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PULMONARY • CRITICAL CARE • SLEEP

Coding & Billing Quarterly

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Letter From the Editor

Physicians' mighty struggle to modify or, preferably, eliminate the flawed sustainable growth rate (SGR) continues! In November, Congress passed and President Obama signed a one-month fix until January 1, 2011. It is my strong hope, but not necessarily my expectation, that passing a year-long Medicare SGR fix will be one of the items Congress tackles in its lame duck session. Unless Congress acts, physicians will see a 25-percent cut in Medicare physician reimbursement beginning January 1, 2011.

While the percentage of cuts changes each year, the fact that Congress is once again waiting until the last minute—or even well after the last minute—to restore some fiscal sanity to the Medicare payment is tiring at best, and disheartening at worst. Physicians can't be expected to continue to provide quality care in the midst of prolonged fiscal uncertainty.

Although you are probably tired of hearing this, the most important thing healthcare providers can do is to continue hammering Congress to demand that they fix this mess, permanently!

We know the New Year will bring a number of changes in Medicare reimbursement. This issue of the *ATS Coding & Billing Quarterly* covers the final Medicare rule and its impact on pulmonary, critical care and sleep medicine, including:

- increased payments for pulmonary rehabilitation services;
- changes in Medicare reimbursement for sleep testing;
- new CPT codes for 2011; and
- a new Physician Quality Reporting System (formerly Physician Quality Reporting Initiative or PQRI) group measure for asthma.

Three Q & A's are added as a holiday bonus!

A happy holiday season to you all!

Sincerely,

Alan L. Plummer, MD
Editor



In This Issue

- 2011 CPT Codes, page 5
- Acoustic PFTs, page 5
- Asthma Measures Group, page 6
- Balloon Occlusion, page 4
- Bronchial Valves (CPT III), page 6
- CPAP Initiation and Management, page 1
- Critical Care, page 7
- PAR vs. Non-PAR vs. Opt-Out, page 3
- Six-minute Walk Test, page 7
- Sleep Medicine, pages 2, 3, 5

Coming in March

Physician Quality Reporting Update

CPAP Initiation and Management

Q. Can you provide any information regarding the billing for and the documentation of 94660 (CPAP initiation and management)? Specifically, does 94660 have to be performed by a physician or can a lay

person provide the service under the direct supervision of a physician?

A. CPT 94660 is an evaluation and management (E/M) service. We conferred with a WPS Medicare Contractor Medical Director, who said: "CPT 94660 can be billed 'incident to' a physician's service.

There is no requirement for the physician to be in the clinic. However, if another E/M is performed on the same day, the 94660 will be bundled into that E/M service. Also, the employee performing the CPAP initiation and management must have the skills required to perform the service, i.e., an RT, RN or NPP."

continued on page 7

CHANGES IN MEDICARE SLEEP REIMBURSEMENT

The family of sleep codes will see some reimbursement volatility in 2011 and beyond. There are four major forces impacting the family of sleep codes.

New CPT Codes for Unattended Sleep Studies

Starting January 1, 2011, providers can use the two new CPT codes for unattended sleep studies (95800, 95801). At press time, we still didn't know the Medicare payment for the new unattended sleep studies. The final rule, which discussed these news codes, contained significant data errors in the practice expense calculations for both of these codes. We are awaiting the Centers for Medicaid & Medicare Services' correction for both codes and will share this information as soon as it is available.

Work Values Reduced for Facility-Based PSGs

The physician work component for facility-based sleep studies (CPT 95807) and polysomnography (CPT 95808, 98510 and 95811) has been cut—ranging 20 to 25 percent. These physician work reductions will result in across-the-board cuts in interpretation only sleep codes reported with the modifier 26.

