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Coding & Billing Quarterly

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Letter from the Editor

Welcome to the July 2011 issue of the *ATS Coding & Billing Quarterly*. We sincerely hope that ATS members and their staff members did not miss the June 30 deadline for transmitting 10 unique prescriptions through electronic prescribing (eRx). If your practice did not participate in eRx by June 30, then you will be facing a 1-percent penalty for all Medicare patients seen in the practice for 2012. To avoid a 1.5 percent-penalty for 2013, an eligible physician must have 25 unique eRx events transmitted by December 31, 2011. If you are not already participating in the eRx incentive program, it is a good idea to familiarize yourself and your staff members with it and decide if it is appropriate for your practice. For more information about this, please see page 4 of the March 2011 issue of the *CBQ*.



This issue includes an article on how to calculate your Medicare payments and provides the URL to section of the Centers for Medicare & Medicaid Services' (CMS) Web site where you can query how much Medicare will pay for specific procedures in your geographic area, as well as the formula inputs for calculating these values on your own. In addition, we have answered several reader questions covering a wide range of topics. We hope this information is helpful to you and your practice staff. Please share this and the archived issues of the *ATS Coding & Billing Quarterly* with your administrative staff and provide them with the link where they can access it online: www.thoracic.org/clinical/coding-and-billing/index.php.

If you have questions on coding, billing or regulatory compliance, please send an e-mail to codingquestions@thoracic.org. We would be happy to respond.

Sincerely,

Alan L. Plummer, MD
Editor

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Q&A

Multiple Bronchoscopies

Q. When performing multiple biopsies during a transbronchial needle aspiration (TBNA), how many times may we report **31629** and **31633**?

A. Code **31629**, Bronchoscopy, rigid or flexible, including fluoroscopic guidance,

when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i) for a TBNA, is reported only once for upper airway biopsies, regardless of how many TBNA biopsies are performed in the upper airway or in a lobe. Code **31633**, Bronchoscopy, rigid or flexible, including fluoroscopic

guidance, when performed; with transbronchial needle aspiration biopsy(s), each additional lobe—list separately, in addition to the code for the primary procedure—is reported for TBNA biopsies performed on additional lobes. This was published in the April 2011 issue of the *AMA CPT Assistant* on page 12. Please also

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2011 PAYMENTS: THE GOOD, THE BAD & THE UGLY

During 2010, Congress passed five different bills that averted the 25-percent reduction in Medicare payments that was scheduled to go into effect on January 1, 2011. The reduction was scheduled because of a flawed sustainable growth rate (SGR), which has been in force since 1997. On December 15, 2010, the Medicare and Medicaid Extenders Act (MMEA) negated the 25-percent reduction and proscribed a 0-percent update in 2011. One would have thought that the conversion factor (CF), which converts RBRVS RVUs into dollars, would have remained at \$36.8729 (2010) for 2011. Wrong! The CMS elected to rebase the practice expenses (PE) and professional liability insurance (PLI), which resulted in a drop in CF of nearly \$3 (\$33.9764, *see table 1*). The Medicare Economic Index (MEI) used in the calculations was rebased from 2000 to 2006, which increased the values of PE and PLI.



inpatient bronchoscopies (\$0.70-\$5.40); and inpatient procedures (\$0.80-\$2.74).

The ugly effects were seen in the markedly reduced payments for sleep studies, particularly the polysomnography codes **95810** and **95811**. All the sleep codes were surveyed by the RUC in 2010. The surveyees felt that physician work had decreased primarily due to technological

improvements in sleep measurements and reporting. This resulted in decreases in payments for interpretations for all sleep codes, **95803-95811** (\$3.26-\$53.95). The payments for the TC of **95810** and **95811** decreased \$27.84 and \$44.94, resulting in a severe decrease in payments, \$75.03 & \$90.90, for these codes. The decreases in payments for **95806-95808** were \$9.46-\$19.37, which was less than seen in **95810, 95811** because of the increase in TC payments for these codes. Even though payments for sleep codes went down, it was felt the decreases for 2011 could have been much worse!

Because of the payment changes outlined above, the pulmonary physician's payments are projected to decrease overall by 1 percent in 2011. Those pulmonologists whose practices are mainly in the outpatient arena may see increases in payments, as most of the outpatient codes have increased payments. Those hospital-based pulmonologists and critical care specialists likely will see decreased payments because of the lower reimbursement for inpatient codes. Sleep physicians may see a decrease in overall payments whether they only interpret sleep studies or work in sleep labs, although the impact of the payments for unattended sleep studies may offset part or all of these projected decreases.

