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Letter from the Editor

Once again, as the New Year approaches, the physician community is left wondering what Congress will do about the Medicare sustainable growth rate factor (SGR). The 2012 Medicare Physician Fee Schedule has been released and, as expected, calls for a 27.4-percent cut in physician reimbursement.

Watching Congress struggle with Medicare's SGR reminds me of the movie "Ground Hog Day," where protagonist Bill Murray is forced to relive the same day over and over again until he gets it right and learns valuable life lessons—and, as a reward, wins the affection of the female lead. Congress and the physician community seemed to be trapped in a similar script, where every year Congress waits until the last minute, or well beyond the last minute, to address the SGR. There are important differences between Congress and "Ground Hog Day." Watching Bill Murray is funny and entertaining. Watching Congress's failure to act is not. And while "Ground Hog Day" has a happy ending, we are still waiting for a permanent solution to the SGR crisis.

This issue of *ATS Coding & Billing Quarterly* includes information several areas of interest to ATS members, including four new CPT codes for reporting pulmonary function tests, two new CPT tracking codes for bronchial thermoplasty, a new CPT modifier for prevention services and new telehealth codes for smoking cessation services.

The issue also discusses the very concerning cuts in Medicare reimbursement for hospital outpatient pulmonary rehabilitation. The ATS and its sister organizations met with the Centers for Medicare and Medicaid Services (CMS) to discuss why we felt the CMS's recommendation was based on flawed data and how more reliable data could be collected and used to calculate reimbursement rates. We believe we provided the CMS with reasonable and responsible alternatives to calculate pulmonary rehabilitation reimbursement rates, but the CMS rejected all of our recommendations. The ATS is extremely upset and frustrated with this decision. These cuts are of great concern to the ATS and we will be working hard to restore reimbursement as soon as possible. However, the reality is that relief from the pulmonary rehabilitation cuts is not expected in the near future.

I hope the SGR and pulmonary rehabilitation cuts do not get in the way of a happy holiday season for all involved in the ATS community.

HAPPY HOLIDAY SEASON!

Sincerely,

Alan L. Plummer, MD
Editor





MEDICARE CUTS PULMONARY REHABILITATION REIMBURSEMENT

The Medicare final rule for the Hospital Outpatient Prospective Payments System included steep cuts in reimbursement for pulmonary rehabilitation. CMS finalized its proposal to cut reimbursement for pulmonary rehabilitation (**G0424** Pulmonary Rehabilitation for patients with COPD) from \$62 to \$38. Patients who have diseases other than COPD should be reported with the timed, 15 minute **G0237**, **G0238** codes or the group code, **G0239**.

The ATS believes CMS based its decision on faulty data. CMS based its decision on data collected from hospital cost reports. The hospital cost reports are problematic for a number of reasons. First, the cost reporting forms have undergone several format changes in recent years and hospital staff are still learning how to report accurately using the new format. Second, there is a significant learning curve in reporting the cost associated with new services—such as pulmonary rehabilitation (**G0424**). Lastly, CMS has 10-years of data from **G0237**, **G0238** and **G0239** that it could have used for calculating payments for **G0424**.

In our meetings with CMS, while CMS agreed that hospital cost report data is flawed, it rejected recommendations to consider alternative ways of collecting cost data and rejected our recommendation to use **G0237**, **G0238** and **G0239** data for calculating reimbursement rates.

The ATS and its sister organizations are very frustrated with the CMS decision and remain committed to ensuring appropriate payment for pulmonary rehabilitation services. We will continue to work with CMS, and if necessary Congress, to fix this situation.

NEW & DELETED PFT CODES

Starting on January 1, 2012, 10 CPT codes used to report pulmonary function tests will be replaced with four bundle codes for reporting PFT services. The Centers for Medicare and Medicaid Services (CMS) issued a directive to bundle the PFT codes through the AMA RUC process, due to the CMS's belief that PFT codes had duplicative reimbursement for pre-service and post-service times when billed together. As of the first of the year, all pulmonary function tests should be reported with the new CPT codes. Reimbursement will not be processed using the deleted codes.