CMS Re-Bases Practice Expense Data

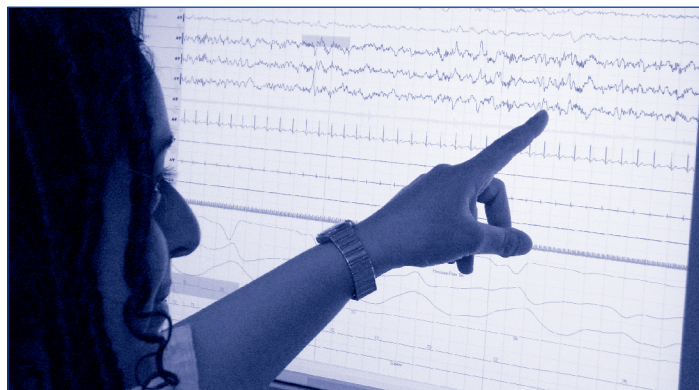
Due to the CMS re-basing of practice expense data, several sleep codes have seen an increase in the practice expense component of the code, as well as token increases in the malpractice component of the code. In many cases, but not all, the practice expense increases more than offset the loss in physician work. Due to the practice expense increases, all technical component only codes—those filed with TC modifier—will see a payment increase.

Practice Expense Increases are Temporary

The 2011 practice expense increases are temporary. Over the next four years, the CMS is transitioning to a new system for collecting and reimbursing practice expense costs that will impact the entire CPT system. For sleep codes, the practice expense component will be reduced seven to 20 percent, with codes having the largest practice expense values seeing the greatest reductions.

What's the bottom line for 2011? Technical component-only (TC) code reimbursements will go up. Interpretation only (26) codes will go down. For full services, providers will see increased payment for CPT codes 95803, 95805, 95806, 95807 and 95808, as well as small cuts for codes 95810 and 95811.

The accompanying table provides a summary of the 2011 Medicare reimbursement for sleep codes. Please note the



Courtesy of Imperial College London-Royal Brompton Hospital-UK

SLEEP CPT CODES				
CPT code*	Descriptor	2010 payment	2011 payment	\$ change
95800	Sleep study unattended	NA	†	N/A
95800-TC	Sleep study unattended	NA	†	N/A
95800-26	Sleep study unattended	NA	†	N/A
95801	Sleep study unattended w/anal	NA	†	N/A
95801-TC	Sleep study unattended w/anal	NA	†	N/A
95801-26	Sleep study unattended w/anal	NA	†	N/A
95803	Actigraphy testing	\$120.57	\$176.25	+\$55.68
95803-TC	Actigraphy testing	\$70.43	\$125.74	+\$55.31
95803-26	Actigraphy testing	\$50.15	\$50.52	+\$0.37
95805	Multiple sleep latency test	\$395.65	\$446.90	+\$51.25
95805-TC	Multiple sleep latency test	\$302.73	\$379.79	+\$77.06
95805-26	Multiple sleep latency test	\$92.92	\$67.11	-\$25.81
95806	Sleep study unattend & resp effort	\$204.28	\$198.38	-\$5.90
95806-TC	Sleep study unattend & resp effort	\$122.05	\$130.16	+\$8.11
95806-26	Sleep study unattend & resp effort	\$82.23	\$68.21	-\$14.02
95807	Sleep study attended	\$479.35	\$511.80	+\$32.45
95807-TC	Sleep study attended	\$397.86	\$443.21	+\$45.35
95807-26	Sleep study attended	\$81.49	\$68.58	-\$12.91
95808	Polysomn 1-3 channels	\$668.87	\$707.59	+\$38.72
95808-TC	Polysomn 1-3 channels	\$537.98	\$609.88	+\$71.90
95808-26	Polysomn 1-3 channels	\$130.90	\$97.71	-\$33.19
95810	Polysomnograph 4 or more	\$769.17	\$756.26	-\$12.91
95810-TC	Polysomnograph 4 or more	\$596.60	\$619.83	+\$23.23
95810-26	Polysomnograph 4 or more	\$172.57	\$136.43	-\$36.14
95811	Polysomnography w/cpap	\$848.08	\$816.00	-\$32.08
95811-TC	Polysomnography w/cpap	\$662.97	\$673.67	+\$10.70
95811-26	Polysomnography w/cpap	\$185.10	\$142.33	-\$42.77

*Note that all payment rates assume a 2010 Medicare conversion factor of \$36.8729 and are national payments that do not reflect geographic differences in payment.

