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Coding & Billing Quarterly

SEPTEMBER 2009

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Notes from the Editor



This summer, the Centers for Medicare & Medicaid Services (CMS) released proposed rules for both the 2010 physician fee schedule and hospital outpatient services. Both rules contain policy changes that, if implemented, will have significant impacts on clinical practices. This issue of the *ATS Coding & Billing Quarterly* focuses on how the proposed rules may impact the respiratory, critical care and sleep communities, if left unchanged when the CMS issues its final policies in November 2009.

The CMS has proposed cutting the 2010 conversion factor by 21.5 percent, eliminating consultation codes, implementing a new pulmonary rehabilitation coverage and reimbursement policy and increasing practice expense costs for pulmonary practices.

There are also large ICD system changes on the horizon. In a two-part article, we provide background information on the new ICD-10 system that the CMS will implement on October 1, 2013. While four years may seem like a long time, moving from ICD-9 to ICD-10 will mean significant system changes for all healthcare providers. Practices will need to start planning for the transition.

Always, there are Q & A's submitted by readers and answered by ATS experts. Please keep those questions coming.

Sincerely,

Alan L. Plummer, MD
Editor

Proposed Medicare Physician Fee Schedule May be Troubling for Respiratory Community

If implemented, the physician payment schedule proposed by the CMS this summer could negatively impact healthcare providers in the fields of pulmonary, critical care and sleep. Here is an overview of some of the most pressing issues that will affect ATS members.

2010 Conversion Factor or CF

The CF is the dollar unit used to convert the relative value units for different physician services into the actual reimbursement. In 2009, each 1-unit of physician relative value was worth \$36.0666.

The CMS is projecting that the 2010 CF will be cut by 21.5 percent (\$28.3208). This was expected, because the formula used for calculating the CF—known as the sustainable growth rate or SGR—is deeply flawed, which has resulted in steep projected cuts in the CF for several years. To date, the physician community has been successful in getting Congress to enact temporary fixes to forestall the annual projected cuts, but legislators have failed to fix the underlying SGR formula.

The good news is that Congress and the Obama administration are aware of the problem and have taken incremental steps to address it, by removing the cost of drug administration from the SGR calculation, for example. The bad news is that permanently fixing the SGR is projected to cost \$228 billion over 10 years. And whether the SGR formula is corrected may depend on the outcome of the healthcare reform debate. All of the health care reform bills moving through Congress include provisions to fix the SGR and provide annual updates for Medicare physician reimbursement.

Pulmonary Rehabilitation: Covered Conditions

The ATS was very disappointed to learn that the CMS has proposed only covering pulmonary rehabilitation services for all Medicare beneficiaries who have moderate or severe COPD (level II and level III COPD as defined by the Global Initiative for Chronic Obstructive Lung Disease or GOLD). While this proposed policy recognizes that patients with other respiratory conditions may benefit from pulmonary rehabilitation, it concludes that there is not sufficient scientific evidence to support coverage of PR as a standard treatment. The CMS policy does note that additional conditions may be accommodated through the National Coverage Determination process as further research is conducted.

The Society also believes that the policy should cover PR as a therapy for patients with level IV COPD as well as for other respiratory disorders, such as interstitial lung disease, pulmonary hypertension and pulmonary fibrosis.

Pulmonary Rehabilitation: Duration of Benefit, Reimbursement and Bundled Services

The proposed policy also limits PR coverage. If implemented, the CMS would pay for up to 36 one-hour PR sessions, limiting payment to one session per day. The CMS would pay for this using a new G-code (**GXX30**), which has a reimbursement rate of approximately \$15 in hospital outpatient departments and \$16.71 in physicians' offices. Bundled in the reimbursement are a number of monitoring services that currently are separately billable (including the six-minute walk test).

The ATS is concerned about the duration of PR therapy specified in the CMS's proposed reimbursement policy. All of the statements and guidelines published by the ATS and its sister societies recommend at least 70 hours are needed to make PR most effective. Clinical data also suggests that patients do best when receiving two to three hours of therapy each session.

