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# Coding & Billing Quarterly

JULY 2009

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## Q&A

### TBNA Zones For Billing

**Q.** How does a pulmonologist count “lobes” for transbronchial needle aspiration (TBNA) biopsy(s)?

**A.** Billing for TBNA procedures is not based on lymph node station as clinically relevant, but has been instead designated to sampling in different lobes. As there is no direct correlation, the ATS recommends a method developed by Henry Ford Medical Center’s Michael Simoff, M.D., in which all lymph node stations are assigned to the most appropriate lobe of the lung. The Society encourages members to use the table below—which has been submitted for publication in the AMA’s *CPT Assistant*—as a reference for accurately reporting the number of lobes, the corresponding nodal stations and the lobe which best represents their anatomic location.

Anatomic Location	Corresponding Lymph Node Stations
Right Upper Lobe	2R, 4R, 10R
Right Middle Lobe	7
Right Lower Lobe	11R, 12R
Left Upper Lobe	2L, 4L, 5, 10L
Left Lower Lobe	11L

The ATS gives a special thanks to Dr. Simoff for developing this transbronchial needle aspiration coding chart and granting the Society permission to share it with ATS members.

(Q&A continued on page 4)

## Notes from the Editor

Welcome to the July 2009 *ATS Coding & Billing Quarterly*. Please note that this will be the last printed issue of the newsletter. As part of the Society’s efforts to cut costs and become more environmentally conscious, the *ATS Coding & Billing Quarterly* will become electronic-only, starting in September 2009.

The ATS will continue to post a PDF of the newsletter on its Web site at [www.thoracic.org/go/ats-coding-and-billing](http://www.thoracic.org/go/ats-coding-and-billing).

As a new issue is posted, the Society will also send all members an e-mail highlighting stories of interest and providing links to the electronic version of the publication. For readers who miss this monthly message, back issues of the *ATS Coding & Billing Quarterly* are archived online.

If you wish to continue receiving a hardcopy of the publication, or want the newsletter to be e-mailed to your coding and billing staff, please send us an e-mail at [CodingQuestions@thoracic.org](mailto:CodingQuestions@thoracic.org).

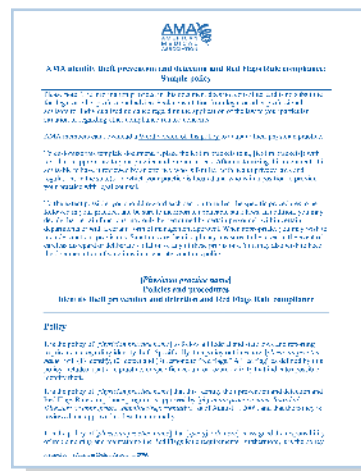
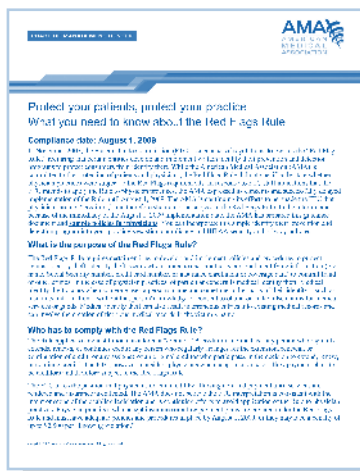
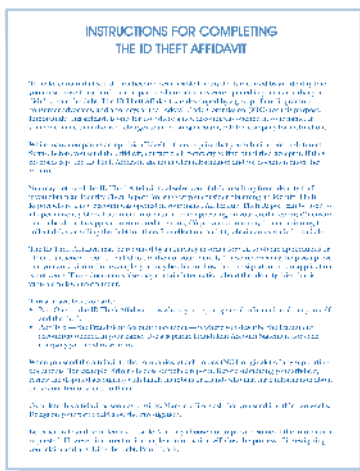
In this issue of the *ATS Coding & Billing Quarterly*, you will find information on a new federal identify theft regulation that applies to physician practices, news of a critical care edit correction and billing guidance for multiple transbronchial needle aspirations. This issue also covers thoracentesis versus thoracostomy coding, as well as an update on the Centers for Medicare and Medicaid Services (CMS) Physician Quality Reporting Initiative (PQRI). Please also note the errata regarding the previous issue’s article on critical care billing.