† 2011 payments for CPT 95800 and 95801 pending corrections notice from CMS
continued on page 3

continued from page 2

reimbursement values in the table use the 2010 Medicare conversion factor. If Congress fails to address the sustainable growth rate formula, 2011 payment rate for all codes—including the sleep codes—will be 24.9 percent lower than shown in the table.

Why the change in physician work? The Medicare program is required by law periodically to review the relative value of the procedure codes in the Resource Based-Relative Value System used by Medicare and most other insurance payers. CPT **95810** was created in 1994 and CPT **95811** was established in 1998. When these two codes were first established, they captured the intensity of and time required to conduct polysomnography. The technical staff time, equipment and supplies needed to provide these services were evaluated in January 2002. Since then, the sleep community has developed many advances that allow polysomnography to be conducted and analyzed with less physician time, less sleep lab technician time and with lower practice expense costs. The CMS was aware of these efficiencies, and following establishment of reimbursement for unattended studies in the home setting, initiated steps to review and adjust the reimbursement for facility-based polysomnography services.

The ATS responded to this challenge by working with its sister sleep and respiratory societies and the CMS to review and refine polysomnography reimbursement comprehensively. The ATS Assembly on Sleep and Respiratory Neurobiology and the ATS Clinical Practice Committee, in collaboration with sister societies, collected data from physicians performing these studies on the time and intensity associated with facility-based polysomnography and gathered practice expense data and invoices to substantiate current costs. They then recommended that these recent data be used to calculate the revised payment rates for polysomnography. The reductions in polysomnography reimbursement that the CMS announced, while painful, accurately reflect the current time and costs associated with providing these specific procedures. The CMS reimbursement reflects its legal mandates to manage the physician fee schedule within the constraints of the relative value system and budget neutrality.

So what's next? While receiving news of a significant reduction in reimbursement for critically important, high volume diagnostic tests within the specialty is never pleasant, the ATS believes sleep medicine, as a clinical endeavor and business opportunity, will continue to remain strong. The Society, again in collaboration with its sister societies, recently developed additional codes for unattended home sleep studies (CPT **95800** and **95801**) that transitioned from CPT Category III codes **0203T**, **0204T**. These codes will be available to providers starting January 1, 2011, in

parallel with revisions in the existing codes **95806**. The ATS believes that, over time, the reductions in facility-based polysomnography services may be off-set by the expected growth in unattended sleep studies. The Society also believes that facility-based testing will continue to play an important role in the diagnosis of atypical and challenging patients suspected with sleep-related disorders.

The ATS will continue to advocate on behalf of its members for the CMS to address both academic aspirations and the clinical business realities of pulmonary, critical care and sleep medicine.

PULMONARY REHABILITATION

Medicare reimbursement for pulmonary rehabilitation services will increase in both the hospital outpatient and physician office setting. In the hospital outpatient department, the 2011 payment will be \$62.98 per session, an increase of 24 percent over the 2010 payment. In the physician office, the 2011 payment for **G0424** will be \$33.18, an increase of 38 percent. These reimbursement rates assumed a Medicare conversion factor of \$36.8729 for 2010 and 2011. Exact payment rates will vary slightly due to geographic costs adjustments.

The increase is a result of the successful efforts of the ATS and its sister organizations to convince the CMS to use physician work values and practice expense costs that accurately reflect the costs associated with providing pulmonary rehabilitation services.

MEDICARE PHYSICIAN PARTICIPATION OPTIONS

December is the month during which physicians should review their Medicare participation options for the coming year. With continued uncertainty in Medicare payment rates for 2011, understanding your participation options is even more important. Below is a brief description of the three Medicare physician participation options.

