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Letter from the Editor

Welcome to the July 2010 issue of the *ATS Coding & Billing Quarterly*. Physicians and other Medicare providers should be aware that July 1, 2010 is an important deadline for enrolling in Medicare Provider Enrollment, Chain and Ownership System (PECOS). Patient Protection and Affordable Care Act, all physicians who prescribe durable medical equipment or provide eligibility certifications for home health services were required to be enrolled in PECOS by July 1, 2010.

Providers can enroll in PECOS online at:

http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp.

In a proposed rule, the Centers for Medicare and Medicaid Services (CMS) has proposed expanding the PECOS enrollment requirement to all Medicare physicians—not just those who order DME or home health services.

At press time, the ATS was working with American Medical Association (AMA) and other concerned organizations to delay the PECOS enrollment deadline to January 3, 2011.

Because of the numerous billing and coding articles in past issues of this publication, we have not been able to publish many questions from our readers. This issue is dedicated to answering your questions, which range from sleep medicine and pulmonary function tests to bronchoscopic procedures and ventilator management. We have collected a series of questions submitted by our readers and asked our experts on billing and coding to answer them. Questions range from the basic to the highly technical, so I hope there is something for everyone in this issue. As always, please submit your billing and coding questions to us at codingquestions@thoracic.org.

Sincerely,

Alan L. Plummer, MD
Editor



Q&A

Sleep: Medication Reconciliation

Q. Is it really necessary to reconcile medications in the documentation of the medical record for a sleep patient?

A. It's a National Patient Safety goal, and it is supposed to be done with every patient encounter, including all office visits. Medication reconciliation is part of the vignettes or clinical examples for performing an evaluation and management service. It is clinically relevant because patient medications can potentially affect a patient's sleep and

ability to tolerate a mask or nasal pillows. It is important to assess the potential impact of medication(s) on the treatment plan. There is also a CMS Physician Quality Reporting Initiative (PQRI) performance measure on reconciliation of medications.

Navigational Bronchoscopy

Q. Can I report conscious sedation in addition to the navigational bronchoscopy code **31627**?

A. No, moderate (conscious) sedation is included in the navigational bronchoscopy

code **31627**, as evidenced by the bull's-eye symbol (⊙) in the CPT book before the code number.

Q. In 2010, is planning included in the new navigational bronchoscopy code, **31627**, or is the planning separately reported with the unlisted code **76499**?

A. Yes, planning is included in the new navigational bronchoscopy code, **31627**. A separate unlisted code is not reported for the planning phase of navigational bronchoscopy.

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A CPT descriptor may not describe all that is involved with a code. CPT guidelines are also important to review. Planning is clearly described as being part of navigational bronchoscopy on page 93 of the American Medical Association's 2010 CPT Changes book, which is published annually.

CPT **31627** includes importing computed tomography (CT) images of the lungs into a computer with special software to generate a 3D image for performing navigational bronchoscopy. In the planning phase, the physician marks the anatomical points and target lesion(s) on the virtual and CT images that are used to plan that path to guide the bronchoscopist to the target lesion. This may occur on a day different from the bronchoscopy. After moderate sedation is administered, the guide and steerable catheter are inserted together into the standard bronchoscope channel and CT images are used to navigate to the target areas. Endobronchial tools are inserted through the guide catheter to collect tissue samples, which are separately reported by the appropriate code (usually a biopsy).

By reporting planning separately with an unlisted code, one is likely to trigger an audit, since planning is included in the navigational bronchoscopy add-on code.

Lung Volumes and Diffusing Capacity PFTs

Q. I am new on my job. Hospital coders have told me that they cannot bill for the interpretation of lung volume measurements when spirometry is performed. They also tell me that the interpretation of diffusing capacity measurements cannot be billed when spirometry is performed. How should one bill for interpretation of a "complete PFT" spirometry, lung volumes and diffusing capacity measurements?

A. Your clinic coders are partially correct. The hospital bills for the technical component of the pulmonary function tests and the physician who interprets the tests bills for the professional components of the tests. The ATS and its sister organizations are currently developing a CPT code proposal for a bundled code for lung volumes airway resistance and diffusing capacity that hopefully will be approved for 2012. The CMS claims data found that more than 75 percent of the lung volumes and diffusing capacity codes are reported together for the same patient, on the same day. For more information, read Dr. Alan Plummer's diffusing capacity article in *Chest* (Plummer A. The carbon monoxide diffusing capacity (DLCO): Clinical Implications, Coding and Documentation. *Chest* 2008; 134:663-667).

