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Coding & Billing Quarterly

MARCH 2011

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Letter from the Editor

The March issue of the *ATS Coding & Billing Quarterly* addresses the various bonus payments—and looming payment penalties—for participating in the Medicare quality improvement programs. Congress has created incentive payments for providers to report quality data and to adopt electronic health records, electronic prescribing and maintenance of certification programs. These various programs all use the “carrot and stick” approach, providing incentive payments for earlier adoption and levying penalties for failure to participate by certain dates. If you are not already participating in these incentive payment programs, now might be a good time to become familiar with them and decide if they are right for your practice.

With the Centers for Medicare & Medicaid Services (CMS) finally issuing the Medicare rule corrections notice and Congress finally addressed the Medicare conversion factor for 2011, we can now share with you the corrected payment rates for sleep codes. Please note your actual payment will vary somewhat due to geographic payment adjustments. If you have questions on coding, billing or regulatory compliance, please contact us at codingquestions@thoracic.org. We would be happy to respond to your questions.



Sincerely,

Alan L. Plummer, MD
Editor

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Q&A

BRONCHOSCOPY

Q. When an endobronchial biopsy (31625) is performed in addition to a transbronchial biopsy (31628), we get an edit stating that 31625 is a component of 31628. When would it be appropriate to add a modifier 59? Would a modifier be appropriate when the two biopsies are from separate lobes? Would a modifier be appropriate when the two biopsies are from different lesions of the same lobe?

A. The bronchial biopsy requires a 59 modifier. The biopsy of the bronchus

and the transbronchial lung biopsy must be from different lobes in order to report both, 31628, 31625-59. If the bronchial biopsy is from the same lobe as the TBLBx, one cannot charge for the bronchial biopsy, and can only charge for the TBLBx, 31628.

Q. What should I code if the pulmonologist performs multiple bronchial biopsies in one lobe; multiple bronchial biopsies in two lobes on the same side (right or left); multiple bronchial biopsies on two lobes on different lungs (right and left)?

A. You should code 31625 for one or more bronchial biopsies in one lobe or another lobe in the same lung.

OMALIZUMAB

Q. What are the appropriate codes to report for Xolair injections? We are currently billing CPT 96372 and usually administer two to three injections at a time. I am receiving feedback from other clinics stating they bill CPT 96401. Can you tell me if CPT 96401 is appropriate for us to bill?

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2011 PHYSICIAN QUALITY REPORTING SYSTEM

In 2006, Congress directed CMS to create the Physician Quality Reporting Initiative or PQRI as a tool for participating providers to report on approved quality of care measures for Medicare beneficiaries.

2011 brings a number of changes to CMS's quality reporting system. The most obvious is the change in name—the system has been renamed the Physician Quality Reporting System or PQRS. The name change is only the tip of the iceberg. There are several more substantial changes of which physicians should be aware.

PQRS is Voluntary—Until It Isn't

In 2011, participation in the program is voluntary and successfully participating providers will receive a 1.0 percent bonus payment of their total estimated Medicare Part B Physician Fee Schedule (PFS) allowed charges for covered professional services furnished during the same reporting period. For 2012-2014, the bonus payment will be reduced to 0.5 percent. In addition to the PQRS program, physicians can also receive a 0.5 percent bonus for participating in the Maintenance of Certification Program Incentive (*for more information, please see box*).

Starting in 2015, providers who do not successfully participate in PQRS will be subject to a 1.5 percent penalty on all Medicare Part B reimbursements. That penalty increases to 2.0 percent in 2016 and beyond. So while the program remains *technically* voluntary, physicians are strongly incentivized to participate by the reimbursement penalties.

Quality Reports—Going Public

What is CMS going to do with all this quality data it is collecting? CMS does not yet have plans for making specific report data public. All participating providers will receive annual reports from CMS summarizing the quality reporting data. Starting in 2013, CMS will maintain a publically searchable Web site listing all providers who have successfully participated in the PQRS program.

How to Participate

Physicians do not need to enroll to participate in PQRS—they can submit either on three individual measures OR one measures group. To participate in the 2011 Physician Quality Reporting System, providers have

three methods to choose from: 1) reporting quality data on Part B claims submissions; 2) participating in a CMS-approved registry; or 3) submitting quality data to the CMS via an approved electronic health record. To qualify under claims-based reporting, physicians must report on at least 50 percent of patients (80 percent in past years) for whom the selected measure applies. To qualify under registry-based or EHR reporting, physicians must report on at least 80 percent of patients for whom the selected measure applies. Physicians can report for a full year (January to December) or for six-months of the year (the reporting period starts on July 1).