PAR

Participating physicians—also known as PAR physicians—agree to accept Medicare payments on assignment, meaning they accept the Medicare payment rate in full. PAR physicians do not have to accept all Medicare beneficiaries, but for those that they do treat, they must accept assignment.

There are two major incentives for PAR physicians:

- 1) Medicare payments to PAR providers are 5 percent higher than non-PAR payments; and
- 2) Medicare processes PAR claims more quickly than non-PAR claims.

continued on page 4

continued from page 3

Non-PAR

Non-participating or non-PAR physicians have the option of accepting Medicare assignment on a case-by-case basis, but that flexibility comes at a cost. Non-PAR physicians can only charge 95 percent of the Medicare-approved charge for assigned claims. So non-PAR physicians would only receive \$95 for providing the same service for which PAR physicians would be paid \$100 (\$80 from Medicare/\$20 from the patient co-pay). In cases where non-PAR providers do not accept Medicare assignment, they are allowed to charge 115 percent of the non-PAR rate—but keep in mind that they can only charge 115 percent on 95 percent of the Medicare-approved charge. In this example, non-PAR physicians could charge \$109.25 (1.15 x \$95) for the service they have provided.

The one major advantage for non-PAR providers is their ability to charge the maximum limiting charge—which is effectively 9.25 percent higher than the total PAR payment.

There are two major disadvantages for non-PAR providers. As noted above, their claims are not processed as quickly. In the case of unassigned claims, the Medicare payment is made directly to the patient—not to the physician. The physician’s office must collect the Medicare payment, the patient co-pay and additional limiting charge payments directly from the patient. Depending on the practice’s patient population and the efficiency of the practice’s billing staff, the additional collections cost associated with unassigned claims could be prohibitive.

According to the American Medical Association, if non-PAR providers charge and collect the full maximum allowed charge on more than 35 percent of the Medicare services they provide, they will have exceeded the 5 percent increased payment provided to PAR providers.

Participation Type	Total Payment	Patient/ Supplemental Co-Pay	Additional Patient Co-Pay	Medicare Payment to Physician
PAR	\$100	\$20	\$0	\$80
Non-PAR – assignment	\$95	\$19	\$0	\$76
Non-PAR non-assignment	\$109.25	\$19	\$90.25 (\$76 Medicare + \$14.25 patient maximum limiting payment)	\$0

Private Contracting

The third option is private contracting. In this scenario, physicians enter into private contracts with patients and essentially operate outside the Medicare system. Private contracting physicians agree to forego billing Medicare for any service for a minimum of two years.

NEW CPT CODES FOR 2011

BALLOON OCCLUSION

CPT code **31634** has been established to report bronchoscopy with balloon occlusion, with assessment of air leaks, and with the administration of an occlusive substance, if performed. This procedure had been performed in the past as a last effort to resolve persistent bronchopleural fistulas. It is becoming more common as an earlier therapy for this disease. Bronchoscopy with balloon occlusion may be performed in conjunction with navigational bronchoscopy procedures. Code **31634** includes fluoroscopic guidance, when performed, and the patient undergoes the procedure under moderate sedation, which is inherent in the procedure and not separately reportable. For removal of implanted bronchial valves, report **0251T**, **0252T**.

Category I

Surgery

Respiratory System

Trachea and Bronchi

Endoscopy

- ⊙ **31622** Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)
- ⊙ **31634** with balloon occlusion, with assessment of air leak, with administration of occlusive substance (eg fibrin glue), if performed
- 31635** Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of foreign body
(To report removal of implanted bronchial valves, see **0251T**, **0252T**)

Balloon Occlusion Clinical Vignette: (31634)

A 65-year-old male with pneumonia and respiratory failure on a mechanical ventilator develops a pneumothorax with a persistent air leak on the right side due to a bronchopleural fistula.

