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PULMONARY • CRITICAL CARE • SLEEP

Coding & Billing Quarterly

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Q&A

Pulmonary Rehabilitation

Q. After January 1, how do I charge a Medicare patient with COPD for pulmonary rehabilitation services?

A. For the COPD patient whose disease severity is classified as GOLD stage II, III or IV, you must report **G0424** for each hour of service, regardless of your practice type and location. The hour of service must include aerobic exercise, and may also include components of assessment (psychosocial or outcomes) or self-management education. No other charges are allowable for pulmonary rehabilitation services. A maximum of two sessions are allowed per day, up to a total of 36 sessions. Thirty-six additional sessions may be approved by your MAC/contractor, if deemed medically necessary.

Examples:

Initial assessment, including aerobic exercise (six-minute walk). Total time: One hour. Allowable charge: **G0424**.

Supervised exercise training for one hour.
Allowable charge: **G0424**.

Supervised exercise training for one-and-a-half hours and 30 minutes of self-management education. Total time: Two hours. Allowable charge: **G0424** times two.

Q. After January 1, how do I charge a Medicare patient with a diagnosis other than COPD for pulmonary rehabilitation services?

A. For patients with a diagnosis other than COPD that meet medical necessity criteria, continue to follow the billing guidelines as you did prior to January 1, 2010.

(Q&A continued on page 4)

Notes from the Editor

In 2010, many changes to coding and billing practices will be implemented, a process that will affect virtually every pulmonary, critical care and sleep medicine provider in the United States. One of the biggest changes is the Centers for Medicare and Medicaid Services' (CMS) decision to eliminate all inpatient and outpatient consultation codes from the Medicare program. CMS finalized this policy despite near universal opposition from the physician community. It is probable that private payers will adopt similar policy. This issue covers what codes to use in place of the eliminated consultation codes, where the RVUs from the eliminated codes went and provides examples for reference.



A second important change for 2010 will be the new Medicare code for pulmonary rehabilitation (**G0424**). After years of effort, the ATS and its sister organizations were successful in getting Congress and the CMS to create this benefit. In this issue of the *ATS Coding & Billing Quarterly*, we discuss who will and will not be covered under the new policy, which becomes effective January 1, 2010, as well as what codes to use and other important requirements.

This edition describes the new and revised CPT codes available in 2010, including two new CPT codes for interventional bronchoscopy (**31626, 31627**), five new or revised codes for pleural procedures (**32552, 32553, 32560-32562**), three new codes for pediatric pulmonary function tests (**94011-94013**) and two revised photodynamic codes (**96570, 96571**).

That said, the biggest issue that will face the physician community in 2010 is the status of the sustainable growth rate fix. As you know, the SGR formula, if left uncorrected, will result in a 21.2 percent cut in the 2010 Medicare Physician Fee conversion factor, with further cuts occurring in subsequent years. At press time, the Senate was debating a bill passed by the House of Representatives that would permanently eliminate the SGR. The Senate health reform bill contains a one-year SGR fix that provides a 0.5 percent update for 2010. If no SGR fix passes Congress, the 2010 conversion factor will be \$ 28.3895. The ATS will continue to educate Congress about the need to resolve the issue before January 1, 2010.

May it be a safe and prosperous New Year for you and your family!

Sincerely,

Alan L. Plummer, MD
Editor

CMS Eliminates Consultation Codes

Starting January 1, 2010, the CMS will no longer recognize inpatient or outpatient consultation codes. Physicians will have to use the existing evaluation and management (E/M) codes to report services that were previously considered consult services. While most consultation services will be replaced with hospital and outpatient E/M codes, other E/M codes could be used to describe consultation encounters, including those for nursing care, emergency department and observation.

The elimination of consultation codes raises a number of unresolved questions in the provider community regarding how the policy will be implemented. While the answers to most of these questions are not yet available, the Society expects the CMS to address these issues in a "Medicare Learning Network (MLN) Matters" article in the very near future. The ATS will keep its members apprised of ongoing developments in the *ATS Washington Letter*.

Economic Impact

The CMS has attempted to implement the policy in a budget neutral way by redistributing the RVUs from the eliminated consultation codes into the existing E/M codes. This represents a six percent increase in physician work for the office/outpatient E/M RVUs and a two percent increase for inpatient E/M RVUs. These redistributed RVUs are applicable to all E/M visits, so physicians should see an increase in E/M revenue as a result of the policy, which will offset some of the revenue lost from the eliminated consultation codes. CMS estimates that Medicare payments for pulmonary services will decrease by about 1 percent, but practices that relied heavily on consultations codes will likely experience a much greater drop in revenue.

