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# Coding & Billing Quarterly

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## Participate in the Third Annual Medicare Contractor Provider Satisfaction Survey

The Centers for Medicare & Medicaid Services (CMS) has begun its third annual Medicare Contractor Provider Satisfaction Survey (MCPSS) to a new sample of Medicare providers. The survey is designed to garner quantifiable data on provider satisfaction levels with key services performed by the Medicare fee-for-service contractors.

MCPSS offers providers an opportunity to contribute directly to the CMS' understanding of contractor performance, as well as aid future process improvement efforts at the contractor level. Specifically, the CMS will use the survey as an additional measure to evaluate contractor performance. In fact, all Medicare Administrative Contractors (MACs) will be required to achieve performance targets on the MCPSS as part of their contract requirements by 2009.

The CMS will contact approximately 35,000 randomly selected providers, including physicians and other healthcare practitioners, suppliers and institutions that serve Medicare beneficiaries across the country. If you are selected to participate in the survey, you will be notified by January 2008.

The CMS urges all Medicare providers who are selected to complete and return their surveys upon receipt. The CMS plans to make the survey results available in July 2008. The survey is designed so that it can be completed in about 15 minutes and providers can submit their responses via a secure Web site, mail, fax, or over the telephone. The full survey results and further information about the MCPSS will be available at [www.cms.hhs.gov/MCPSS](http://www.cms.hhs.gov/MCPSS).

## ATS Launches Coding, Billing and Regulatory Compliance Newsletter

Dear ATS Colleague:

On behalf of the American Thoracic Society, I want to introduce the inaugural edition of the *ATS Coding & Billing Quarterly*, a newly launched communication that will summarize key information on coding, billing, documentation and regulation policy changes that are relevant to clinicians in respiratory, critical care and sleep medicine. The quarterly newsletter will cover issues such as new CPT and ICD-9-CM codes, changing CPT and ICD-9-CM nomenclature and numbering, regulatory policies, and Medicare coverage of pulmonary patients. Much of the information published will be important not only to providers, but also to office staff responsible for coding, documentation and billing.

The first issue focuses on new and renumbered CPT codes and modifier descriptor changes for 2008, as well as the growing Medicare Physician Quality Reporting Initiative (PQRI). Please feel free to submit suggestions for future issues and share any billing and coding questions that you may have.

I hope the *ATS Coding & Billing Quarterly* will serve as a helpful tool in your practice. Please keep this newsletter on file for future reference and share with your staff responsible for coding, documentation and billing.

Sincerely,

Alan L. Plummer, MD  
Chair, ATS Clinical Practice Committee

### ATS: A SOURCE FOR CODING AND BILLING INFORMATION

If you have a question related to coding, billing, or regulatory compliance, ask the ATS! The Society has contracted the services of Diane Krier-Morrow, MBA, MPH, CCS-P, a nationally recognized expert in medical procedure coding and reimbursement, to answer ATS members' queries about these issues.

Ms. Krier-Morrow is a consultant and lecturer who 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. She can be reached by e-mail at [dkriermorr@aol.com](mailto:dkriermorr@aol.com).



## NEW PULMONARY CODES FOR 2008

### Smoking Cessation Codes

In 2008, physicians should use new CPT codes for reporting smoking cessation counseling services. The new codes will replace the temporary G-codes created by Medicare to report these services. Research shows that patients are more responsive to ceasing tobacco use when asked to by their physicians (Fiore 2000). Most pulmonologists provide this service to their patients, but are not reporting it for reimbursement. The codes listed below are reported in addition to an evaluation and management (E/M) code, appended with modifier 25 when a significant, separately identifiable E/M service is provided by the same physician on the same day of the procedure or other service. Smoking cessation counseling less than 3 minutes is included in the E/M code. Medicare will cover a total of 8 sessions in a 12-month period and requires the patient's record to show medical necessity. Use appropriate ICD-9-CM diagnosis codes such as 305.1 (tobacco dependence) and 492.8 (emphysema).



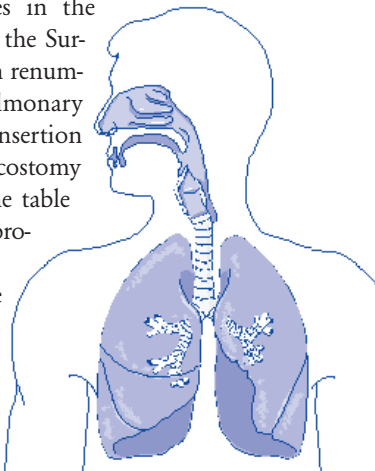
As with any time-based code, counseling time must be documented, as well as the medical condition or therapeutic agent that is adversely affected by tobacco use.

NEW 2008 CPT CODE	2007 CODE	Descriptor
99406	G0375	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	G0376	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes (Do not report 99407 in conjunction with 99406)

### Lungs and Pleural Codes Renumbered

The family of CPT codes used to describe thoracentesis and other procedures in the Lungs and Pleural subsection of the Surgery/Respiratory section has been renumbered for 2008. The affected pulmonary procedures are: thoracentesis, insertion of pleural catheter, tube thoracostomy and chemical pleurodesis. See the table for the new CPT codes for these procedures.