Description of procedure:

The patient is placed on supplemental oxygen in the bronchoscopy suite, which has resuscitative equipment in place. An IV is started and the physician supervises the nebulized administration of inhaled topical anesthesia. Second, the respiratory therapist (RT), registered nurse (RN) or non-physician provider (NPP) next administers local topical anesthesia to the pharynx and nasopharynx. The RT, RN or NPP then supervise administration of moderate sedation while a registered nurse, respiratory therapist or a non-physician provider (NPP) properly monitors the pulse, blood pressure, SpO₂, and ECG. The physician inserts the bronchoscope through the upper airways, noting any

continued on page 5

continued from page 4

abnormalities. The vocal cords and airways are visualized and the structure and function are noted. The patient undergoes a systematic balloon occlusion of the bronchial subsegments with measurements of the air leak after each occlusion and with the placement of glue or sealant, if performed.

UNATTENDED SLEEP-Transition 0203T, 0204T

Category I CPT codes **95800**, **95801** have been established for reporting unattended sleep study testing services. These codes appear in CPT 2011 out of numerical sequence, following **95806**.

95806 Sleep study, unattended, simultaneous recording of heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg thoracoabdominal movement)

(Do not report **95806** in conjunction with **93041-93227**, **93228**, **93229**, **93268-93272**, **95800**, **95801**)

●**#95800** Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (e.g., by airflow or peripheral arterial tone) and sleep time (do not report **95800** in conjunction with **93041-93227**, **93228**, **93229**, **93268-93272**, **95803**, **95806**, **95801**)

(For unattended sleep study that measures a minimum of heart rate, oxygen saturation and respiratory analysis, use **95801**)

●**#95801** Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation and respiratory analysis (eg by airflow or peripheral arterial tone)

(Do not report **95801** in conjunction with **93041-93227**, **93228**, **93229**, **93268-93272**, **95806**, **95800**)

(For an unattended sleep study that measures heart rate, oxygen saturation, respiratory analysis and sleep time, use **95800**)

Typical Patient (**95800**): A 55-year-old man with fatigue, prominent snoring, complaints of difficulty sleeping and who has a BMI of 33 is evaluated with an unattended sleep study.

Typical Patient (**95801**): A 55-year-old man with prominent snoring, excessive daytime sleepiness, whose wife reports he has nocturnal gasping and who has a BMI of 33 is evaluated with an unattended sleep study.

RIGHT HEART CATHETERIZATION

For Right Heart Catheterization, CPT **93501** has been deleted and replaced with:

93451 Right heart catheterization, including measurements of oxygen saturation and cardiac output, when performed

For 2011, a new ZZZ add-on code was created for a vasodilator trial performed in the context of a diagnostic

cardiac catheterization procedure (eg, code **93503**, Swan Ganz catheter insertion).

+**93463** Pharmacologic agent administration (eg inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent), including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed.

No code exists for the associated vasodilator study done in association with an E/M service. At present, report the vasodilator study done without the cardiac catheterization as an E/M service.

ACOUSTIC PFTs (CPT Category III Codes)

Two new CPT Category III codes have been established for reporting acoustic respiratory measurements for diagnosing wheeze or cough-related diseases. Two parenthetical notes have been added to **0243T** to report only once per 24 hour period and to not report both codes together for the same 24 hour period. The minimum threshold of 3 hours of continuous measurement is stipulated in the descriptor for **0244T**.

● **0243T** Intermittent measurement of wheeze rate for bronchodilator or bronchial-challenge diagnostic evaluation(s), with interpretation and report.

(Use **0243T** once per 24 hour period)

(Do not report **0243T**, in conjunction with **0244T** for the same 24-hour period)

● **0244T** Continuous measurement of wheeze rate during treatment assessment or during sleep for documentation of nocturnal wheeze and cough for diagnostic evaluation 3 to 24 hours, with interpretation and report.

Typical patient (0243T)

A 4-year-old boy presenting with shortness of breath during exercise. Spirometry flow/volume loop technically unsatisfactory due to inability to accomplish forced expiratory maneuver.

