. Diagnostic tests payable under the physician fee schedule that are furnished without the required level of supervision by a physician are not reasonable and necessary.

A positive test for OSA is established if either of the following criterion using the Apnea-Hypopnea Index (AHI) or Respiratory Distress Index (RDI) are met:

- 1) AHI or RDI greater than or equal to 15 events per hour; or
- 2) AHI or RDI greater than or equal to 5 and less than or equal to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease or history of stroke.

The AHI is equal to the average number of episodes of apnea and hypopnea per hour. The RDI is equal to the average number of respiratory disturbances per hour.

If the AHI or RDI is calculated based on less than two hours of continuous recorded sleep, the total number of recorded events to calculate the AHI or RDI during sleep testing is at least the number of events that would have been required in a two hour period.

CMS is deleting the distinct requirements that an individual have moderate to severe OSA and that surgery is a likely alternative.

CPAP based on clinical diagnosis alone or using a diagnostic procedure other than PSG or Type II, Type III, or a Type IV measuring at least three channels is covered only when provided in the context of an approved clinical study when that study meets CMS criteria. ■



PUT YOUR CLINICAL SKILLS TO THE TEST

Each month, ATS members challenge their colleagues with a difficult clinical case they, themselves, had to solve.

Each case study, whether in pulmonary, critical care, or sleep medicine, poses a series of questions.

You'll find the answers there, too, along with important references so that you will have the latest and best information to help your patients.



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