Providers will need to use the renumbered codes when reporting these services in 2008, as using the 2007 number will result in denied claims by Medicare and other providers.



NEW 2008 CPT CODE	2007 CODE	Descriptor
32421	32000	Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent (If imaging guidance is performed, see 76942, 77002, 77012) (For total lung lavage, use 32997)
32422	32002	Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure) (Do not report 32422 in conjunction with 19260, 19271, 19272, 32503, 32504)
32550	32019	Insertion of indwelling tunneled pleural catheter with cuff (Do not report 32550 in conjunction with 32421, 32422, 32551, 32560, 36000, 36410, 62318, 62319, 64450, 64470, 64475) (If imaging guidance is performed, see 76942)
32551	32020	Tube thoracostomy, includes water seal (eg, for abscess, hemothorax, empyema), when performed (separate procedure) (Do not report 32551 in conjunction with 19260, 19271, 19272, 32503, 32504) (If imaging guidance is performed, see 75989)
32560	32005	Chemical pleurodesis (eg, for recurrent or persistent pneumothorax)

### New Subcutaneous Infusion Codes

In 2008, there are three new codes for subcutaneous infusion of immune globulin (CPT codes 90769-90771). The chart below describes these new codes. To learn more about appropriate use, please consult the allergy chapter in the 2008 ACCP book *Coding for Chest Medicine 2008: A Practice Management Tool*. To order a copy, visit [www.chestnet.org](http://www.chestnet.org).

NEW 2008 CPT CODE	2007 CODE	Descriptor
90769	-	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 90772)
90770	-	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure) (Use 90770 in conjunction with 90769) (Use 90770 for infusion intervals of greater than 30 minutes beyond one hour increments)
90771	-	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 90771 in conjunction with 90769) (Use 90769 and 90771 only once per encounter)

## 2008 MODIFIER REVISIONS

At the November 2007 AMA CPT Symposium, all changes to CPT modifiers for 2008 were presented. Substantial revisions were made to both existing modifiers and to the modifier 51 exempt list (CPT Appendix E) to eliminate redundancy, inconsistency, and variable interpretations. A new modifier 92 Alternative Laboratory Testing is introduced. In the professional edition of the CPT book, all revisions to modifiers 22, 25, 32, 51, 58, 59, 76 and 78 are noted in green. Modifier definitions have been clarified and restated to avoid ambiguity, and references to “global period” were avoided.

Modifiers were introduced into the coding system in 1992 and are an integral part of coding and billing processes to result in correct payment. The intent of modifiers is to indicate that there is some alteration by some specific circumstance to the code reported. Modifiers respond to third-party payment policy requirements.

### Modifier 22

Modifier 22 is intended to identify physician work, not practice expense and should not be appended to Evaluation and Management (E/M) Services, CPT 99201-99499. In the title, the word “Unusual” was editorially revised and replaced with “Increased,” and defines the modifier for work “that is substantially greater than typically required.” Documentation must support the substantial additional work. Examples of increased additional work provided are: increased intensity, time, technical difficulty of procedure, severity of patient’s condition, physical and mental effort required to perform the procedure, which eliminates the ambiguity of the previous definition.

### Modifier 25

The “physician” restriction was eliminated since modifiers are used by other qualified non-physician providers. This removes a restriction from use of this modifier by designated individuals as defined by third-party payment programs. For example, Medicare provides separate coverage and payment for limited license practitioners and nonphysician providers (NPP) such as chiropractors, physical and occupational therapists, speech language pathologists, physician assistants, nurse practitioners, clinical psychologists, social workers and dietitians. This revision is also applied to modifiers 58, 59, 76 and 78. A statement was added to modifier 25 to differentiate its use from modifier 59: *For significant, separately identifiable non-E/M services, see modifier 59 (Distinct Procedural Service).*

### Modifier 32

“PRO” was omitted from the parenthetical because terminology is obsolete.

### Modifier 51

To support the comprehensive revision to CPT Appendix E, it is noted that use of modifier 51 is not applicable to physical medicine and rehabilitation services or provision of supplies (e.g., vaccines and immune globulins). Note that the lungs and pleura thoracentesis, tube thoracostomy and arterial puncture codes, formerly numbered 32000, 32002, 32020, and 36600, were removed from the modifier 51 exempt list, CPT Appendix E. Inclusion/exclusion criteria were established and the first criteria indicated if a procedure is typically adjunctive (ie, typically performed with a more extensive procedure or service) to another procedure, and that there is no pre- or post-service overlap with other procedures, than a code would be included as a modifier 51 exempt code (source *AMA cpt Changes 2008*, page 311).

### Modifier 58

Removal of the “physician” designation, as described under modifier 25 above, and the phrase “planned prospectively at the time of the original procedure” is replaced with “planned or anticipated.” The word “diagnostic” was eliminated because it excluded circumstances where a procedure was performed for therapeutic reasons.