0243T Description of Work

Intermittent measurement of Wheeze Rate (Wz%) is a simple substitution for spirometry. The patient is connected to the acoustic monitor via two sensors; one placed on the trachea and one on the thorax. The patient is measured for Wz% for 2 to 3 minutes, and then administered a bronchodilator while measurement continues. A reduction in Wz% demonstrates bronchodilator response. Testing is accomplished by the physician or a trained technician. An alternative method is to use an acoustic monitor to intermittently measure Wheeze Rate before and after

continued on page 6

continued from page 5

administration of a bronchodilator or before and at each testing level of a bronchial-challenge test. The physician uses wheeze rate to interpret the test response.

Typical patient (0244T)

A 27-year-old male with a history of mild asthma and daytime hypersomnolence.

0244T Description of Work

When performing continuous measurement of Wheeze Rate, the patient is connected to the acoustic monitor via two sensors; one placed on the trachea and one on the thorax. The patient is monitored for the prescribed time (usually eight hours for a sleep evaluation). The physician analyzes the measured data and makes an interpretation.

BRONCHIAL VALVES (CPT Category III Codes)

Three new CPT Category III codes have been established for reporting bronchoscopic procedures for insertion, along with the basic bronchoscopy code **31622** or balloon occlusion code **31634**, and removal of bronchial valves.

⊕+ • **0250T** Airway sizing, and insertion of bronchial valve(s), each lobe (List separately in addition to code for primary procedure)

(Use **0250T** in conjunction with **31622**, **31634**)

⊕ • **0251T** Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe.

(Do not report **0251T** in conjunction with **31622-31626**, **31628-31631**, **31634-31636**, **31638-31646**)

⊕+ • **0252T** with removal of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure)

(Use **0252T** in conjunction with **0251T**)

Typical Patient (0250T)

A 65-year-old female with persistent air leak after a surgical resection. The leak has been isolated to one lobe.

0250T Description of Procedure

After the air leak is localized, a sizing balloon is inflated in the target airway to measure the size of the airway and is used to determine the appropriate bronchial valve size for the selected airway. An appropriately-sized bronchial valve is then loaded into a deployment catheter. The bronchoscope is advanced to the target bronchus and the deployment catheter, introduced via the working channel, is positioned in the target airway orifice under direct vision. The valve is then deployed. The catheter is removed from the bronchoscope and correct positioning of the bronchial valve is confirmed. The sizing,

loading and insertion steps are repeated for additional valve(s) inserted in appropriate subsegment(s) of a given lobe.

Typical Patient (0251T)

A 65-year-old female had endobronchial valve(s) placed in a single lobe for control of a persistent air leak. Removal of the valve(s) from one lobe is indicated.

0251T Description of Procedure

Bronchoscopy is performed to identify the target valve(s) and conditions affecting removal. Removal is accomplished by clearing any obstruction and using the appropriate forceps or other retrieval device introduced via the working channel of the bronchoscope and directed to the target valve. The removal rod on the bronchial valve is grasped using the forceps and the valve is gently pulled until it dislodges from the airway wall. The valve is pulled as close as possible to the end of the bronchoscope. The bronchoscope and valve are carefully withdrawn from the patient, with care taken to navigate the valve within the endotracheal tube or rigid bronchoscope to prevent dislodgment. Intubation is strongly recommended to avoid potential valve dislodgement at the vocal cords or in the posterior oropharynx. Intraoperative fluoroscopy may also be required to facilitate valve removal in some cases.

The process is repeated until all target valves are removed from one lobe.

Typical Patient (0252T)

A 65-year-old female had endobronchial valve(s) placed in more than one lobe for control of a persistent air leak. Removal of the valves from an additional lobe(s) is indicated.

0252T Description of Procedure

Add-on code for each additional lobe from which valve(s) are removed.

Tracking codes—including the most current listing and guidelines for Category III codes—are available on the CMS Web site at www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/category-iii-codes.shtml.