But pulmonologists should also see a 1 percent increase in Medicare revenue, thanks to new practice expense and malpractice expense payments for pulmonary services. This should offset the overall impact of the eliminated consultation codes.

Documentation

One benefit of this new CMS policy is that physicians will no longer be required to meet the extensive documentation requirements and frequent audits associated with consultation codes. However, pulmonologists will still need to meet the requirements of the 1995 and 1997 Documentation Guidelines for E/M Codes. For a refresher on E/M documentation guidelines, please visit the CMS Web site at www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp.

Coding

Tables 1 and 2 (above, right) demonstrate the crosswalks for the consultation codes to the new patient codes in the hospital and outpatient arenas. In the outpatient site of service, the five consultation codes crosswalk to the 10 new and established outpatient visit codes. In the hospital, there are only three initial hospital care codes, but there are five inpatient consultation codes (see table 1, which shows how you can crosswalk the different levels of consult codes to the initial hospital care codes. Please note the tables are not final and are subject to change pending the forthcoming "MLN Matters" article).

Low-Level Consultation Codes

At press time, the CMS had not yet provided guidance on how the two lowest inpatient consultation codes (99251, 99252) should be reported. While some coding experts have suggested a crosswalk to subsequent hospital visits (99231, 99232), the CMS has not issued final guidance on this issue. The three highest consultation codes (99253-99255) crosswalk to the three initial hospital care codes (99221-99223). Nationwide, pulmonary medicine E/M reporting is generally at the higher levels, with 26.6 percent reporting 99222 and 73.2 percent reporting 99223 in 2007. A modifier identifying the admitting physician will need to be added, however CMS has not yet published the modifier. Further guidance is expected in the forthcoming "MLN Matters" article.

Three-Year Rule

When the patient has been seen, as an outpatient, by the physician or a member of the physician's practice within the past 3 years, the encounter must be reported using an established patient visit code (see tables 1 and 2). The 3-year

rule does not apply in the inpatient setting. In table one, please note that the "or" in the "Observation Patients" column refers to whether the patient is a new or established patient.

Third-Party Payers

At this point, it is unclear how third party payers will respond. If the CMS policy is broadly adopted by third-party payers, the economic impact will be further exacerbated. If third-party payers continue to honor the consultation codes, physician practices will be in the awkward position of creating separate billing and coding systems for the various payers.

Trying to force the issue, the CMS stated in its final rule: "If the primary payer does continue to recognize those [consultation] codes, the physician will need to decide whether to bill the primary payer using visit codes, which will preserve the possibility of receiving a secondary Medicare payment, or to bill the primary payer with the consultation codes, which will result in a denial of payment for invalid codes. Medicare Advantage programs are not required to adopt this policy, but may do so at their discretion."

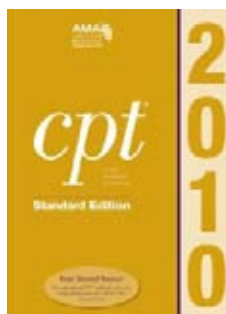
Table 1 – Inpatient Consultation Codes

Current Coding for 2009	Inpatient 2010	Nursing Facility 2010
99251	*	*
99252	*	*
99253	99221	99304
99254	99222	99305
99255	99223	99306

*Crosswalks for 99251 and 99252 and these codes have yet to be defined.

Table 2 – Outpatient Consultation Codes

Current Coding 2009	New Patients 2010	Established Patients 2010	Emergency Room 2010	Observation Patients 2010
99241	99201	99212	99281	99201 or 99212
99242	99202	99212	99282	99202 or 99212
99243	99203	99213	99283	99203 or 99213
99244	99204	99214	99284	99204 or 99214
99245	99205	99215	99285	99205 or 99215



New and Revised Codes for 2010

Here are the new and revised CPT codes of interest to the pulmonary community for 2010, which become effective January 1. Please note that the codes that are underlined are new and the codes that are italicized are revised. Sites of service include "non-facility" (an office or outpatient venue) and "facility" (an inpatient venue like a hospital or nursing facility).