Quality Coding

Each performance measure has a Quality Data Code or QDC (a current procedural terminology [CPT] Category II code or G-code). A QDC code cannot be reported on a claim without the appropriate diagnostic and procedure codes as noted in the CMS specifications document. Note that several measures allow the use of CPT II modifiers: **1P**, **2P**, **3P** and the **8P** reporting modifier. Only allowable CPT II modifiers may be used with a CPT II code.

A claim is considered "eligible" in PQRS when the *International Classification of Diseases* (9th Revision) Clinical Modification (ICD-9-CM) diagnosis and the CPT category I service codes on the claim match the diagnosis and encounter codes listed in the denominator criteria of the measure specification. A claim cannot be resubmitted to Medicare solely for the purpose of adding a QDC code.

Maintenance of Certification Program Incentive

Beginning in 2011, physicians will have the opportunity to earn an additional incentive of 0.5 percent by working with a Maintenance of Certification entity and by:

- Satisfactorily submitting data, without regard to method, on quality measures under Physician Quality Reporting, for a 12-month reporting period either as an individual physician or as a member of a selected group practice;

AND

- More frequently than is required to qualify for or maintain board certification:
 - Participating in a Maintenance of Certification Program and
 - Successfully completing a qualified Maintenance of Certification Program practice assessment.

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Each measure has a reporting frequency or timeframe requirement (called a “measure tag” in PQRS analysis) for each eligible patient seen during the reporting period for each individual eligible professional (NPI). The reporting frequency (e.g., report each visit, once during the reporting period, each episode) is found in the “instructions” section of each measure specification found on the CMS Web site at www.cms.gov/pqri under “measures codes” in the download section. Ensure that all members of your coding team understand and capture this information in the clinical record to facilitate reporting.

PQRS data submission is as simple as adding a code or two on existing claims that have specified ICD-9-CM diagnostic codes and evaluation and management codes (e.g., new and established patient visit codes **99201-99215**, excluding **99211**). For example, for claims-based reporting of individual measures, for your COPD patients, you would indicate that you reviewed and documented spirometry results by adding **3023F** to the claim form with the appropriate ICD-9-CM and CPT codes with \$0.00 in the payment field. For the community acquired pneumonia (CAP) measures group, after reporting the intention code on the very first claim, report **G8550**, instead of separate codes noted on the individual code specifications, to indicate that all of the four individual measures (**#56-#59**) have been performed.

Summary of PQRS Group Measures Relevant to ATS Members

Below is a list of the two quality measures groups most applicable to ATS members—community acquired pneumonia (CAP) and asthma measures group.

CAP Measures Group

Individual Pneumonia Measures included in the CAP Measures Group

- **#56: Vital Signs for Community-Acquired Bacterial Pneumonia (CAP)**
 - o Percentage of patients 18 years and older with diagnosis of CAP with vital signs (temperature, pulse, respiratory rate and blood pressure) documented and reviewed.
- **#57: Assessment of Oxygen Saturation for Community-Acquired Bacterial Pneumonia**
 - o Percentage of patients 18 years and older, with diagnosis for CAP with oxygen saturation (measurement by pulse oximetry or arterial blood gas) documented and reviewed.
- **#58: Assessment of Mental Status for Community-Acquired Bacterial Pneumonia**

- o Percentage of patients 18 years and older with a diagnosis of CAP with mental status assessed (documented that patient is oriented or disoriented).
- **#59: Empiric Antibiotic for Community-Acquired Bacterial Pneumonia**
 - o Percentage of patients 18 years and older, with diagnosis of CAP with appropriate empiric antibiotic in four drug classes: fluoroquinolones, macrolides, doxycycline, beta lactam with macrolide or doxycycline (as defined in current ATS guidelines) prescribed (even for medication ordered prior to encounter if patient is following the treatment plan).