### Modifier 59

Removal of the “physician” designation, as described under modifier 25 above, and omit “patient encounter” terminology. Documentation requirement is specified to support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. When another established modifier is appropriate it should be used instead of modifier 59. *Modifier 59 should not be appended to an E/M service.*

### Modifier 76

Removal of the physician designation, as described under modifier 25, and note correction under modifier 78 related to modifier 76. For modifier 76, “or Service” was added to the title.

### Modifier 78

Note the title change to emphasize that Modifier 78 is Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period. Revisions to modifier 78 make this applicable to both an operating room and a procedure room, and to the same physician who performed the initial procedure. A restriction applied to modifier 76 to be done on the same day was eliminated in the instructional notations.

### Modifier 92

The new 2008 modifier was a response to an urgent need for place of service testing for HIV (86701-86703) when laboratory testing is performed using a single-use kit or transportable instrument. This test doesn’t require permanent dedicated space.

## PQRI AND PULMONARY PRACTICE

In December 2006, Congress passed legislation requiring the CMS to establish a financial incentive for eligible professionals to participate in a voluntary quality reporting program. As part of the Physician Quality Reporting Initiative (PQRI), doctors and other qualified health providers who successfully reported performance measures from a set of designated quality measures on claims for service between July 1 and December 31, 2007 may earn up to a 1.5 percent bonus on all their Medicare reimbursements. The expanded program will continue in 2008.

To help members prepare to participate, the ATS reviewed all 119 performance measures, including the eight measures that took effect during the second half of 2007. Visit [www.thoracic.org](http://www.thoracic.org) to review the existing and new measures. If you have any questions about PQRI, please contact Diane Krier-Morrow at (847) 677-9464 or [dkriermorr@aol.com](mailto:dkriermorr@aol.com).

### 2007 AND 2008 PERFORMANCE MEASURES

- #51 Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation
- #52 Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy
- #53 Asthma: Pharmacologic Therapy
- #56 Vital Signs for Community-Acquired Bacterial Pneumonia
- #57 Assessment of Oxygen Saturation for Community-Acquired Bacterial Pneumonia
- #58 Assessment of Mental Status for Community-Acquired Bacterial Pneumonia
- #59 Empiric Antibiotic for Community-Acquired Bacterial Pneumonia
- #64 Asthma Assessment

### NEW FOR 2008 FOR PULMONARY MEDICINE

- #75 Prevention of Ventilator-Associated Pneumonia - Head Elevation
- #76 Prevention of Catheter-Related Bloodstream Infections (CRBSI) - Central Venous Catheter Insertion Protocol
- #114 Inquiry Regarding Tobacco Use
- #115 Advising Smokers to Quit

### GENERAL CLINICAL PERFORMANCE MEASURES

- #4 Screening for Future Fall Risk
- #46 Medication Reconciliation (within 60 days of prior hospitalization)
- #47 Advance Care Plan
- #110 Influenza Vaccination for Patients greater than or equal to 50 years old
- #111 Pneumonia Vaccination for Patients 65 years or older
- #129 Universal Influenza Vaccine Screening and Counseling

### STRUCTURAL PERFORMANCE MEASURES

- #124 HIT - Adoption/Use of Health Information Technology (Electronic Health Records)
- #125 HIT - Adoption/Use of e-Prescribing

For more information on the PQRI program, please visit the Centers for Medicare and Medicaid Services Web site [www.cms.hhs.gov/pqri](http://www.cms.hhs.gov/pqri)

## ATS AND AMA CONDUCTING PHYSICIAN PRACTICE INFORMATION SURVEY

For the first time in nearly a decade, the American Thoracic Society (ATS), the American Medical Association (AMA) and more than 70 other medical specialty societies have worked together to coordinate a comprehensive multi-specialty survey of America's physician practices. The purpose of the survey is to collect up-to-date information on physician practice characteristics in order to positively influence national decision makers. Thousands of practices will be surveyed in 2008, from virtually all physician specialties to ensure accurate and fair representation for all physicians and their patients.

This project is unique because it explores both the clinical and business side of medical practice. This information is important for the nation's policy-makers to learn what is truly involved in running a practice that provides expert patient care, while operating a business that is sustainable. A complete understanding of the landscape and the requirements for today's care is critical. These data will allow medicine to articulate practice concerns to national policy-makers that will lead to policy initiatives that not only help in the short-term, but will allow

future generations of doctors to continue providing superior care to their patients.

There is a small section in this study pertaining to practice expenses and the amounts that are attributable to you. Please encourage your staff to make these numbers available. The Centers for Medicare and Medicaid Services recently announced that the results of this study are considered critical to update physician payment. This is a vital part of the research and we need to have accurate and complete data. This information remains confidential. The survey firm will not identify any individuals or entities participating in this research to any of the participating organizations.

Dmrkynetec has been retained to conduct the Physician Practice Information survey among a representative random sample of practices in each of the participating specialties. The survey is an important and necessary vehicle for positive change. Please watch for this survey and do your part in completing it in a thorough and accurate manner if selected to represent our specialty.