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The CMS takes a different view of PR in its coverage policy for lung volume reduction surgery, which requires patients to receive PR therapy in daily two-hour sessions, up to 60 hours. It is unclear why the CMS is proposing a more restrictive policy for COPD patients.

The proposed reimbursement rate is also extremely problematic. The proposal to pay \$15-\$17 for a 1-hour session of PR marks a 78 percent cut from current reimbursement. The cut is even deeper when you factor in the lost revenue from services that are currently separately billable that the CMS has proposed to bundle into the PR payment.

INPATIENT CONSULTATION CODES

Codes Under Current Policy		Codes Under Proposed Policy	
CPT Code/Descriptor	Physician Work RVU	CPT Code/Descriptor	Physician Work RVU
99251 – Inpatient Consultation	1.00	99221 – Inpatient Hospital Care	1.92
99252 – Inpatient Consultation	1.50	99221 – Inpatient Hospital Care	1.92
99253 – Inpatient Consultation	2.27	99222 – Inpatient Hospital Care	2.61
99254 – Inpatient Consultation	3.29	99223 – Inpatient Hospital Care	3.85
99255 – Inpatient Consultation	4.00	99223 – Inpatient Hospital Care	3.85

OFFICE/OUTPATIENT CONSULTATION CODES

Codes Under Current Policy		Codes Under Proposed Policy	
CPT Code/Descriptor	Physician Work RVU	CPT Code/Descriptor	Physician Work RVU
99241 – Office Consultation	0.64	99201 – Office/Outpatient visit, new	0.48
		99211 – Office/Outpatient visit, established	0.18
99242 – Office Consultation	1.34	99202 – Office/Outpatient visit, new	0.93
		99212 – Office/Outpatient visit, established	0.48
99243 – Office Consultation	1.88	99203 – Office/Outpatient visit, new	1.42
		99213 – Office/Outpatient visit, established	0.97
99244 – Office Consultation	3.02	99204 – Office/Outpatient visit, new	2.43
		99214 – Office/Outpatient visit, established	1.50
99245 – Office Consultation	3.77	99205 – Office/Outpatient visit, new	3.17
		99215 – Office/Outpatient visit, established	2.11

Consult Codes Eliminated

The CMS is also proposing eliminating office, outpatient and inpatient consultation codes in a budget-neutral manner by blending the relative value units from these codes into existing E/M codes. The chart demonstrates how these codes would be replaced.

The ATS estimates that eliminating these consultation codes will reduce Medicare payments to pulmonary physicians by \$29 million, a cut that will be partially offset by a \$5 million increase in payments to pulmonologists resulting from adding the work RVUs from consultation codes into the existing hospital and office visit codes.

It is not easy to calculate how much practices will save in “hassle factor”—i.e., not having to generate the documentation associated with consultation codes, including the consultation request and consultation results summary. Most payers ask for documentation of consultation codes, which are frequently subjected to pre- and post-payment reviews.

New Practice Expense Data Increases Pulmonary Reimbursement

The proposed rule would also use new data collected from the comprehensive, multi-specialty survey of America’s physician practices conducted by the ATS, American Medical Association and more than 70 other professional healthcare organizations. As a result of the data collected on practice expenses, the CMS has proposed increasing the practice expense/hour ratio for pulmonary medicine from \$44.63 per hour to \$55.26 per hour. The ATS expects that this will result in a total annual increase of \$55 million in Medicare payments to pulmonologists.

ICD-9-CM Changes for Pulmonary, Critical Care and Sleep Medicine

The following changes to ICD-9-CM will become effective on October 1, 2009. Note that you always need to check both the Index and the Tabular List for selection of the appropriate ICD-9-CM codes to include in your encounter forms. The National Center for Health Statistics (NCHS), housed at the CDC, prepares the yearly ICD-9-CM Index to Diseases Addenda (FY10), which becomes effective October 1, 2009.