ECMO Denials Same Group Providers

Q. We are having problems getting paid when one doctor does the first day of extracorporeal membrane oxygenation (ECMO), **33960**, and his partner does the additional 24 hours, **33961**, "each additional 24 hours" for the management of the extracorporeal membrane oxygenation (ECMO). Since they are partners, they file their claims under the same tax ID, so you would think the insurance company would realize the **33960** is on his partner's claims. However, they are denying **33961**, saying the add-on code was reported without the primary procedure. What would you suggest?

A. The usual practice is to bill everything under the name of the first provider and use internal accounting to recognize the billing of the second provider. According to the Medicare Claims Processing Manual, "Medicare payment policy states that physicians in the same group practice who are in the same specialty must bill and be paid as though each were the single physician" (refer to pub. 100-04, chapter 12, section 30.6.12I or visit www.cms.gov/manuals/downloads/clm104c12.pdf). This same situation comes up with other codes, such as critical care, for which more than one in a group might provide services. In other words, an add-on **ZZZ** code requires that the primary code be reported on the same claim form.

Omalizumab and E/M

Q. Our physician has hired a registered nurse to give omalizumab injections. He is under the impression that he can bill an office charge for that day because he is in the office. I thought that was only done for a physician assistant or nurse practitioner who saw the patient and gave the injection. The registered nurse or nurse practitioner is taking vitals and giving a brief exam, but because he or she can't make any medical decisions, I thought an office charge could not be billed unless the physician himself saw the patient.

A. This is akin to the physician billing an office visit simply for being in the vicinity when patients were coming in for flu shots. An office E/M code can be reported with modifier **25** (in addition to the administration code for omalizumab) only if a legitimate, medically necessary, separately documented (hence separately identifiable) E/M service was performed.

Therapeutic Bronchoscopy: Initial and Subsequent

Q. We are unable to find information from the American Medical Association regarding the intent of **31646**. Can you explain what CPT means by "subsequent?" Is this a bronchoscopy that is repeated after initial, same day or next, that involves further treatment, including aspiration or more extensive mucous removal?

A. The relationship between "initial" and "subsequent" is a clinical episode, such as a hospitalization. If you perform an initial therapeutic bronchoscopy for the first time today (**31645**) and then perform the procedure again the next day, you would report it as a subsequent therapeutic bronchoscopy (**31646**). If the patient has a prolonged hospitalization and the pulmonologist performs a therapeutic bronchoscopy many days later, it would still be reported as a subsequent therapeutic bronchoscopy.

The presumption would be that the assessment of the patient, review of the endobronchial anatomy, discussion of the procedure, etc., would require less physician work in the subsequent code.

Ventilator Management

Q. I work in a long-term acute care (LTACH) facility where there are full-time hospitalists. I manage the ventilators, seeing patients about two to three times per week. What is the appropriate code? Is it ventilation management, critical care or a follow-up visit?

A. If you are just managing the ventilator and not managing the patient, then the ventilator management codes would be appropriate. For the initial day in the hospital inpatient/observation unit, you would report CPT **94002**, and for each subsequent day, you would report CPT **94003**. In a nursing facility, CPT **94004** would be reported per day. Under certain circumstances, if you were present and the patient required active intervention, then you might justify critical care time, using CPT code **99291** for the first 30 to 74 minutes, and code **99292** for each additional 30 minutes. If you are managing other problems beyond ventilation, then you could, with proper documentation, use a follow-up visit code. With hospitalists taking care of the patients, the latter seems to be a problematic choice. Documentation is the key to using any of these codes.

Q. I remain confused as a pulmonologist on how to code for daily ventilator management. For example, a patient goes into acute respiratory failure in the emergency department due to congestive heart failure, is stabilized on the ventilator and sent to the ICU. The attending cardiologist requests that a pulmonologist follow the patient for ventilator management. The pulmonologist sees the patient daily for ventilator management only. Basically, there are several physicians handling various organ systems (i.e., renal, cardiology, neurology and infectious disease). Is it appropriate to bill a critical care service **99291** for daily management of the ventilator, even though the pulmonologist makes no changes in the overall treatment, except possibly adding nebulizers?