As always, if you have questions on coding, billing, documentation or regulatory compliance issues, please feel free to send us an e-mail. We respond to every question and your inquiries help us craft Q & As for future editions of the publication.

Sincerely,

Alan L. Plummer, MD  
Editor





## Identify Theft Protection - Red Flag Rule

In 2007, the Federal Trade Commission (FTC) passed a rule requiring financial institutions and “creditors” to develop and implement plans to prevent identity theft. Unfortunately, the FTC considers physicians to be creditors and practices therefore must develop identify theft prevention plans to safeguard patient information. The deadline for implementing these plans is August 1, 2009.

The ATS has expressed its strong opposition to the FTC’s interpretation of “creditors” to include physician practices. The Society, in collabora-

tion with the American Medical Association (AMA) and other physician organizations, will continue to lobby the FTC to revise its decision on this matter.

Until this issue is resolved, the ATS encourages its members to visit [www.ama-assn.org/ama/no-index/physician-resources/red-flags-rule.shtml](http://www.ama-assn.org/ama/no-index/physician-resources/red-flags-rule.shtml) to download materials that can help their practices meet the August 1 deadline.

## PQRI Update

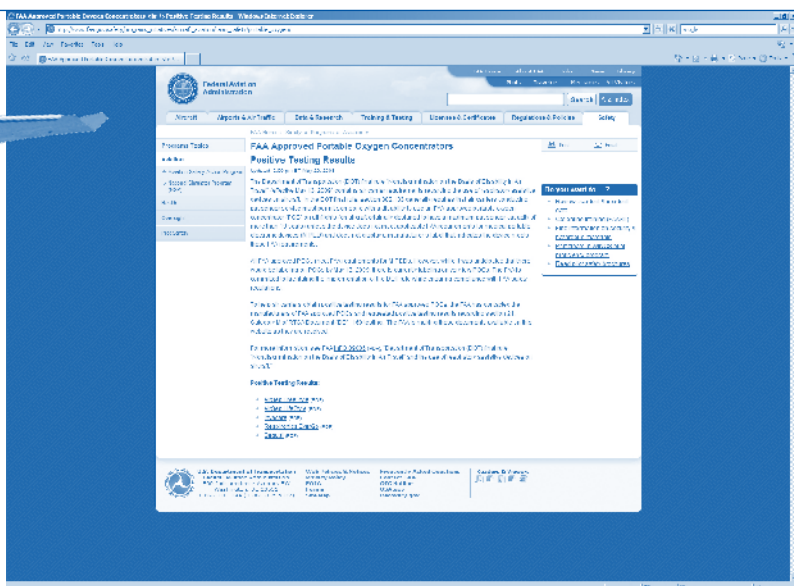


The CMS recently briefed medical specialty staff on the status of its Physician Quality Reporting Initiative (PQRI). Highlights of interest to the ATS membership include:

- The CMS stated that the number of participants and the success rate of reporting in 2008 have improved over the six-month reporting period in 2007. In 2007, the National Provider Identifier (NPI) was an issue. If a claim was reported without the NPI, it was rejected. Processing adjustments have been made in regard to missing NPIs. If a claim is submitted without the NPI, it will be sent back to the physician for correction and resubmission.
- 2008 PQRI data will be available on the CMS Web site in October 2009, when 2008 bonuses and 2007 fixed payments will be made. Preliminary data from the first three quarters show that some physicians did not report the appropriate ICD-9-CM diagnosis and CPT procedure codes associated with each measure.
- In 2010, the HHS secretary will be allowed to have discussions regarding any revisions of the reporting period, and stakeholders have

been asked to comment before the proposed rule is published (usually in July) regarding revisions to the reporting period.

- Individual physicians will be able to access their feedback reports through their own Medicare contractors at the individual level. Physicians had problems accessing their reports due to security issues with the CMS system. Group-level claims will continue using this system for their feedback reports. The CMS is fine-tuning the feedback reports.
- An overview of the 2009 PQRI program can be accessed at [www.cms.hhs.gov/MLNMattersArticles/downloads/MM6394.pdf](http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6394.pdf).
- The 2010 measures will be published in the Medicare Physician Fee Schedule proposed rule, expected to be released in July and open for comment. Final 2010 measures will be published in the final rule, around November 1. The CMS usually tweaks measure specifications until December 31.