Official code revision packages are referred to as addenda and available on the NCHS Web site. The complete addenda Index (Volume I) for October 1, 2009, can be reviewed at: www.cdc.gov/nchs/data/icd9/icdidx10add.pdf. The Tabular list of diseases addenda (Volume II) can be viewed at: www.cdc.gov/nchs/data/icd9/icdtab10add.pdf.

- 348.89 Brain death
- 415.1 Pulmonary embolism and infarction
Excludes: chronic pulmonary embolism (416.2)
personal history of pulmonary embolism (V12.51)
- 416.2 Chronic pulmonary embolism
- 453.2 Venous embolism and thrombosis of inferior vena cava
- 453.4 Acute venous embolism and thrombosis of deep vessels of lower extremity
 - 453.40 Acute venous embolism and thrombosis of unspecified deep vessels of lower extremity
 - 453.41 Acute venous embolism and thrombosis of deep vessels of proximal lower extremity
 - 453.42 Acute venous embolism and thrombosis of deep vessels of distal lower extremity
- 453.5 Chronic venous and thrombosis of deep vessels of lower extremity
 - 453.50 Chronic venous embolism and thrombosis of unspecified deep vessels of lower extremity
 - 453.51 Chronic venous embolism and thrombosis of deep vessels of proximal lower extremity
 - 453.52 Chronic venous embolism and thrombosis of deep vessels of distal lower extremity

- 453.6 Venous embolism and thrombosis of superficial vessels of lower extremity
Saphenous vein (greater) (lesser)
- 453.7 Chronic venous embolism and thrombosis of other specified vessels
- 453.71 Chronic venous embolism and thrombosis of superficial veins of upper extremity
- 453.72 Chronic venous embolism and thrombosis of deep veins of upper extremity
- 453.73 Chronic venous embolism and thrombosis of upper extremity, unspecified
- 453.74 Chronic venous embolism and thrombosis of axillary veins
- 453.75 Chronic venous embolism and thrombosis of subclavian veins
- 453.76 Chronic venous embolism and thrombosis of internal jugular veins
- 453.77 Chronic venous embolism and thrombosis of other thoracic veins
- 453.79 Chronic venous embolism and thrombosis of other specified veins
- 453.8 Acute venous embolism and thrombosis of other specified veins
- 453.81 Acute venous embolism and thrombosis of superficial veins of upper extremity
- 453.82 Acute venous embolism and thrombosis of deep veins of upper extremity
- 453.83 Acute venous embolism and thrombosis of upper extremity, unspecified
- 453.84 Acute venous embolism and thrombosis of axillary veins
- 453.85 Acute venous embolism and thrombosis of subclavian veins
- 453.86 Acute venous embolism and thrombosis of internal jugular veins
- 453.87 Acute venous embolism and thrombosis of other thoracic veins
- 453.89 Acute venous embolism and thrombosis of other specified veins
- 488.0 Influenza due to identified avian influenza virus (Bird flu)
- 488.1 Influenza due to identified novel H1N1 influenza virus (Swine flu)
- 768.7 Hypoxic-ischemic encephalopathy (HIE)
- 768.70 Hypoxic-ischemic encephalopathy, unspecified
- 768.71 Mild hypoxic-ischemic encephalopathy
- 768.72 Moderate hypoxic-ischemic encephalopathy
- 768.73 Severe hypoxic-ischemic encephalopathy
- 784.42 Hoarseness
- 799.82 Apparent Life Threatening Events (ALTE) in newborn and infant
- 995.24 Failed moderate (conscious) sedation, during procedure
- V10.90 Personal history of unspecified malignant neoplasm
- V10.91 Personal history of malignant neuroendocrine tumor (carcinoid tumor)
- V12.51 Personal history of pulmonary embolism
- V15.80 Personal history of failed moderate (conscious) sedation during a procedure
- V15.84 Contact with and exposure to asbestos
- V87.4 Personal history of drug therapy
- V87.43 Personal history of estrogen therapy
- V87.44 Personal history of inhaled steroid therapy
- V87.45 Personal history of systemic steroid therapy
- V87.46 Immunosuppressive therapy