Finally, payments for practice expenses are scheduled to decrease each year for the next three years, 2012-2014, due to the rebasing of payments. The CMS feels that they are paying more than they should now, but will gently correct that over the next three years. Isn't that nice of them?

MEDICARE PAYMENTS FOR THE SAME PROCEDURE DIFFER BASED ON PRACTICE LOCATION

Medicare reimbursement levels vary widely based on where your practice is located. Medicare determines these levels based on several inputs into a complicated formula.

The CMS's Physician Fee Schedule Search Web Site (www.cms.gov/apps/physician-fee-schedule/overview.aspx) allows you to search for payment values for individual

TABLE 1

December 2010 CF	\$36.8729
MMEA Zero % Update	0.0 (1.0000)
CY 2011 RVU Budge Neutral Adjustment	0.43% (1.0043)
CY 2011 MEI Rescaling	-8.3% (0.9175)
CY 2011 CF	\$33.9764

In order to preserve budget neutrality, the positive effects of the rebasing on PE and PLI had to be decreased by 8.3 percent, resulting in a 7.86-percent decrease of the CF.

The good effects were seen in increases in payments for outpatient new patients (\$2.37-\$3.02), outpatient return visits (\$2.23-\$2.65), outpatient bronchoscopies (\$3.13-\$15.02), outpatient procedures (\$0.62-\$31.30) and inpatient new patient **99222** (\$0.17), and second day pleurolysis **32552** (\$1.35). Two new codes for unattended sleep studies were added: **95800** (modifier **26**—\$58, TC -\$208) and **95801** (modifier **26**—\$51, TC-\$97). There were increases in technical component (TC) payments for sleep codes **95803, 95805, 95807** and **95808** (\$8.84-\$45.87).

The bad effects were seen with modest decreases in payments for inpatient new patients, **99221** and **99223**, (\$0.17 and \$0.31); inpatient subsequent visits, **99231-99233**, (\$0.33-\$1.11); critical care, **99291** and **99292**, (\$3.76 and \$1.56);

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codes, as well as for all of the factors/inputs needed to derive the payment value. Using this site, you can search your practice's specific reimbursement amount for most services, including payments for modifiers **26** and **TC**. To determine your own specific reimbursement rate for a procedure, search for a specific CPT code (e.g., **99214** for an established patient) and then find your specific carrier locality number to produce accurate resulting Medicare pricing. Alternately, you can also find this information on your local carrier's Web site. For example, TrailBlazer (www.trailblazerhealth.com) has a querying tool under fee schedules in its quick links menu bar.

The range of reimbursement rates for **94060**, Evaluation of Wheezing, is a good example of how widely reimbursement levels vary. The national non-facility reimbursement rate for **94060** is \$60.82. The non-facility reimbursement ranges from a low of \$52.62 for practices in Puerto Rico to a high of \$82.07 in San Mateo County, California, in the San Francisco Bay area.

The formula that the CMS uses for determining Medicare payments consists of three parts: physician work, practice expense and malpractice risk. Each portion is expressed as a relative value unit or RVU, modified by Geographic Practice Cost Index (GPCI) to account for your practice's location and then multiplied by a conversion factor (CF), which for 2011 is \$33.9764.

The GPCI is the factor that causes reimbursement to vary for the same service across different parts of the country. The GPCI for physician work is derived from data on varying levels of professional wages from the Bureau of Labor by location. The GPCI for practice expense is determined by the varying costs for operating a practice (employee wages,

office rent, equipment, supplies and other fees). The GPCI for malpractice is determined by geographic differences in practice liability and differences in malpractice insurance premiums by specialty, insurer and territory.

Hopefully, your practice will find the Physician Fee Schedule Search Web Site useful for both budgeting, as well as for determining which services it will provide in the future by reviewing and comparing the costs per procedure to Medicare reimbursement per procedure.

PQRS Web Address Changed

On April 12, the Centers for Medicare & Medicaid Services announced that the Physician Quality Reporting System (PQRS) Web address had been revised. In its 2011 final physician fee schedule rule for Medicare, the CMS indicated that the Physician Quality Reporting Initiative (PQRI) would be renamed the Physician Quality Reporting System. As a result of the name change, the URL at which PQRS can be accessed has also changed. The new URL is www.cms.gov/pqrs. The old Web address still forwards you to the new page.