# FAA Makes Skies Friendlier for Lung Patients

As of May 13, 2009, patients flying with supplemental oxygen will have expanded travel options and greater independence. The Federal Aviation Administration (FAA) is implementing new rules that require all airlines that operate within the U.S. to allow patients to bring on board and use during flight their own approved portable oxygen concentrators (POCs). Previous FAA regulations permitted airlines to board passengers with POCs, but did not require them to do so.

Below is the current list of FAA-approved POCs:

- AirSep FreeStyle POC
- AirSep LifeStyle POC
- Inogen One POC
- Respironics EverGo POC
- Sequal Eclipse POC
- Delphi Medical Systems RS-00400
- Invacare Corporation XPO2

Each of the above systems have been tested and approved by the FAA for use during air travel. While airlines must allow travelers in need of supplemental oxygen to board with and use their own FAA-approved

POCs, they may require advanced notification and physician-signed documentation stating medical need. Patients should be encouraged to contact the airline in advance when making travel arrangements involving supplemental oxygen.

The new FAA rule also applies to respirators, ventilators, CPAP machines and other respiratory assistive devices. However, fewer respiratory assistive devices have been tested to ensure that they do not interfere with aircraft avionics. In the future, the ATS expects more respiratory assistive device manufacturers to develop, test and label products for FAA air travel approval.

The ATS, working with patient organizations, lobbied hard to force the FAA to improve travel options for patients with respiratory diseases. The Society is pleased that these advocacy efforts helped bring this new policy to fruition.

For more information on the new FAA regulation, please visit: [www.faa.gov/safety/programs\\_initiatives/aircraft\\_aviation/cabin\\_safety/portable\\_oxygen](http://www.faa.gov/safety/programs_initiatives/aircraft_aviation/cabin_safety/portable_oxygen).

## HIGHMARK® Highmark Critical Care Edits

Highmark—the Medicare Administrative Contractor (MAC) for Washington, D.C., Delaware, Maryland, New Jersey and Pennsylvania—has corrected an automatic coding edit that was inappropriately denying claims for procedures submitted with critical care codes. It appears that Highmark had a series of automatic edits that were correct individually, but when layered on top of each other, led to inappropriately denied procedure claims. Highmark says the problem has been resolved and should not be a problem going forward.

Physicians who practice in states administered by Highmark should review their critical care denials. Claims dating back to October 1, 2007 that were inappropriately denied can be resubmitted or appealed. While providers generally have 120 days after the initial denial to appeal claims, providers can use the “Good Cause for Late Filing” clause for submitting appeals after the 120-day deadline.

(Q&A continued from page 1)

## Thoracentesis vs. Thoracoscopy

**Q.** There seems to be two codes in CPT 2009 for chest tubes (CPT **32422** *Thoracentesis with insertion of tube* and CPT **32551** *Tube thoracostomy*). In the code descriptor, the two CPT codes are virtually identical except for the reason of the chest tube placement (CPT **32422** for pneumothorax or pleural effusion versus CPT **32551** for abscess, hemothorax or empyema).

Additionally, physicians will often document a “thoracentesis with a Yueh catheter” and only describes catheter placement and drainage of a pleural effusion. Our interpretation has been that a Yueh catheter is another variant of a “chest tube” and, as such, CPT **32422** is more appropriate to report than CPT **32551**. Unfortunately, my research has not shown any clear consensus on what products are definitely “chest tubes” versus simply “tubes.” Do you agree that a Yueh catheter warrants the use of CPT **32422** rather than CPT **32551**?

Also, CPT 2009 and our coding program doesn’t cross reference CPT **32551** *Tube thoracostomy* with ICD-9-CM **511.9** (pleural effusion) or **512.8** (pneumothorax). CPT **32551** does cross reference to abscess, hemothorax, or empyema diagnoses. Is diagnosis the chief determinant for coding chest tube placement?

**A.** There are two thoracostomy (chest tube insertion) codes, CPT **32550** and **32551**. Chest tubes are inserted and left in place to drain air or fluid over days. Chest tube insertions for pneumothorax and persistent pleural effusions are performed many times.

Code **32550** *Insertion of indwelling tunneled pleural catheter with cuff* indicates the chest tube is inserted using a tunneled procedure (e.g., Denver catheter). For **32551** *Tube thoracostomy, includes water seal (e.g., for abscess, hemothorax, empyema), when performed*, a trocar is used or the chest tube is inserted using forceps. These chest tubes are usually 14F up to 38F, but pigtailed catheters may be a little smaller (10-12 F) (F is for French).