CMS Issues H1N1 Vaccine Billing Guidance

The Centers for Medicare & Medicaid Services (CMS) has created two new HCPCS codes for H1N1 vaccine administration, effective for dates of service on and after September 1, 2009:

- **G9141**—Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)
- **G9142**—Influenza A (H1N1) vaccine, any route of administration

Payment for **G9141** (Influenza A (H1N1) immunization administration, will be paid at the same rate established for **G0008** (Administration of influenza virus vaccine). H1N1 administration claims will be processed using the diagnosis of **V04.81** (influenza), and, depending on the provider type, using revenue code **771**. Same rules apply as with seasonal influenza virus vaccine with one exception: since the vaccine is available at no cost, Medicare will not pay providers for the vaccine. Therefore, do not report **G9142** on the claim form. Providers will not be paid for office visits when the only purpose of the visit is to administer either the seasonal and/or H1N1 vaccine(s). For additional information on CMS reimbursement policy for H1N1 vaccine administration please visit the CMS website at: www.cms.hhs.gov/MLNMattersArticles/downloads/SE0920.pdf

The ICD-10 Transition (Part I)

by Diane Krier-Morrow

The final rules for replacing the 30-year-old International Classification of Diseases (ICD-9-CM) with the code set ICD-10 and the 5010 Health Insurance Portability and Accountability Act (HIPAA) standards were both released in the Federal Register on Jan. 16, 2009. New electronic protocols will become effective on Jan. 1, 2013 and ICD-10-CM diagnosis codes will be implemented on Oct. 1, 2013. Physicians and others in the healthcare community must start using the new version of HIPAA 5010 transaction standards by Jan. 1, 2012, as the current version, 4010, does not accommodate use of the ICD-10 codes.

Diagnoses

ICD-10 was published in 1992 and is the most recent revision of the ICD. The World Health Organization (WHO) authorized the NCHS to develop a clinical modification of ICD-10 for use in the United States. This version is called ICD-10-CM and is the new diagnosis coding system that will replace ICD-9-CM, volumes 1 and 2, which have been in use since 1979. The NCHS maintains the ICD-10-CM code set for diagnoses, which can be accessed by visiting the NCHS website. In total, there are 68,000 ICD-10-CM codes that are three to seven alphanumeric characters in length (none of which are case sensitive). In contrast, there are more than 13,500 ICD-9-CM diagnosis codes, which are three to five digits long.

For ICD-10-CM, the first digit is numeric or alphabetical (except U), digit two is numeric and digits three to seven can be alphabetic or numeric. ICD-9-CM features 17 chapters (Chapter 8 is Diseases of the Respiratory System (460-519) and all characters are numeric. For supplemental chapters, the first digit is alpha (E or V) or numeric, and digits two to five are numeric.

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CPT

Current Procedural Terminology (CPT) and the Healthcare Common Procedure Coding System (HCPCS), which are used for all ambulatory and physician procedure reporting, are not being replaced by ICD-10 so there will be no impact on CPT and HCPCS codes. In other words, hospital coding staff will be using the ICD-10-PCS code set for inpatient reporting, where physician reporting of procedures performed in the hospital or any setting will be CPT.

The Plan: Begin Practice Assessment and Education Now

Moving to ICD-10 will certainly affect all pulmonary, critical care and sleep physicians, so its time to enhance your knowledge of the ICD-10-CM and ICD-10-PCS coding systems. Due to the increased number of codes, the change in the number of characters per code, and increased code specificity, this transition will require significant planning, training and software/system upgrades/replacements, as well as other necessary investments. The American Health Information Management Association's checklist is a good place to start: you can download this from www.ahima.org/icd10/icd-10preparationchecklist.mht. In 2010, you should also perform a needs assessment on the impact of this major diagnostic coding change on your practice.