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A. Since the ventilator management codes became effective in CPT 2007, they have raised many questions. Note the parenthetical immediately after **94004** reads: “Do not report **94002-94004** in conjunction with Evaluation and Management services **99201-99499**.” In the description above, the pulmonary physician is simply providing ventilator management, so critical care coding is inappropriate. However, just because you are asked to manage a ventilator does not mean that you can’t code for critical care if you provide additional services. Critical care reporting requires documentation of time at the bedside and on the unit/floor. The services billed must match the care provided.

Physician Quality Reporting Initiative (PQRI)

Q. Do I report the performance measure code on every encounter? Do pulmonologists have to perform every individual measure in a measures group?

A. The answer is “yes” to both questions. To report the community-acquired pneumonia (CAP) measures group, each of the individual pneumonia performance measures (**#56-#59**) need to be performed.

The HCPCS code **G8546** is only reported on the very first claim. Its use informs the CMS that you intend to report the measures group. HCPCS code **G8550** is also reported on that first claim. After that, each claim is reported with **G8550** and without **G8546**.

Q. Could you define what it means to report three measures? Does each claim require three measures or is three measures the max? There are often times we are only reporting two measures on each claim (i.e., inquiry regarding tobacco and medication). Patients are not always older than 65 and often do not fall under any of the other guidelines.

A. Reporting three measures means reporting three overall performance measures over the course of the year, not reporting three measures on a single claim.

Thoracoscopy

Q. A patient has a thoroscopic biopsy performed, during which the patient has talc placed via an insufflator. The surgeon then uses the thoracoscope to assist in the placement of the talc. Is this reported as **32650** Thoracoscopy, surgical; with pleurodesis or **32560** Instillation; via chest tube/catheter, agent for pleurodesis (e.g., talc for recurrent or persistent pneumothorax)?

A. This is not **32560**. You describe two procedures: **32602**, diagnostic thoracoscopy with biopsy, and **32650**, surgical thoracoscopy with pleurodesis.

Report the higher procedure first and a **51** modifier on the second line to indicate both were performed during the same surgical session, i.e., **32650** (18.54 facility RVUs) and **32602-51** (9.38 facility RVUs at 50 percent). This means you would be reporting a total of 23.23 RVUs (18.54 + 4.69). The surgical thoracoscopy includes diagnostic thoracoscopy work, so the talc pleurodesis is the additional procedure.

Mannitol Bronchial Challenge Testing

Q. Since CPT does not designate any specific product for bronchial provocation to be used in conjunction with **94060**, would a new inhalation agent such as mannitol be appropriately reported with codes **94060**, **94070**, **94664** and **95071**?

A. That is a reasonable question since this agent (mannitol) is not specified in the code descriptors. Mannitol is used to provoke bronchospasm (bronchoconstriction), similar to methacholine challenge. **94070** describes the multiple spirometries associated with the challenge test and the parenthetical lists (e.g., cold air, methacholine).

Code **95070** is the nearest code for the administration of the bronchial challenge agent (this specifically excludes the spirometries, reported separately by **94070**).

95071 is for “other antigens or gases.” Since mannitol is neither an antigen nor a gas, use **95070**.

94060 is bronchodilator responsiveness with pre- and post-bronchodilator spirometry. **94664** should be reported for sputum induction. Neither would be used to code for provocation testing.

The proper coding would be **95070**, **94070** and the J code for mannitol, **J2150**.

Nitric Oxide Inhalation Challenge Test

Q. What is the most appropriate CPT code to use for a nitric oxide inhalational challenge test during a right heart catheterization? The purpose of the challenge is to test the effectiveness of nitric oxide in treating pulmonary hypertension patients. This does not seem to be included in the catheterization code **93501**. I have ruled out **95012**, which is exhaled nitric oxide, so I’m not sure where to go from here.

A. There is no code for this procedure. Inhaled nitric oxide has a code only for neonatal respiratory distress. Currently, diagnostic right heart catheterization does not have component codes or separate codes for vasodilator trials. Therefore, report the most appropriate code (e.g., **93501** or **93503**) if a Swan-Ganz catheter is used.

Removal of a Pleural Catheter is Unlisted

Q. Is the removal of a pleural catheter included in the insertion when performed by the same physician? Is this inclusive of an E/M service if performed by a physician other than the inserting physician? May the unlisted **32999** lungs/pleura code be reported to reflect this procedure? How is removal of a pleural catheter reported, if removal included incisional access and a combination of blunt and sharp techniques to release adhesions between the tissue in the hemithorax. The proximal portion was brought through a skin exit site with the distal portion removed from the hemithorax.