CPT Code	Short Descriptor	2010 Non-Facility RVUs	2010 Facility RVUs
<u>31626</u>	Bronchoscopy w/markers	11.72	5.85
<u>31627</u>	Navigational bronchoscopy	32.29	2.84
<u>32552</u>	Remove lung catheter	5.01	4.44
<u>32553</u>	Ins mark thor for rt perq	16.11	5.73
<u>32560</u>	Treat pleurodesis w/agent	7.05	2.44
<u>32561</u>	Lyse chest fibrin init day	2.61	2.00
<u>32562</u>	Lyse chest fibrin subq day	2.32	1.79
<u>94011</u>	Up to 2 years old, spirometry	2.67	2.67
<u>94012</u>	= 2 yrs, spirometry w/dilator	4.12	4.12
<u>94013</u>	= 2 yrs, lung volumes	0.87	0.87
<u>96570</u>	Photodynmc tx, 30 min add-on	1.63	1.63
<u>96571</u>	Photodynamic tx, addl 15 min	0.76	0.76

(continued on page 3)

(continued from page 2)

Examples for the Use of the New Codes

31626: A patient with a 0.8 cm RUL nodule undergoes placement of fiducial markers utilizing navigational bronchoscopy to assist the thoracic surgeon during surgery. Code **31626, 31627**.

31627: A patient with a 1.2 centimeter nodule undergoes transbronchial lung biopsy (**31628**) utilizing navigational bronchoscopy. Code **31628, 31627**.

32552: A patient with a malignant effusion has the cuffed pleural catheter removed in a pulmonologist's office. Code **32552**.

32561 and **32562:** A patient with a parapneumonic effusion undergoes two instillations of an intrapleural lytic agent on day one and three instillations of the same agent on day two. Code **32561** on day one and **32562** on day two. The codes pertain to a day of pleurolysis rather than to the number of instillations per day which occurred.

94011-94013: A 20-month-old infant suspected of having asthma undergoes spirometry with bronchodilator and lung volume measurements under general anesthesia. Code **94012, 94013**.



CMS Finalizes Pulmonary Rehabilitation Coverage Policy

by Bonnie Fahy, R.N., M.N., C.N.S., who is director of a pulmonary rehabilitation program in Arizona and a nationally recognized leader on pulmonary rehabilitation policy.

As of January 1, Medicare will begin covering pulmonary rehabilitation services for some patients. Below is a summary of the CMS's new policy. The complete policy can be found in the 2010 Medicare Physician Fee Schedule rule (PFS) (<http://edocket.access.gpo.gov/2009/E9-26502.htm>) and the 2010 Medicare Hospital Outpatient Prospective Payment System rule (<http://edocket.access.gpo.gov/2009/E9-26499.htm>).

Definition of Pulmonary Rehabilitation:

- Physician-supervised program for COPD and certain other chronic respiratory diseases designed to optimize physical and social performance and autonomy.

Beneficiaries:

- Moderate, severe and very severe COPD (GOLD stages II-IV) when referred by the physician treating the chronic respiratory disease.

Coverage of Diagnoses Other Than COPD:

- Should adequate evidence become available in the future to support PR for additional diagnoses, it will be appropriate to initiate the process to establish a national coverage determination (NCD).
- In the interim, the respiratory services previously allowed by local contractors for other medical conditions under other Part B benefit categories remain in effect.

Number of Allowable Sessions:

- PR is covered for up to 36 one-hour sessions, with a maximum of two sessions per day, and with contractor discretion to approve up to 72 sessions when medically necessary.
- The maximum number of one-hour sessions allowed per day is two.

Mandatory components to receive payment from Medicare:

- Physician-prescribed exercise:** physical activity, including aerobic exercise, prescribed and supervised by a physician that improves or maintains an individual's pulmonary functional level. Physical activity includes techniques such as exercise conditioning, breathing retraining, step and strengthening exercises. Some aerobic exercise must be included in each PR session.
- Education or training** that is closely and clearly related to the individual's care and treatment and is tailored to individual needs, including information on respiratory problem management and, if appropriate, brief smoking cessation counseling. Any education or training prescribed must assist in achievement of individual goals toward independence in activities of daily living, adaptation to limitations and improved quality of life.
- Psychosocial assessment** written evaluation of individual's mental and emotional functioning as it relates to rehabilitation or respiratory condition, including an assessment of those aspects of an individual's family and home situation that affects rehabilitation treatment and a psychosocial evaluation of the individual's response to and rate of progress under the treatment plan.
- Outcomes assessment** of the patient's progress, including beginning and end evaluations, based on patient-centered outcomes (exercise performance and self-reported measures of shortness of breath and behavior), conducted by the physician.
- Individualized Treatment** (see below)

Written Individualized Treatment Plan:

- Must be developed by a physician who is involved in the patient's care and has knowledge of his/her condition; however there can be input from PR staff.
- If the plan is developed by the referring physician that is not the PR physician, the PR physician must also review and sign the plan prior to initiation of PR.
- Plan must be established, reviewed and signed by a physician every 30 days.
- Plan must include diagnosis, scope of services in terms of type, amount, frequency and duration, as well as individualized treatment goals.