Transition tools, referred to as ICD-10 General Equivalence Mappings (GEMs), serve as general-purpose ICD-9/ICD-10 translation dictionaries and are designed for use by all providers, payers and data users. The CMS routinely sends out messages alerting providers about the implementation of ICD-10 and has developed a GEM fact sheet on the topic. To access the fact sheet, visit www.cms.hhs.gov/MLNProducts/downloads/ICD-10_GEM_factsheet.pdf.

ICD-10-CM (Diagnoses) Code Structure

ICD-10-CM is similar in many ways to ICD-9-CM: it has the same hierarchical structure and many of the same conventions, instructional notes and guidelines. It is entirely alphanumeric (all letters except "u" are used) and codes may be up to seven characters in length. The first three digits are the "category," the next three digits are the "etiology, anatomic site and severity," and the seventh digit is reserved as an "extension" for obstetrics, injuries and external causes of injuries.

ICD-10-CM has other differences in code structure. An "x" is used as a placeholder to save space for future expansion. Another change in ICD-10-CM is the use of extensions, which provide additional information under certain circumstances, such as conditions with a recently discovered etiology or new treatment protocol that has been reassigned to a more appropriate chapter.

Factors influencing health status and contact with health services (known as "V codes" in ICD-9-CM) and external causes of morbidity and mortality (known as "E codes" in ICD-9-CM) are considered part of the main classification in ICD-10-CM, not "supplementary" classifications.

ICD-10-CM also includes added standard definitions for two types of "excludes" notes. Excludes1 indicates not coded here. The code being excluded is never used with the code. The two conditions cannot occur together. Excludes2 indicates not included here. The excluded condition is not part of the condition represented by the code.

Injuries are grouped by body part, rather than category of injury. Codes for postoperative complications have been expanded and moved to the appropriate procedure-specific body system chapter, and a new concept of post-procedural

disorders has been added. Combination codes have been created for commonly occurring symptoms/diagnoses and etiologies/manifestations. The table on the right features examples of current ICD-9-CM codes and what they will be in 2013, if nothing changes in the next four years. There is national discussion on when to freeze ICD-9-CM and make no further updates in preparation for ICD-10-CM.

ICD-9-CM Code	Descriptor	ICD-10-CM Code
493.0x	Asthma	J45.909
466.0	Bronchitis, acute	J20.x
491.0	Bronchitis, chronic	J42
197.0	Cancer – Lung, metastatic	C34.xx
491.2	COPD	J44.9
786.09	Dyspnea	R06.00
327.23	Obstructive Sleep Apnea (adult) (pediatric)	G47.33
480.9	Pneumonia, viral	J12.9
482.9	Pneumonia	J18.9
995.92 & 785.52	Severe Sepsis with Septic Shock	R65.21
786.05	Shortness of Breath	R06.02

For Additional Information:

Centers for Medicare & Medicaid Services (CMS)
www.cms.hhs.gov/ICD10/
www.cms.hhs.gov/MLNProducts/downloads/ICD-10_GEM_factsheet.pdf

Q & A: Plethysmography

Q. My pulmonary group bills plethysmography with codes **97320**, along with **94260** and **94360-59**. They do an interpretation and report for each patient. Are these the appropriate codes? If not, what are the appropriate codes to bill for the plethysmography? Do you have any reference material on this topic?

A. To review the codes, the CPT **93720** global plethysmography (body box) code includes interpretation and report. **93721** would be reported if only the tracing (technical component) was performed. **93722** would be reported if only the interpretation and report were performed. This is different than other PFT codes that would be reported with -TC or -26 modifier. Note that the TGV **94260** code and the airway resistance code **94360** are each bundled with code **93720**.

The American College of Chest Physicians annually publishes *Coding for Chest Medicine*, which includes information about choosing among the multiple codes related to lung volume measurement.