A. For 2010, there is a new code for removal of pleural catheter (in part recognizing that different physicians might place and remove the catheter). Report code **32552** for the removal of pleural catheter with cuff.

Bronchoscopy Risk Assessment

Q. We recently took over the internal audit process for our pulmonary specialists. I need to know if bronchoscopy should always be considered a high-risk endoscopic procedure or if I should look for identified risk factors like coagulation problems, anatomical anomalies, etc. I need to know so that I am counting the highest level of risk possible in the medical decision making (MDM) element. The National Institute of Health states that bronchoscopy is relatively safe, but I was wondering if there was some other source I could reference for level of risk that would always make bronchoscopy a high-risk procedure.

A. We don’t know of any risk assessment data on bronchoscopies. In general, a diagnostic bronchoscopy, **31622**, is a relatively safe procedure. A bronchial biopsy, **31625**, adds more risk, particularly if the patient is in renal failure (in this case, bleeding is risk, even with a normal coagulation screen). Bronchial alveola lavage (BAL), **31624**, and brushings, **31623**, also add an increased risk of bleeding, particularly in patients with low platelet counts, renal failure or coagulopathy. Transbronchial needle aspiration (TBNA), **31629**, increases the risk, as does a transbronchial lung biopsy (TBLBx), **31628**, after which a pneumothorax may occur. (The chance of this happening is less than 1 percent with fluoroscopy, but the incidence is higher if fluoroscopy is not used). Adding a second lobe for TBNA, **31633**, or TBLBx, **31632**, also increases the risks. **31640** or **31641** are much higher-risk procedures, particularly if done under moderate sedation, rather than general anesthesia. Therapeutic bronchoscopies, **31645** and **31646**, have higher risk than **31622**. Those bronchoscopies which are performed under general anesthesia (codes **31630**, **31636** and **31637**) have much higher risks than **31622**. Adding ultrasound, **31620**, also increases the risk somewhat due to the special bronchoscope that is usually used and the associated diagnostic sampling.

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Bronchoscopy

Q. My physician did a BAL from right-lower lobe (RLL) and TBLBx RLL and suctioned out “lots of thick yellow secretions from both endobronchial trees.” Is it proper to bill **31628**, **31624** and **31645**? Medicare doesn’t want modifier **51** on multiple procedures.

A. This is a fair question. Certainly one should bill the **31628** and **31624**. What it comes down to is the definition of a therapeutic bronchoscopy. Usually, therapeutic bronchoscopy stands alone as an intervention for copious secretions obstructing the airways. Suctioning secretions before any diagnostic bronchoscopy is included in the code.

Therapeutic Bronchoscopy

Q. Would you please help me determine what codes I would use based on the following documentation?

Procedures: Laryngoscopy, followed by bronchoscopy and tracheostomy tube change

Procedure detail: After preparation with 1 percent Lidocaine, an Olympus video bronchoscope was placed via the left naris into the proximal airway. There were copious amounts of secretions in the supraglottic area that were suctioned out. The vocal cords showed no abnormal motion or polyp. There was, however, extensive mucus on the vocal cords and in the subglottic area. One percent Lidocaine was utilized to anesthetize the vocal cords and the bronchoscope passed easily through the vocal cords. Again, aggressive suctioning was required to relieve extensive mucus plugging and obstruction of the subglottic airway proximal to the tracheostomy tube.

The scope was then removed from the naris and placed via the tracheostomy tube into the distal trachea. Again, suctioning was performed, relieving mucus plugging. The sutures were then removed from the size 10 Shiley tracheostomy tube and the tracheostomy tube was removed. An eight cuffless fenestrated tracheostomy tube was replaced over direct bronchoscopic visualization into the trachea. At the end of the procedure, the tracheal, both subglottic and supraglottic, secretions were cleared. The new tracheostomy tube was in place, in good position and functioning normally. There were no obvious complications during the procedure.

Please note that while, I am assuming this is a flexible diagnostic laryngoscope, I will be advising the physician to document further in future procedure notes.

A. **31645**, therapeutic bronchoscopy, would be the best code to use, as a bronchoscope, not a laryngoscope, was used. You cannot code for the tracheostomy tube change, but the work of the change could be included in an E/M service if it were provided on the same day.