Approved Settings:

- Physicians' offices.
- Hospital outpatient settings.
- All settings must have available for immediate use and accessible at all times the necessary cardio-pulmonary emergency, diagnostic, and therapeutic life-saving equipment accepted by the medical community as medically necessary (e.g. oxygen, CPR equipment, defibrillator).

Supervising Physician's Standards:

- Is responsible and accountable for the PR program, including oversight of the PR staff.
- Has expertise in the management of individuals with respiratory pathophysiology and cardiopulmonary training and/or certification including basic life support.
- Licensed by the state in which services are provided.
- In consultation with appropriate staff, is involved substantially in directing the progress of individuals in the program, including direct patient contact related to the periodic review of his or her treatment plan.

Direct Physician Supervision:

- In PR, the direct physician supervision definition applies only to a physician (doctor of medicine or osteopathy).
- At all times PR is being provided, the physician must be immediately available and accessible for medical consultation and medical emergencies.
- In physician's office, the physician must be present in the office suite and immediately available.
- For PR services provided in the hospital and in an on-campus provider-based department (PBD) of the hospital, direct supervision would mean that the physician must be present on the same campus (including physician's office, on-campus SNF, RHC, or other non-hospital space) and immediately available to furnish assistance. It does not mean that the physician must be in the room.

(continued on page 4)

(continued from page 3)

- For services furnished in a hospital, physician availability shall be presumed.
- “In the hospital” is defined to mean areas in the main building(s) of the hospital that are under the ownership, financial and administrative control of the hospital; are operated as part of the hospital; and for which the hospital bills the services furnished under the hospital’s CCN.
- In the off-campus PBD setting, direct supervision continues to mean that the physician must be on the premises the off-campus PBD and immediately available. The physician need not be present in the room.

Coding and Payment:

- One single HCPCS code, **G0424, Pulmonary rehabilitation**, including aerobic exercise (includes monitoring), per hour, per session, has been approved to cover ALL services provided in PR in the physician’s office and in outpatient hospital settings.
- Payment for **G0424** in the physician office is \$23.44 (assuming the 2009 conversion factor of \$36.0660). However the ATS has identified significant errors in the data CMS used to calculate the practice expense payment and we are working with CMS to correct these errors. Fixing CMS’s data errors will increase the physician office reimbursement.
- Payment for **G0424** in the hospital outpatient setting is \$50.64.
- Education and training is included in **G0424**.
- Component services are not to be unbundled and billed separately or by different providers or practitioners such as physical therapy.
- PR evaluations and individualized treatments may be provided by one or more members of the multidisciplinary team (MD, DO, RN, RT, PT, OT) but are not separately billable and are to be included in **G0424**.
- If a patient should require medically necessary physical therapy (PT) services that are outside of the PR plan of care, it would not be expected that the PT and PR services be provided in the same day.
- Policies for occupational therapy are the same as for PT.
- The CMS recognizes that a patient may require additional services, physician E/M or PT, outside of the PR plan of care but warn that billing patterns will be monitored.

Application of these regulations to a CORF:

- These regulations do not apply to a Comprehensive Outpatient Rehabilitation Facility (CORF).
- Current HCPCS G-codes (**G0237, G0238, G0239**) continue to be appropriate for use in CORFs.

News in Brief

CMS Extends Medicare Participation Enrollment Deadline

Due to recent revisions to the 2010 Medicare Physician Fee Schedule, the Centers for Medicare and Medicaid Services has extended the deadline for the 2010 annual participation enrollment program from December 31, 2009 to **January 31, 2010**.

Red Flag Alert – Delayed Implementation Date

The Federal Trade Commission has delayed the implementation of its red flag identity rule until June 2010. The rule will require all “creditors”—including physician offices—to take steps to protect the identity of their clients. For more information on how practices can comply with the new requirement, visit the American Medical Association’s Web site at www.ama-assn.org/ama/no-index/physician-resources/red-flags-rule.shtml.