NEW ASTHMA MEASURES GROUP FOR 2011

In addition to changing the name for the program from Physician Quality Reporting Initiative (PQRI) to the new Physician Quality Reporting System, the CMS has added a new Asthma Measure Group for 2011, which is described below.

Asthma Measures Group

Applicable G-Codes for the Asthma Measures Group

continued on page 7

continued from page 6

G8645: I intend to report the Asthma Measures Group—reported on the very first claim form, not the first claim form for every patient.

Individual Asthma Performance Measures Included in the Asthma Measures Group

- **#53 Asthma: Pharmacologic Therapy**
- Percentage of patients aged 5 through 50 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.
- 4015F** Persistent asthma, preferred long-term control medication or acceptable alternative treatment prescribed AND
- 1038F** Persistent asthma (mild, moderate or severe)
 - **#64 Asthma Assessment**
 - Percentage of patients aged 5 through 50 years with a diagnosis of asthma who were evaluated during at least one office visit during the reporting period for the frequency (numeric) of daytime and nocturnal asthma symptoms.
- 1005F** Asthma symptoms evaluated (includes physician documentation of numeric frequency of symptoms or patient completion of an asthma assessment tool/survey/questionnaire)
 - **#231 Asthma: Tobacco Use Screening—Ambulatory Care Setting**
 - Percentage of patients aged 5 through 50 years with a diagnosis of asthma who were queried about tobacco use and exposure to secondhand smoke in their home environment at least once within 12 months.
- G8686** Currently a tobacco smoker or current exposure to secondhand smoke
- G8687** Currently a tobacco non-user and no exposure to secondhand smoke
- G8689** Tobacco use not assessed, reason not otherwise specified
 - **#232 Asthma: Tobacco Use Intervention—Ambulatory Care Setting**
 - Percentage of patients aged 5 through 50 years with a diagnosis of asthma who were identified as tobacco users (patients who currently use tobacco AND patients who do not currently use tobacco, but are exposed to second hand smoke in their home environment) who received tobacco cessation intervention within 12 months.
- 4000F** Tobacco use cessation intervention, counseling **or**
- 4001F** Tobacco use cessation intervention, pharmacologic therapy **and**

G8690 Current tobacco smoker or current exposure to secondhand smoke or

G8691 Current tobacco nonuser AND no exposure to secondhand smoke or

G8693 Tobacco use not assessed, reason not specified

Additional information on specifications for these and all other performance measures is available for download from www.cms.gov/pqri under “Code Measures.”

Q&A

continued from page 1

Six-Minute Walk PFT Testing

Q. The six-minute walk is performed twice in one day to determine if oxygen therapy is indicated. Medicare states they will only pay for one walk per day or one unit. To determine if the patient meets the criteria, oxygen saturation levels are performed while sitting or at rest. If the saturation is at 89 percent or above, a six-minute walk test is performed while wearing an oximeter and oxygen saturation levels are tracked. Without having to appeal every claim, how do we get the CMS to allow two walks in one day?

A. It is unlikely that the CMS would allow two six-minute walk tests in one day. For the scenario described, you could conduct and code for an oxygen titration study, which reimburses less than a six-minute walk test. Also, be aware that for patients in pulmonary rehabilitation, a six-minute walk test done to assess progress with therapy is bundled into the **G0424** code, and even a single study cannot be billed separately.

