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PULMONARY • CRITICAL CARE • SLEEP

Coding & Billing Quarterly

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Q&A

CONSULTATIONS

Q. An interventional pulmonologist in our practice uses the same Medicare group number, the same tax identification number (TIN) and the same specialty code number as all of our physicians. After I have seen a patient in the hospital or office, I order a formal consultation from my interventional pulmonary colleague. As long as he documents a consultation, he can bill the consultation codes. Can he report a consultation code on the same day that I report a follow-up visit for a hospitalized patient if it was performed for a different diagnostic reason (i.e., I would report a different ICD-9-CM diagnosis code than he would)?

A. NO. When the interventional pulmonologist sees the same patient, on the same day, at the same site of service as a pulmonary colleague in the same practice, he cannot report a consultation. However, if he saw the individual as an outpatient, after discharge from the index hospitalization, and on a different calendar day, the answer is **YES**: he can report a consultation.

CRITICAL CARE

Q. The hospitalist will frequently see a patient in the ER, evaluate and bill critical care time, then send the patient to the ICU. Our coders are billing the critical care time for the hospitalist and our ICU time is then thrown out. The reason given is that we are duplicating services and the first to bill is the first and only to be paid. Are our coders correct? How do we get paid for the work we are doing? We are not only losing the revenue, but also our RVUs.

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Notes from the Editor

Welcome to the December 2008 issue of the *ATS Coding & Billing Quarterly*. The Centers for Medicare and Medicaid Services (CMS) has now published the final rule for the Physician Fee Schedule for 2009. Because of all the coding changes in this issue, the ATS will share with its members via e-mail how the regulations will impact pulmonary, critical care and sleep practices.



In this issue of the newsletter, ATS member Burt Lesnick, MD, provides a summary and vignette on how to use the new pediatric critical care codes. CPT 2009 revises the codes for newborn care, neonatal and pediatric critical care, and provides additional codes for patients from the ages of 2 to 5. This issue also covers the re-numbered codes for drug infusion and injection, the new actigraphy code **95803**, the revised prolonged service codes, **99354-99359**, and the deleted modifier 21, because of these revisions.

95803 Actigraphy testing, recording, analysis, interpretation, and report
(minimum of 72 hours to 14 consecutive days of recording)
(Do not report **95803** more than once in any 14 day period)
(Do not report **95803** in conjunction with **95806-95811**)

As the *ATS Coding & Billing Quarterly* contains important information on supporting payment for inappropriately denied claims and partial payments, I recommend that you share all issues of this newsletter with your coding/billing staff and keep copies on file with your practice compliance plan. For easy reference, this issue includes an index of what the publication has covered this year. Back issues are archived on the ATS Web site at www.thoracic.org/go/ats-coding-and-billing.

If you are interested in getting more information, please also consider attending the postgraduate course "Billing, Coding and Pay for Performance" during ATS 2009 in San Diego. The course, which will take place on Saturday, May 16 from 8:00 a.m. to 4:00 p.m., will offer clinicians an interactive format to discuss the latest information related to coding, billing and regulatory compliance for clinicians who specialize in pulmonary, critical care and sleep medicine. Fellows and those at the beginning of their careers are especially encouraged to attend.

As always, we encourage our readers to submit questions to CodingQuestions@thoracic.org. All questions will receive a response, and will help craft Q&As for future editions of the *ATS Coding & Billing Quarterly*.

Sincerely,

Alan F. Plummer, MD
Editor

Neonatal and Pediatric Critical Care Codes Expanded

Beginning January 1, 2009, neonatal and pediatric critical care codes must be submitted under new CPT codes. The old CPT codes, **99293-99296**, will be renumbered **99468-99472** in 2009 (*please see table*). There are also new bundled critical care codes for children:

99475 Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age

99476 Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age

These new codes follow the similar codes for critical care services for younger children and infants. A single physician/provider can report these codes only once per patient, per day. These are bundled codes that include management, monitoring and treatment of the patient, including respiratory, pharmacologic control of circulatory system, enteral and parenteral nutrition, metabolic/hematologic maintenance, parental/family counseling, case management services, and direct personal supervision of the healthcare team in the performance of cognitive and procedural activities.

Pediatric patients 6 years of age and older should be reported with the adult critical care codes **99291, 99292**. Additional critical care services not noted above provided by another specialty or in an outpatient environment, such as an emergency department, can be billed with the adult critical care code **99291** and the subsequent code **99292**.

Example:

A 5-year-old girl is in a motor vehicle accident, suffering blunt trauma to the left side resulting in splenic laceration, rib fractures, flail chest on the left and acute respiratory failure. The pediatric critical care physician reports **99475** for initial inpatient critical care. The child, on day 2 of her hospital stay, develops infiltrates in the left chest and left pleural effusion on chest radiograph. A pediatric pulmonologist is consulted to assist in management of possible pulmonary contusion. The pediatric pulmonologist documents spending 60 minutes at bedside, making suggestions on ventilator strategies to the intensivist and discussing the issues with the family. The pediatric pulmonologist would report **99291** (4.5 RVW) for his or her efforts that day. An alternative would have been to use codes **99251-99255** (4.0 RVW for **99255**) to report inpatient hospital consultation.