Applicable G-Codes for the CAP Measures Group

- **G8546:** I intend to report the CAP Measures Group. Report this code only once to notify CMS of your intention to participate in the CAP Measures Group.
 - o Report **G8546** ONLY on the first claim ever submitted (not first claim for each patient).
 - o The claim can only be for a patient \geq 18 years of age, with ICD-9-CM pneumonia diagnosis codes **481-483.8, 486, 487.0**.
 - o The applicable CPT codes for the CAP Measures group are: New Patient **99201-99205**, Established Patient **99212-99215**, Emergency Department **99281-99285**, Critical Care **99291** (must report ED place of service 23 on Part B claim form ONLY for **99291**), Domiciliary, Rest Home, Custodial Care **99324-99337**, Home Services **99341-99350**.
- **G8550:** All quality actions for the applicable measures in the CAP Measures Group (**#56-#59**) have been performed for this patient.
 - o Reported in lieu of the individual quality-data codes for each of the measures within the group (ie, **#56, #57, #58** and **#59** cannot be submitted individually)
 - o This CAP group measures code is reported once during each occurrence (ie, 45-day period from onset of CAP).

Asthma Measures Group

Individual Asthma Performance Measures Included in the Asthma Measures Group

- **#53 Asthma: Pharmacologic Therapy**
 - o 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.

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- **#64 Asthma Assessment**
 - o 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.
- **#231 Asthma: Tobacco Use Screening—Ambulatory Care Setting**
 - o Percentage of patients aged 5 through 50 years with a diagnosis of asthma who were queried about tobacco use and exposure to second hand smoke in their home environment at least once within 12 months.
- **#232 Asthma: Tobacco Use Intervention—Ambulatory Care Setting**
 - o 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.

Applicable G-Codes for the Asthma Measures Group

- **G8645:** I intend to report the Asthma Measures Group
 - o Report **G8645** ONLY on the first claim ever submitted (not first claim for each individual patient).
 - o The claim can only be made for a patient with ICD-9-CM asthma diagnostic codes **493.00, 493.02, 493.10, 493.12, 493.20, 493.22, 493.90, 493.92**.
 - o The applicable CPT codes for the Asthma Measures group are: New Patient **99201-99205**, Established Patient **99212-99215**, Observation Care **99217-99220**, Home Care **99341-99350**.
- **G8646:** All quality actions for the applicable measures in the Asthma Measures Group have been performed for this patient.
 - o Reported in lieu of the individual quality-data codes for each of the asthma measures within the group (i.e., **#53, #64, #231** and **#232** cannot be submitted individually).
 - o This Asthma group measures code is reported at least once during the reporting period when billing a patient claim for either the 30 Patient Sample and the 50% Patient Sample Methods.

ELECTRONIC PRESCRIBING INCENTIVE PROGRAM (eRx)

The Electronic Prescribing Incentive Program (eRx) is an incentive program for eligible professionals (EPs) who are successful electronic prescribers as defined by

the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). The eRx incentive payment for both 2011 and 2012 is 1.0 percent of total estimated allowed charges. For 2013, the incentive payment will be reduced to 0.5 percent. Beginning in 2012, there will be a penalty for not participating in eRx. The penalty will be a reduction in Physician Fee Schedule payments by 1.0 percent in 2012, 1.5 percent in 2013 and 2.0 percent in 2014.

In order to avoid a penalty in 2012, an eligible professional or group practice must have 10 unique eRx events between January 1 and June 30, 2011. To avoid a penalty in 2013, an eligible physician must have 25 unique eRx events in calendar year 2011. CMS has not yet announced whether or not eRx filings in 2012 will count towards avoiding penalties in 2013. Due to this ambiguity, we strongly recommend not waiting until 2012 to start filing.

EPs do not need to participate in PQRS to participate in the eRx program or even sign up to participate. In order to qualify, EPs must have and use a qualified eRx system and report on his or her adoption and use of the eRx system. The EP must also meet the criteria for successful electronic prescriber specified by the CMS for a particular reporting period. Finally, at least 10 percent of a successful electronic prescriber's Medicare Part B covered services must be made up of codes that appear in the denominator of the eRx measure.

Reporting eRx participation only involves a single quality-data code:

G8553: At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system. (G codes were different for 2010)

eRx Exemption Codes

There is possibility for hardship exemptions from the eRx penalty, provided that the physician falls under one of the following G codes:

G8642: The eligible professional practices in a rural area without sufficient high-speed Internet access and requests a hardship exemption from the application of the payment adjustment under section 1848(a)(5)(A) of the Social Security Act.