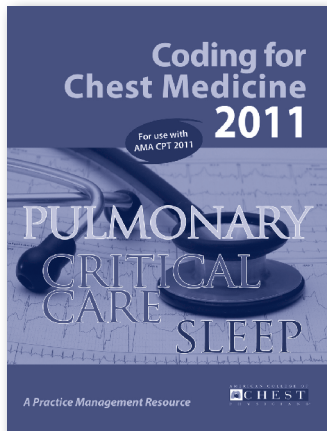
Critical Care

Q. Is there a Medicare rule/regulation regarding how many critical care codes billing per day are allowed per physician?

A. Critical care is a time-based service provided on an hourly or fraction of an hour basis. Payment should not be restricted to a fixed number of hours, a fixed number of physicians or a fixed number of days, on a per patient basis, for medically necessary critical care services. Time counted towards critical care services may be continuous or intermittent and aggregated in time increments (e.g., 50 minutes of continuous clock time or (5) 10 minute blocks of time spread over a given calendar date). Only one physician from a group may bill for critical care services during any one 24 hour period of time, even if more than one physician from that group provided care to a critically ill patient during that day. (Credit for each physician’s contribution to critical care can be done internally within the practice.)

Examples of critical care billing that may require further review could include claims from several physicians submitting multiple units of critical care for a single patient and submitting claims for more than 12 hours of critical care time by a physician for one or more patients on the same given calendar date.

ACCP CODING BOOK AVAILABLE TO ATS MEMBERS



The 2011 American College of Chest Physicians (ACCP) coding book is available to ATS members at the ACCP member price of \$125. This volume includes updated chapters on:

- Allergy and immunology
- Bronchoscopy
- Critical care
- Consultations
- Electronic medical records
- ICU procedures
- Malpractice issues
- Pay-for-performance
- Pulmonary function testing
- Pulmonary rehabilitation
- Rapid response teams
- Sleep medicine services
- Thoracic surgical procedures

Also included are discussions of new codes for 2011:

- Balloon occlusion
- Unattended sleep studies
- Bronchial valve insertion and removal
- Acoustic PFT, category III

To purchase the ACCP coding book, please call the ACCP member service line at (800) 343-2227 and tell them you are an ATS member and would like to purchase the book at the member price.

2010 ATS Coding & Billing Quarterly INDEX

ARTICLES	ISSUE	PAGE			
2011 CPT Codes	12/10	5	Fibrinolysis	4/10	1
Asthma Measures Group	12/10	6	ICD-9-CM for Air Trapping	7/10	4
Balloon Occlusion	12/10	4	ICD-9-CM for Upper Airway Resistance Syndrome	7/10	4
CPT Category III Codes			Lung Volumes and Diffusing Capacity PFTs	7/10	2
Acoustic PFTs	12/10	5	Mannitol Bronchial Challenge Testing	7/10	3
Bronchial Valves	12/10	6	Multiple Bronchoscopy	7/10	4
E-Prescribing (eRX) Update	4/10	1	Navigational Bronchoscopy	7/10	1, 2
ICD-9-CM Changes for Pulmonary, Critical Care and Sleep Medicine	9/10	2-4	Nitric Oxide Inhalation Challenge Test	7/10	3
Is PQRI Right for You?	4/10	2	No Deconditioning Diagnostic Code	9/10	1
Medicare Physician Participation Option	12/10	3	Omalizumab and E/M	7/10	2
Proposed Pulmonary Rehabilitation Payment Changes	9/10	4	Pediatric Pulmonary	7/10	4
Final Pulmonary Rehabilitation Payment Changes	12/10	3	Physician Supervision Requirements for PFTs	4/10	1, 6
Pulmonary Performance Measures	4/10	4-6	Pleural Plaques	9/10	4
Sleep Medicine	12/10	2, 3, 5	PQRI	7/10	3
			Removal of a Pleural Catheter is Unlisted	7/10	3
QUESTIONS & ANSWERS	ISSUE	PAGE	Six-Minute Walk Test	12/10	7
Bronchoscopy	7/10	4	Sleep: Medication Reconciliation	7/10	1
Bronchoscopy Risk Assessment	7/10	3	Therapeutic Bronchoscopy	7/10	4
CPAP Initiation and Management	12/10	1	Therapeutic Bronchoscopy: Initial and Subsequent	7/10	2
Critical Care	12/10	7	Thoracoscopy	7/10	3
ECMO Denials Same Group Providers	7/10	2	Ventilator Management	7/10	2, 3