The 10 deleted PFT codes are:

- (**93720-93722** Plethysmography codes have been deleted. To report, use **94726**)
- (**94240** Residual Lung Capacity has been deleted. To report see **94726**, **94727**)
- (**94260** Thoracic Gas Volume has been deleted. To report, see **94726**, **94727**)
- (**94350** Lung Nitrogen Washout Curve has been deleted. To report, see **94727**)
- (**94360** Measure Airflow Resistance has been deleted. To report, see **94726**, **94728**)
- (**94370** Breathe Airway Closing Volume has been deleted. To report, see **94727**)
- (**94720**, **94725** Diffusing Capacity codes have been deleted. To report, see **94729**)

CPT Code Descriptors for 4 New 2012 PFT Codes:

- 94726** Plethysmography for determination of lung volumes and, when performed, airway resistance (Do not report **94726** in conjunction with **94727**, **94728**)
- 94727** Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes (Do not report **94727** in conjunction with **94726**)
- 94728** Airway resistance by impulse oscillometry (Do not report **94728** in conjunction with **94010**, **94060**, **94070**, **94375**, **94726**)
- +94729** Diffusing capacity (eg, carbon monoxide, membrane) (List separately in addition to code for primary procedure) (Report **94729** in conjunction with **94010**, **94060**, **94070**, **94375**, **94726-94728**)

Pulmonary Function Test Crosswalks for 2012

| 2011 Deleted Code | 2011 Deleted Descriptor (Shortened) | 2012 New Code |
|-------------------|---|----------------|
| 93720 | Plethysmography, complete | 94726 |
| 93721 | Plethysmography, tracing | |
| 93722 | Plethysmography, interp& report | |
| 94240 | Functional residual capacity or residual volume: helium, nitrogen, or other | 94726 94727 |
| 94260 | Thoracic gas volume | 94726 94727 |
| 94350 | Determination of maldistribution of inspired gas: nitrogen or helium | 94727 |
| 94370 | Determination of airway closing volume, single breath tests | |
| 94360 | Determination of resistance to airflow, oscillatory or plethysmographic methods | 94726 94728 |
| 94720 | Carbon monoxide diffusing capacity (eg, single breath, steady state) | 94729 |
| 94725 | Membrane diffusion capacity | |

2012 NEW PFT INTRODUCTORY LANGUAGE

Remember, DLCO (94729) is an add-on code and cannot be used without reporting another PFT code, e.g., spirometry. Also, CPT changed the header for the PFT section of the CPT book to “Pulmonary Diagnostic Testing and Therapies.”

The new introductory language for codes 94010-94799 has been expanded substantially from the 2011 two sentences, where the only change was a “may” instead of “should” be reported in addition to an evaluation and management (E/M) code.

Additional language for remaining codes is defined and indicates that measurement of vital capacity (94150) is part of spirometry and only reported when performed alone.

Spirometry (94010, 94060) includes maximal breathing capacity (94200) and flow-volume loop (94375), when performed.

Measurement of lung volumes may be performed using plethysmography, helium dilution or nitrogen washout.

Plethysmography (94726) is utilized to determine total lung capacity, residual volume, functional residual capacity, and airway resistance.

Nitrogen washout or helium dilution (94727) may be used to measure lung volumes, distribution of ventilation and closing volume.

Impulse oscillometry (94728) assesses airway resistance and may be reported in addition to gas dilution techniques.

Spirometry (94010, 94060) and multiple spirometry measurements (94070) are not included in 94726 and 94727 and may be reported separately.

Diffusing capacity (+94729) is most commonly performed in conjunction with lung volumes or spirometry and is an add-on code to 94726-94728, 94010, 94060, 94070 and 94375.

Pulmonary function tests (94011-94013) are reported for measurements in infants and young children through two years of age.

Pulmonary function testing measurements are reported as actual values and as a percent of predicted values by age, gender, height, and race.

ICD-9-CM DIAGNOSIS CODES

ICD-9-CM coding revisions of possible relevance to ATS members, which went into effect on October 1, 2011, were listed in the September issue of the *ATS Coding & Billing Quarterly*. ICD-9-CM annual code revisions, known as addenda, are available on the National Center for Health Statistics (NCHS) Web site. When using diagnostic codes, be sure to use both the Diagnostic Index (www.cdc.gov/nchs/data/icd9/ICD-9-CMINDEXADDENDAfy12.pdf) and the Tabular List (www.cdc.gov/nchs/data/icd9/ICD-9-CM%20TABULARADDENDAfy12.pdf).

NEW CPT CATEGORY III TRACKING CODES FOR BRONCHIAL THERMOPLASTY

Two new bronchial thermoplasty tracking codes will be available in 2012. It is important that physicians and their staff members report tracking codes because they provide data to support ATS requests to transition procedures to CPT Category I codes, as well as having the codes subsequently valued and paid.

0276T Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe

0277T Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes

Highlights of the Medicare Physician Fee Schedule (MPFS)

The Centers for Medicare & Medicaid Services (CMS) displayed its Medicare Physician Fee Schedule final rule on 11/1/11 with a 60 day comment period, providing final decisions on 2012 payment policies for the Medicare Physician Fee Schedule.