G8643: The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing and requests a hardship exemption from the application of the payment adjustment under section 1848(a)(5)(A) of the Social Security Act.

G8644: The eligible professional does not have prescribing privileges.

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ELECTRONIC HEALTH RECORDS (EHR) INCENTIVE PROGRAM

The Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs will provide incentive payments to EPs as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. EPs who meet the eligibility requirements for both the Medicare and Medicaid EHR Incentive Programs may participate in only one program, and must designate which one they prefer. Registration for the Medicare EHR incentive program opened on January 3, 2011, and ended on January 31, 2011. CMS will develop a plan by 2012 to integrate EHR and PQRS.

EPs who do not successfully demonstrate meaningful use of certified EHR technology will be subject to payment adjustments for their covered professional services beginning in 2015.

EHR Medicare Incentive Program

A qualifying EP can receive EHR incentive payments for up to five years with payments beginning as early as 2011. In general, the maximum amount of total incentive payments that an EP can receive under the Medicare program is \$44,000. A qualifying EP will receive an incentive payment equal to 75 percent of Medicare allowable charges for covered professional services furnished by the EP in a payment year, subject to maximum payments. An EP who predominantly furnishes services in a geographic health professional shortage area (HPSA) is eligible for a 10-percent increase in the maximum incentive payment amount.

The last year for which an EP can begin receiving incentive payments in this program is 2014. The total maximum EHR incentive payment amounts for Medicare EPs is outlined in the table below:

Calendar Year (CY)	First CY for which the EP Receives an Incentive Payment				
	2011	2012	2013	2014	2015 & Beyond
2011	\$18,000	—	—	—	—
2012	\$12,000	\$18,000	—	—	—
2013	\$8,000	\$12,000	\$15,000	—	—
2014	\$4,000	\$8,000	\$12,000	\$12,000	—
2015	\$2,000	\$4,000	\$8,000	\$8,000	—
2016	—	\$2,000	\$4,000	\$4,000	—
TOTAL	\$44,000	\$44,000	\$39,000	\$24,000	\$0

Medicaid EHR Incentive Program

The Medicaid EHR Incentive Program is voluntarily offered and administered by states and territories. Registration for the Medicaid EHR incentive program began in early 2011. The following states already opened registration for their

EHR Medicaid Incentive Program: Alaska, Iowa, Kentucky, Louisiana, Oklahoma, Michigan, Mississippi, North Carolina, South Carolina, Tennessee and Texas. Registration for California, Missouri and North Dakota opened in February. Other states likely will launch their Medicaid EHR Incentive Programs during the spring and summer of 2011. Some states may choose not to offer the Medicaid EHR incentive program.

The Medicaid EHR program continues through 2021. For calendar years 2011 to 2021, participants can receive up to \$63,750 over six years under the Medicaid EHR incentive program, as long as they begin participation in 2016 or before. EHR incentive payments are made by the state based on the calendar year. See the payment table below. Medicaid-eligible professionals who also treat Medicare patients will have a payment adjustment to Medicare reimbursements starting in 2015 if they do not successfully demonstrate meaningful use.

The total maximum EHR incentive payment amounts for Medicaid EPs (for participating states) are outlined in the table below.

Calendar Year (CY)	First CY for which the EP Receives an Incentive Payment					
	2011	2012	2013	2014	2015	2016
2011	\$21,250	—	—	—	—	—
2012	\$8,500	\$21,250	—	—	—	—
2013	\$8,500	\$8,500	\$21,250	—	—	—
2014	\$8,500	\$8,500	\$8,500	\$21,250	—	—
2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	\$0
2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
2017	—	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
2018	—	—	\$8,500	\$8,500	\$8,500	\$8,500
2019	—	—	—	\$8,500	\$8,500	\$8,500
2020	—	—	—	—	\$8,500	\$8,500
2021	—	—	—	—	—	\$8,500
TOTAL	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

Questions

The ATS encourages practices to participate in PQRS, eRx and EHR. If you have any questions about PQRS, eRx and/or EHR, please do not hesitate to contact the ATS coding and reimbursement staff at codingquestions@thoracic.org. You can also find more information by contacting the QualityNet Help Desk at (866) 288-8912 or qnet-support@sdps.org. The Web sites listed below can also be useful resources.