The Yueh catheter would be considered a chest tube and **32551** would be the appropriate code. A Seldinger technique is used to insert this chest tube. A needle is inserted into the pleural space through which a guide wire is inserted and left in the pleural space after the needle is removed. Successive dilations are made with the dilators being inserted over the guide wire. Once the desired size is achieved, a Yueh catheter is inserted and secured.

Code **32422** *Thoracentesis with insertion of tube, includes water seal (e.g., for pneumothorax), when performed* is just that—a thoracentesis (removing fluid for diagnosis or relief of dyspnea) using a needle over which or through which a small catheter is inserted into the pleural space/fluid, not a chest tube per se. Most often a thoracentesis with catheter insertion is a one-time, in and out, event. In infrequent cases (involving large effusions), the catheter may be secured and left in the pleural space overnight for repeat drainage the next day.

A quick thoracentesis (a small amount of fluid is removed for diagnostic purposes, 30-50 mls for example, or for a quick removal of air) utilizes a large syringe and a needle only. The code for this would be **32421** *Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent*. A cross reference in CPT states: “Do not report **32550** in conjunction with **32421**, **32422**.”

Check with your physicians for the reasons that the procedure was performed. The reason should translate into an ICD-9-CM diagnosis code to support medical necessity for the thoracentesis codes and which support the chest tube insertion codes.

We suggest the coder observe a thoracentesis and a tube thoracostomy to see what transpires during these procedures. That would answer a lot of questions.

## Thoracentesis

**Q.** If the physician performs a thoracentesis in the hospital with an ultrasound, do we charge the **76942** with a **26** modifier and the thoracentesis code?

**A.** Yes. A parenthetical in the CPT book indicates that it is appropriate to report **76942** *Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation* for ultrasound guidance if imaging guidance is performed with the thoracentesis codes, **32421** or **32422**. You may charge for the ultrasound as long as you document how you did the procedure. It helps to attach a photo of the ultrasound picture with the report. In the hospital setting, even if you (i.e., the doctor, the practice or the pulmonary department) owns the ultrasound equipment, you can still ONLY bill the professional component (i.e., the procedure code appended with the modifier **26**) and not the global code, because the hospital has already been paid for ALL the technical components (either through a DRG payment for an inpatient or an APC payment for a hospital outpatient). It is very important to read introductory comments in the relevant section of CPT and parentheticals specific to procedure codes reported in the practice. CPT is updated annually.

## Multiple Bronchoscopies

**Q.** My coders are only letting us report one bronchoscopy code, regardless of what we perform and document. Can you provide supporting information to help convince them to report bronchoscopies appropriately?

**A.** Your coders are incorrect and are denying you and your institution a range of appropriate codes for reporting bronchoscopic services. The *ATS Coding & Billing Quarterly* has published a series of articles and Q & A’s on appropriate use of the family of bronchoscopic codes (please see the July and September 2008 issues). We recommend you and your billing staff refer to these issues for proper use of bronchoscopic codes. Back issues of the *ATS Coding & Billing Quarterly* are archived on the ATS Web site at [www.thoracic.org/go/ats-coding-and-billing](http://www.thoracic.org/go/ats-coding-and-billing).

## Local Medicare Contractors: They Can Help

Did you know that your local Medicare contractor is a valuable source of news and information regarding Medicare business in your specific practice location? Through their electronic mailing lists, your local contractor can quickly provide you with information pertinent to your geographic area, such as local coverage determinations, local provider education activities, etc. If you have not done so already, you should go to your local contractor Web site and sign up for their listserv or e-mail list. Many contractors have links on their homepages through which you can subscribe. If you do not see a link on a contractor’s homepage, just search the site for “listserv” or “e-mail list” to find the registration page. If you do not know the Web address of your contractor’s homepage, it is available at [www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip](http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip).

## Errata

The “Expert Advice: Tips on Critical Care Coding” article that appeared in the March 2009 issue of the *ATS Coding & Billing Quarterly* included an error. On page 3, the second paragraph of tip number seven should have read: “If the consultation is provided and merits the criteria for critical care (critical instability documented and **30 minutes or greater** of time spent providing critical care), code **99291** may be reported, rather than a consult code (**99241-99245**).” The ATS apologizes for this error.