CMS Release 2010 PQRI Measures

CMS has released the Physician Quality Report Initiative (PQRI) measures for 2010 including measures for COPD, asthma, smoking cessation, catheter-related blood stream infection prevention, pneumonia, and lung cancer staging. Physician can participate in PQRI either through claims-based reporting or by participation in a CMS approved registry effort. Practices that successfully report on 30 patients or over 80 percent of eligible patients can receive bonus payments from CMS for participating in the program.

For more information about the pulmonary, critical care and sleep medicine PQRI measures and how to participate in the PQRI program, please visit the ATS website at www.thoracic.org.

Physician’s Current Procedural Terminology (CPT®) codes, descriptions and numeric modifiers are ©2008 by the American Medical Association. All rights reserved.

For patients 18 years and older, report **G8546** only on the first claim to show that you intend to report the measures group. On the same claim form report the appropriate ICD-9-CM pneumonia diagnosis codes **481-483.8, 486, 487.0**, where the following office or other outpatient procedure was performed: New Patient **99201-99205**, Established Patient **99212-99215**, Emergency Department **99281-99285**, Critical Care **99291** (must report ED place of service 23 on Part B claim form ONLY for **99291**), Domiciliary, Rest Home, Custodial Care **99324-99337**, Home Services **99341-99350**.

On same claim form you must also report the CAP Measures Group Composite G code **G8550**: ALL quality actions for the applicable measures in the CAP Measures Group have been performed for this patient. This CAP measures code is reported once during each occurrence (ie, 45-day period from onset of CAP).

Specific information is available at www.cms.hhs.gov/pqri and on the ATS website at www.thoracic.org.

Q&A (continued from page 1)

Q. Does the CMS policy stipulate staff-to-patient ratios?

A. It does not. The 2006 ATS/ERS Statement on Pulmonary Rehabilitation, however, cites the AACVPR recommendation of 1:4 for exercise and 1:8 for education. To read the statement in full, visit www.thoracic.org/sections/publications/statements/pages/respiratory-disease-adults/atserpr0606.html.

Q. Can a non-physician provider (NP, CNS, PA) supervise pulmonary rehabilitation?

A. Unfortunately, an NP cannot, according to the final ruling in the physician fee schedule. Pulmonary rehabilitation must be supervised by a physician, regardless of where care is furnished. An NPP providing PR services would bill using **G0424**.

2009 ATS Coding & Billing Quarterly INDEX

Article	Issue Found
CMS Medicare Physician Fee Schedule Rules:	
2010 Conversion Factor (proposed 09/09, p1), Final	12/09, p 1
2010 CPT New and Revised Codes	12/09, p 2, 3
Consultation Codes (proposed 09/09, p2), Final	12/09, p 2
Practice Expense Data Increases (proposed 09/09, p20), Final	12/09, p 2
Pulmonary Rehabilitation (proposed 09/09, p1), Final	12/09, p 3, 4
Critical Care:	
CMS Transmittal 1548	03/09, p 4
Defined	03/09, p 4
Diagnoses Supporting Medical Necessity	03/09, p 3
Highmark Critical Care Edits	07/09, p 3
Sample Documentation	03/09, p 4
Tips on Critical Care Coding (Errata 07/09, p4)	03/09, p 2, 3
FAA Portable Oxygen Concentrators (POCs) Rules	07/09, p 3
H1N1 (swine flu) vaccine billing guidance	09/09, p 3
ICD-9-CM Changes Effective October 1, 2009	09/09, p 2
ICD-10 Effective October 1, 2013	09/09, p 3, 4
Identify Theft (Red Flag Rule)	07/09, p 2
Local Medicare Contractors	07/09, p 4
Medicare Enrollment Deadline Extended	12/09, p 4
Physician Quality Reporting Initiative (PQRI) Update	07/09, p 2
Red Flag Alert – Delayed Implementation Date	12/09, p 4
TBNA Zones/Billing Lobes (see AMA CPT Assistant, Nov. 2009)	07/09, p 1
Coding Q & A	
Multiple Bronchoscopies	07/09, p 4
Plethysmography	09/09, p 4
Pulmonary Rehabilitation	12/09, p 1, 4
Thoracentesis versus Thoracoscopy	07/09, p 4
Thoracentesis with Ultrasound	07/09, p 4