Educational materials and content that currently refer to PQRI will be revised over time to reflect the new name as well. The PQRS Web page will be updated regularly, so check it often for timely and reliable information from the CMS. To receive important information on PQRS and the Electronic Prescribing (eRx) Incentive Program, subscribe to the Medicare fee-for-service physician listserv at <https://list.nih.gov/cgi-bin/wa.exe?A0=physicians-l>.

Q&A

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refer to the TBNA zones Q & A, which was published in the July 2009 issue of the *ATS Coding & Billing Quarterly*.

Coding Certifications

Q. What training and certifications should my coding and billing staff have so that my practice has more accurate coding and more efficient reimbursement?

A. There are two prominent and nationally recognized coding certification organizations—the American Health Information Management Association (AHIMA) and the American Academy of

Professional Coders (AAPC). For more information on the certifications that can be obtained, please visit www.ahima.org or www.aapc.com.

PQRS

Q. The physicians in our practice are all participating in the Physician Quality Research System (PQRS). Some of them are only filing the minimum amount of individual measures. For a Medicare patient to count toward the requirements for the PQRS incentive payment, does the physician need to perform the minimum number of individual measures on each

of those patients? Or can a patient still be counted for an individual measure, even if he or she only had one measure performed on them?

A. A physician needs to perform and report on a minimum number of three individual measures during the reporting period. If a patient only has one individual measure, that measure can still count toward your incentive payment. The amount of measures needed to receive a PQRS incentive payment is based on the overall amount of individual measures performed on all the eligible patients. The physician does not have to perform

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all selected individual measures on each individual patient.

To qualify for the PQRS incentive when using claims-based reporting, the correct PQRS quality data code must be reported on at least 50 percent of the claims that are eligible for each selected measure. Eligibility is based on the appropriate ICD-9-CM diagnosis and CPT service/procedure code provided on the CMS specifications document and reported on the same claim. A practice cannot resubmit a claim just to add a quality data code.

Q. We are struggling to identify appropriate PQRS measures to report in our sleep medicine practice. The only measure we have identified is #128 Body Mass Index (BMI) Screening and Follow-Up. Can you help us find two other appropriate measures to report for our practice?

A. According to staff from the CMS contractor for PQRS questions, your practice should consider measures #130 Documentation of Current Medications in the Medical Record and #226 Tobacco Use Screening and Cessation Intervention (the latter of which has combined 2010 measures #114 and #115). Learn more about the CMS's PQRS specifications at www.cms.gov/pqrs/downloads/2011_PhysQualRptg_MeasureSpecificationsManual_033111.pdf?agree=yes&next=Accept. We recommend that the physician and involved practice staff read the three to five-page document for each measure. The March 2011 issue of the *ATS Coding & Billing Quarterly* featured information on quality reporting. To download this issue, please visit www.thoracic.org/clinical/coding-and-billing/resources/2011/march-2011.pdf.

CPT Category III Tracking Codes

Q. What is the benefit to my practice for reporting CPT Category III tracking codes? Since they are not reimbursed, they do not count toward any type of Medicare

incentive program and you are not penalized by Medicare for not reporting them.

A. CPT Category III codes are temporary tracking codes that represent new and emerging technologies, procedures and services. They are used to determine utilization rates of the underlying technology, service or procedure. Though Medicare does not currently reimburse your practice for category III codes, reporting them will increase the likelihood that the technology/service/procedure will become a category I code. If you believe a new and emerging technology/service/procedure increases your practices efficiency and/or quality of care, then it is in your practice's interest to report the CPT Category III codes. There are five new CPT Category III tracking codes for 2011: two acoustic PFT codes, **0243T** and **0244T**, and three new bronchial valve codes, **0250T-0252T**.

Critical Care Analysis of Data

Q. Can I report **99090** to bill for analysis of data by a physician for a patient who is in critical care?

A. Analysis of clinical data stored on computers (**99090**) is one of the several codes that are bundled with the critical care service codes (**99291, 99292**). If a physician is analyzing, for example, a patient's ECG results while that patient is in critical care, then you cannot report **99090** in addition to the critical care service codes, as those codes already include the work of **99090**.

Bronchoscopy

Q. Can you confirm whether or not **31636**, Bronchoscopy: Bronch Stents, and **31641**, Bronchoscopy: Treat Blockage, can be billed together for the same patient on the same day?