The following list includes only the deleted CPT 2008 codes, crosswalked to the new numbers for 2009. This list does not include the new codes **99475, 99476** (noted above) and:

99477 Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or less, who requires intensive observation, frequent interventions, and other intensive care service (note **99477** descriptor revised for 2009).

Deleted CPT 2008 Code	CPT 2009 Code	CPT 2009 Code Descriptor
99289	99466	Critical care services delivered by a physician, face-to-face, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months of age or less; first 30-74 minutes of hands-on care during transport
99290	99467	Critical care services delivered by a physician, face-to-face, during an interfacility transport of critically ill or critically injured pediatric patient, 24 months of age or less; each additional 30 minutes
99293	99471	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age
99294	99472	Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age
99295	99468	Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less
99296	99469	Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less
99298	99478	Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams)
99299	99479	Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 grams)
99300	99480	Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams)

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Deleted and Renumbered

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Deleted CPT 2008 Code	CPT 2009 Code	CPT 2009 Code Descriptor
99431	99460	Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant
99432	99461	Initial care, per day, for evaluation and management of normal newborn infant seen in other than hospital or birthing center
99433	99462	Subsequent hospital care, per day, for the evaluation and management of a normal newborn
99435	99463	Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant admitted and discharged on the same day
99436	99464	Attendance at delivery (when requested by the delivering physician) and initial stabilization of newborn
99440	99465	Delivery/birthing room resuscitation, provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output

Renumbered SCIG Codes for CPT 2009

Deleted CPT 2008 Code	CPT 2009 Code	CPT 2009 Code Descriptor
90769	96369	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); initial, up to one hour, including pump set-up and establishment of subcutaneous infusion site(s) (For infusions of 15 minutes or less, use 96372)
90770	96370	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure) (Use 96370 in conjunction with 90769) (Use 96370 for infusion intervals of greater than 30 minutes beyond one hour increments)
90771	96371	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure) (Use 96371 in conjunction with 96369) (Use 96369 and 96371 only once per encounter)

Renumbered Injection Codes for CPT 2009

Deleted CPT 2008 Code	CPT 2009 Code	CPT 2009 Code Descriptor
90772	96372	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
90773	96373	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial
90774	96374	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug



Renumbered Drug Infusion Codes for CPT 2009

The January 2008 issue of the *ATS Coding & Billing Quarterly* listed three new subcutaneous infusion codes. As part of the renumbering of the Drug Infusion and Injection codes, the subcutaneous infusion of immune globulin (SCIG) for therapy or prophylaxis codes have been renumbered from **90769-90771** to **96369-96371** for 2009. Descriptors remain the same as they were in 2008.

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Deleted CPT 2008 Code	CPT 2009 Code	CPT 2009 Code Descriptor
90775	96375	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)
90776	96376	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure)
90779	96379	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion

Renumbered Intravenous Infusion Codes for CPT 2009

Deleted CPT 2008 Code	CPT 2009 Code	CPT 2009 Code Descriptor
90760	96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour
90761	96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)
90765	96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
90766	96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
90767	96367	Intravenous infusion, for therapy, prophylaxis or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure)

Q & A (Continued from page 1)

A. Your coders are **NOT** correct. Be sure to share the recent version of MedLearn Matters #5993 with the coding staff (www.cms.hhs.gov/MLN MattersArticles/downloads/MM5993.pdf). In your scenario, the hospitalist in the ER could document and report 35 minutes of critical care time from 4:00 p.m. to 4:35 p.m., and the intensivist could document and report two hours of critical care time from 8:00 p.m. to 10:00 p.m. Just make sure that they have different primary diagnoses—for example, sepsis or hypotension or acidosis for the hospitalist, and respiratory or renal or hepatic failure for the intensivist.

HIRING PHYSICIAN ASSISTANTS

Q. Our practice is considering hiring a physician assistant (PA) and we want to know if the Medicare Physician Fee Schedule will reimburse 85 percent for PAs, as it does for nurse practitioners? Can you help?

A. The American Association of Physician Assistant's Web site contains your answer. As of January 1, 1998, Medicare pays PAs' employers for medical services provided by PAs at 85 percent of the physician fee schedule. This rate applies to PAs practicing in all care settings. All visits should be billed at the full physician rate; the PAs' NPI number will signal the Medicare contractor to implement the 15 percent discount. Two notable exceptions to the physician assistant 85 percent reimbursement rate are "incident to" and shared visit billing, available for services meeting strict Medicare criteria. Visit www.aapa.org/gandp/3rdparty.html#PAcoverage for complete details and notable exceptions.

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