Multiple Bronchoscopy

Q. I have a question in regards to multiple bronchoscopy billing. We have a patient that had a bronchoscopy that will code as follows:

31628	Transbronchial biopsy (RUL)
31623-51	Micro and cytology brushing
31624-51	BAL
31625-59	Endobronchial biopsy (LUL)

I am billing a Medicare Advantage Plan (Humana) for this service. Should I also be appending a **59** modifier to alert the insurer that a more extensive type of brushing was done in this procedure? Or do I not need the **51** modifier, and instead only report a **59** modifier?

A. A brushing through the bronchoscope can be done to collect material for culture with a protected brush and, more commonly, a brushing can be done for cytology to look for cancer. The latter uses a different brush than the protected brush, which is used to obtain culture material.

In the situation you describe above, you should use codes **31628**, **31625-59** and **31623**. No **51** modifiers are needed. The **59** modifier is necessary to unbundle the Medicare’s Correct Coding Initiative (CCI) between **31628** (also **31629**) and **31625**.

ICD-9-CM

Q. A fellow physician referred to “air trapping” as “abnormal findings that include evidence of air trapping by both flow volume loop and lung volume measurements and the drop in oxygen saturation with exercise.” In this case, what diagnosis code would I report?

A. There is no specific ICD-9-CM diagnosis code for air trapping. Normally, we would not be coding abnormal findings off a report, unless the physician documents its clinical significance or relevance—or if there is a more specific diagnosis to go along with the finding. For example, air trapping may be seen in obstructive lung diseases like asthma or COPD, so we would code the asthma or the COPD and not the air trapping. If it is necessary to code air trapping at all, use **518.89**. Other diseases of lung not elsewhere classified (NEC) could be used, since air trapping on its own may be clinically benign. However, if you wanted to code the fact that there was an abnormal finding on the pulmonary function test—without a specific diagnosis yet or another sign or symptom—then use **794.2**, which indicates non-specific abnormal results of pulmonary function tests.

ICD-9-CM for Upper Airway Resistance Syndrome

Q. Do you know what the correct diagnosis code for upper airway resistance syndrome would be? We performed a polysomnography (PSG) on a patient who didn’t have sleep apnea, but does have upper airway resistance syndrome. Her respiratory disturbance factor (RDI) is 12.7. What is the correct ICD-9-CM code?

A. You should consider several diagnosis codes. You could use **780.50**, for sleep disturbance, unspecified, or **780.59**, for other sleep disturbance. Some report **786.09** for snoring if the patient has UARS. Or you could report for an organic sleep disorder, not otherwise identified with code **327.8**.

Pediatric Pulmonology

Q. I am a pediatric pulmonologist who is questioning codes for pediatric bronchoscopies, as well as codes for treating kids who are chronically on a ventilator. When I do a bronchoscopy, I report **31624** (with BAL). If I obtain a BAL on both sides, I add a **50** modifier. I code this way whether I go nasally, orally or via endotracheal tube (ETT). Should or can I also code for evaluation of the trachea (**31615**) at the same time I code for a bronchoscopy? If the pediatric ICU requests a bronchoscopy to clear secretions (very commonly to remove mucous plugs) or I suck out plugs during the bronchoscopy without the request, can I also report code **31645**? And if so, am I obligated to add modifier **51** to the **31645**? My billing/coding department says no, that I can only code for the **31624** because this code is bundled and includes anything I would do during a typical bronchoscopy. I’m just not convinced that this is correct.

My second question is in regard to coding for children on chronic ventilatory support with a diagnosis of chronic respiratory failure. How should I properly code for outpatient visits that occur in our outpatient clinic (in cases where no home visits are made). In addition to my usual E/M code, can I use **94005** for home vent supervision, AND either **99374** or **99375** for home health care supervision at each visit?

A. Bronchoscopy is reported the same for kids as adults. We suggest you review Dr. Plummer’s article on bronchoscopy, which appeared in the September 2008 issue of the *ATS Coding & Billing Quarterly*. As for ventilator management, bill the E/M code, plus the home ventilator code, but only if you can provide documentation that you spent 30 minutes or more each month managing the ventilator while the child was at home. The home health management code only requires 15 minutes of documented physician time per month, so it is easier to achieve, but the reimbursement is less. In theory, one could bill both the home health and ventilator codes.