27.4% Payment Reduction if Sustainable Growth Rate (SGR) is not Fixed

CY 2012 Identification and Review of Potentially Misvalued Services

Addressing Interim Final Relative Value Units (RVUs) from CY 2011, Proposed RVUs from CY 2012 and Establishing Interim RVUs for CY 2012

CY 2012 Final Work RVUs of Interest to Pulmonary

New CPT Modifier 33 for Preventive Services

New Telehealth Codes for Smoking Cessation and Critical Care Use of Telehealth Consultation G Codes

CY 2012 Interim/Interim Final Work RVU for New, Revised and Potentially Misvalued Code Decisions of Interest to Pulmonary

Direct PE Recommendations for CY 2012

Expanding the Multiple Procedure Payment Reduction (MPPR) Rule to the PC of Advanced Imaging Services:
There will be a 25% reduction for the 2nd and subsequent services when same physician (or group) performs them on the same patient on the same day. There is a concern that CMS may target future expansion of MPPR to pulmonary procedures and tests.

PQRS Update, eRx Update, New COPD and Sleep Apnea Measures Groups

NEW CPT MODIFIER FOR PREVENTIVE SERVICES

In response to the Affordable Care Act (ACA), health plans will begin covering preventive services without any cost sharing. Modifier **33** has been added to CPT to identify a service as preventive. If a CPT code descriptor identifies a code as preventive, such as preventive medicine counseling, the modifier should not be used.

NEW TELEHEALTH CODES FOR SMOKING CESSATION

CMS had extended its coverage of cessation counseling for all smokers. CMS has added CPT codes **99406** and **99407** to the list of telehealth services for CY 2012 on a category 1 basis. CMS finalized its proposal to add HCPCS codes **G0436** (Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than three minutes, up to 10 minutes) and **G0437** (Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes) to the list of telehealth services for CY 2012. Although not stated, the **99406**, **99407** are to be reported for patients with conditions affected (e.g., cough) by tobacco use, e.g., COPD.

EVALUATION & MANAGEMENT (E/M) CODING ERRORS

According to a new government Web site, www.paymentaccuracy.gov, for 2010, the total amount of improper Medicare payments for Fee-for Service was \$34.3 billion or 10.5% of total payments. The most common errors found by Medicare for improper coding are evaluation and management (E/M) codes, with the overutilization of **99214** when documentation supports **99213**.

The ATS recommends that you perform an internal audit to determine if you would withstand an external audit on reported **99214** E/M visits. The Society also recommends that your practice review E/M reporting for established patients in the outpatient setting to see if your practice's distribution across **99211-99215** matches medical necessity. Pulmonologists generally report all levels of the established outpatient visit E/M

PHYSICIAN QUALITY REPORTING SYSTEM (PQRS)

CMS had proposed to retain all 2011 measures for 2012 for consistency. These include 55 registry-only measures currently used in the 2011 PQRS, and 144 individual quality measures for either claims-based reporting or registry-based reporting.

- CMS did finalize the change to reduce the 80% reporting threshold to 50%.
- PQRS redefined Group Practice to include 25 or more individual eligible professionals who have reassigned their billing rights under one tax identification number (TIN). Group practice was previously defined as two or more individual eligible professionals.

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- The final rule **eliminated the six-month period for claims and registry based reporting of individual measures** reported in 2012. This will align the PQRS reporting periods with the electronic health record (EHR) reporting mechanism. The move will also retain the claims-based, registry and EHR-based reporting mechanisms for 2012 and beyond.
- CMS states that it will not post a list of qualified registries for the 2012 program year until the summer of 2012.
- **PENALTIES** termed “Payment Adjustments” by Medicare in **2015**: -1.5% or paid 98.5% of the MPFS allowed amount based on the January 1 to December 31, 2013 reporting year. **2016**: -2% or paid 98% of the MPFS allowed amount—nothing stated about this year until they decide on the proposal for the 2015 penalty.

NEW 2012 COPD AND SLEEP APNEA MEASURES GROUPS

Unique to PQRS measures groups, an “intent” to report a specific measures group G-code noted below must be reported one time on one claim.

G8546 I intend to report the Community-Acquired Pneumonia Measures Group

G8645 I intend to report the Asthma Measures Group

G8898 I intend to report the Chronic Obstructive Pulmonary Disease (COPD) Measures Group

G8900 I intend to report the Sleep Apnea Measures Group (Registry Only)

There are three participation strategies for satisfactorily reporting measures groups:

- 30 patient sample method for claims-based and registry-based submissions—12 month reporting only, starting January 1, 2012; or
- 50% patient sample method via claims; or
- 80% patient sample method via registry.