A. Both of these stand alone bronchoscopy codes can be reported together, according to several interventionalists to whom we forwarded this question. Also, there are no 2011 Medicare National Correct Coding

Initiative (NCCI) edits for these codes when reported together.

Q. If a physician performs a nasopharyngoscopy, **92511**, in addition to a bronchoscopy with a biopsy, **31625**, can the nasopharyngoscopy be billed separately?

A. Code **92511**, nasopharyngoscopy, cannot be reported with any bronchoscopy procedure. When the bronchoscope is inserted through the upper airway into the trachea, nasopharyngoscopy is inherently included in the bronchoscopy procedure. While performing a bronchoscopy, a physician is already able to examine the inner surfaces of the nose and throat, so billing for both procedures would be duplicative. For your specific example, we recommend that you only report **31625**.

Documentation

Q. Do you have any guidance as to what constitutes an appropriate note when the physician sees a patient with the assistance of a mid-level practitioner who writes the actual hospital note? How much should the physician write on the chart or document in the electronic medical record (EMR) to document that he/she was the actual provider of service, rather than the MLP who can only bill at 85 percent of the physician fee?

A. What you are describing is a classic split/shared service. Our recommendation is to write (and sign) something just like a teaching physician addendum, i.e., "Seen, examined and agree—element of history, element of exam, element of decision-making." This one sentence would cover even the most restrictive of policies and interpretations.

Modifier 53 Discontinued Procedure

Q. If a procedure has to be aborted prematurely due to complications, are we able to still bill Medicare for the service?

A. The answer to this question depends on whether the procedure requires anesthesia

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and in what setting it takes place. Consider these examples:

Procedure requires anesthesia and is performed in an outpatient hospital setting or an ambulatory surgical center: If the service requires anesthesia, and is discontinued before anesthesia is administered, then you should report the CPT code along with the modifier **73** (discontinued outpatient procedure prior to administration of anesthesia). If the procedure is discontinued after anesthesia is administered, then the CPT code should be reported with modifier **74** (discontinued outpatient procedure after administration of anesthesia).

All Other Surgical and Diagnostic Procedures: The CPT code for the procedure should be reported along

with the modifier **53** (discontinued procedure). When submitting a claim with a discontinued procedure, submit the claim as you would normally, and append with the **53** modifier. The payer will determine what the payment will be based on how much of the procedure was performed before it was aborted.

Sleep

Q. The doctor read a sleep study in June 2010 and we billed for the first and second night. He is not board-certified in sleep. We understand the rules went into effect in January 2011. Medicare is not paying for the patient's CPAP machine. Do I need to refund the money to Medicare and then have a board-certified doctor read the sleep study, so that the DME company can be paid for providing the machine?

A. First, check the individual policy for your state—because the rules did not all go into effect at the same time. Why are you billing for the first and second night? A sleep test that begins on day one and lasts until day two is only billed once on the day completed (for the technical component). The physician bills the professional component on the date it was performed, which may or may not be the same date the test was performed. Take a look at the Medicare transmittal at www.cms.gov/transmittals/downloads/R1873CP.pdf.

I would refund the money and ask the DME contractor how to proceed. Many times, there will be a DME question-and-answer section on the Medicare Web site for your state that indicates how to clear up issues like these. Look for this first. Below is a table that lists DME contractors and medical directors.

DME Contractor	States Covered	DME Medical Director
CIGNA Government Services (18003, DME MAC) 2 Vantage Way - Metro Center Nashville, TN 37228	AL, AR, CO, FL, GA, LA, MS, NM, NC, OK, PR, SC, TN, TX, VI, VA, WV	Robert D. Hoover, Jr., MD, MPH, FACP
National Government Services, Inc. (17003, DME MAC) PO Box 6036 Indianapolis, IN 46206-6036	IL, IN, KY, MI, MN, OH, WI	Stacey Brennan, MD
NHIC, Corp. (16003, DME MAC) 75 Sgt. William B. Terry Drive Hingham, MA 02043	CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI, VT	Paul J. Hughes, MD
Noridian Administrative Services (19003, DME MAC) PO Box 6727 900 42nd Street South Fargo, ND 58108-6727	AK, AS, AZ, CA, GU, HI, ID, IA, KS, MO, MT, NE, NV, ND, CNMI, OR, SD, UT, WA, WY	Richard W. Whitten, MD, MBA