It is important to review the *2012 PQRS Getting Started with Measures Groups* available in the downloads section of the CMS Web site at www.cms.gov/pqrs.

COPD Measures Group (New for 2012)

Applicable G-Codes for the COPD Measures Group

- **G8898**: Report this code only once to notify CMS of your intention to participate in the COPD Measures Group.
 - o **ONLY report this code on the first claim submitted.**

- o The claim can only be for a patient >18 years of age, with ICD-9-CM COPD diagnosis codes **491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 496.**
- o The applicable CPT codes for the COPD Measures group are: New Patient **99201-99205**, Established Patient **99212-99215 (note this does not include 99211).**
- o Relevant diagnosis and CPT codes must be on the same claim as the applicable quality codes. Claims cannot be submitted to report missing quality codes.
- o **PQRS Measures in COPD Measures Group includes:**
 - #51 COPD: Spirometry Evaluation**
 - #52 COPD: Bronchodilator Therapy**
 - #110 Preventive Care and Screening: Influenza Immunization**
 - #111 Preventive Care and Screening: Pneumonia Vaccination (for patients 65 and older)**
 - #226 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention**

SLEEP APNEA MEASURES GROUP—REGISTRY ONLY (NEW FOR 2012)

- **G8900**: Report this code only once to notify CMS of your intention to participate in the Sleep Apnea Measures Group.
 - o **ONLY report this code on the first claim submitted via REGISTRY reporting only.**
 - o The claim can only be for a patient >18 years of age, with ICD-9-CM sleep apnea diagnosis codes **327.23, 780.51, 780.53, 780.57**
 - o The applicable CPT codes for the sleep apnea measures group are: New Patient **99201-99205**, Established Patient **99212-99215 (note this does not include 99211).**
 - o Relevant diagnosis and CPT codes must be on the same claim as the applicable quality codes. Claims cannot be submitted to report missing quality codes.
 - o **PQRS Measures in Sleep Apnea Measures Group includes:**
 - #276 Sleep Apnea: Assessment of Sleep Symptoms**
 - #277 Sleep Apnea: Severity Assessment at Initial Diagnosis**
 - #278 Sleep Apnea: Positive Airway Pressure Therapy Prescribed**
 - #279 Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy**

ELECTRONIC PRESCRIBING (eRx)

CMS finalized the proposed criteria for individual eligible professionals to be successful electronic prescribers for the purposes of the 2013 and 2014 payment adjustments. These are similar to criteria for the previous two years. Specifically, for purposes of the 2013 payment adjustment, an individual eligible professional is a successful electronic prescriber if an eligible professional reports the electronic prescribing measure's numerator at least 10 times during the six-month 2013 payment adjustment reporting period (that is, January 1, 2012 through June 30, 2012, regardless of whether the encounter is associated with at least one denominator code of the electronic prescribing measure).

For purposes of the 2014 payment adjustment, an eligible professional is a successful electronic prescriber if: (1) an eligible professional reports that at least one prescription for Medicare Part B PFS patients created during an encounter was generated and transmitted electronically using a qualified electronic prescribing system for at least 25 denominator-eligible visits during the 12-month payment adjustment reporting period (that is, January 1, 2012 through December 31, 2012) (note that this is the same criteria for the 2013 incentive); or (2) an eligible professional reports the electronic prescribing measure's numerator at least 10 times during the six-month payment adjustment reporting period (that is, January 1, 2013 through June 30, 2013).

The applicable electronic prescribing percent for **incentive** payments under the eRx Incentive Program are as follows:

- o 1.0 percent for 2011
- o 1.0 percent for 2012
- o 0.5 percent for 2013

Payment adjustments (i.e., **PENALTIES**) under the eRx Incentive Program are as follows:

- o -1.0 percent in 2012
- o -1.5 percent in 2013
- o -2.0 percent in 2014

Additional Points of Interest (Revalidation of Medicare Enrollment using PECOs Required; Updated Version of ABN Required for 2012)

- CMS is requiring physicians and providers to revalidate their enrollment to Medicare through PECOS.
- In May 2011, CMS released an updated version of the Advance Beneficiary Notice of Noncoverage (ABN) (form CMS-R-131), which will replace the 2008 version. The 2011 version contains no substantive changes from the 2008 version of the notice and was approved by the Office of Management and Budget. The 2008 and 2011 ABN notices are identical except that the release date of "3/11" is printed in the lower left hand corner of the new version. Because of an OMB regulation regarding the revision of forms, beginning Jan 1, 2012, physicians, providers, and suppliers must begin using the 2011 version. ABNs issued after January 1, 2012 that are prepared using the 2008 version of the notice will be considered invalid by Medicare contractors.

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