2011 Medicare Physician Fee Schedule Final Rule (CMS-1503-FC): <http://edocket.access.gpo.gov/2010/pdf/2010-27969.pdf>

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CMS PQRI Web Page (link expected to change in April 2011): cms.gov/pqri

List of Eligible Professionals (EPs) for PQRS: cms.gov/PQRI/Downloads/EligibleProfessionals.pdf

2011 PQRS Measure Specifications and Implementation Manual: www.cms.gov/pqri (look under "measures codes" in the download section at the bottom)

Medicare and Medicaid EHR Incentive Programs: www.cms.gov/EHRIncentivePrograms

List of Certified EHR Technology (CHPL): <http://onc-chpl.force.com/ehrcert>

eRx Incentive Program Information: cms.gov/eRXincentive/01_overview.asp

SAMPLE Quality Reporting for Physicians

Patient Name: _____ Acct #: _____ DOB: _____ Age: _____
 DOS: _____ Last Dx Codes: _____

Measure #51: Spirometry

Age: ≥ 18 Y N
 Dx: 491.0 491.8
 Y N 491.1 491.9
 491.20 492.0
 491.21 492.8
 491.22 496

E/M:
 New 99201 99202 99203
 99204 99205
 Est 99212 99213 99214 99215

REPORT ON SAME CLAIM FORM

3023F Spirometry results doc & rev

OR

Not reviewed and documented for one of the following reasons:

Medical reason 3023F-1P
 Patient reason 3023F-2P
 System reason 3023F-3P

OR

Not doc or rev, no reason 3023F-8P

Measure #52 – Bronchodilator Therapy

Age: ≥ 18 Y N
 Dx: 491.0 491.8
 Y N 491.1 491.9
 491.20 492.0
 491.21 492.8
 491.22 496

E/M:
 New 99201 99202 99203
 99204 99205
 Est 99212 99213 99214 99215

REPORT ON SAME CLAIM FORM

3025F Patient has COPD symptoms, spiro test results = FEV₁/FVC < 70%

Inhaled bronchodilator prescribed
 3025F & 4025F

OR

Bronchodilator not prescribed
 Medical reason 4025F-1P
 Patient reason 4025F-2P
 System reason 4025F-3P

OR

Not prescribed, not documented
 4025F-8P

OR

Patient has no COPD symptoms, spirometry test results = FEV₁/FVC ≥ 70% 3027F

OR

Spirometry not performed, or doc
 3025F-8P

Measure #226 – Preventive Care and Screening: Tobacco Use: Screening and Cessation

Age: ≥ 18 Y N
 No specific Dx required

E/M:
 New 99201 99202 99203
 99204 99205
 Est 99212 99213 99214 99215

REPORT ON SAME CLAIM FORM

4004F Patient Screened for Tobacco Use and counseled on smoking cessation.

OR

Patient screened for Tobacco Use and Identified as a Non-User of Tobacco
 1036F

OR

Tobacco Screening not Performed for Medical Reasons 4004F-1P

OR

Tobacco Screening not Performed for Reason Not Specified 4004F-8P

PHYSICIAN SIGNATURE

X _____

If Age, Diagnosis or CPT codes are NOT as indicated above, do not report performance measure code(s). Report on each of the three measures above ONCE PER REPORTING PERIOD (i.e., report only once between January 1 and December 31, 2011, or if reporting July 1 to December 31, 2011).

CMS RELEASES CORRECTED SLEEP CODE VALUES

Sleep CPT Codes					
CPT Code	Mod	Descriptor	2010 payment	2011 Payment	\$ Change from 2010 to 2011
95800		Sleep study unattended	NA	\$205.56	NA
95800	TC	Sleep study unattended	NA	\$147.46	NA
95800	26	Sleep study unattended	NA	\$58.10	NA
95801		Sleep study unattended w/anal	NA	\$96.83	NA
95801	TC	Sleep study unattended w/anal	NA	\$45.53	NA
95801	26	Sleep study unattended w/anal	NA	\$51.30	NA
95803		Actigraphy testing	\$120.57	\$162.41	\$41.84
95803	TC	Actigraphy testing	\$70.43	\$115.52	\$45.09
95803	26	Actigraphy testing	\$50.15	\$46.89	(\$3.26)
95805		Multiple sleep latency test	\$395.65	\$410.43	\$14.78
95805	TC	Multiple sleep latency test	\$302.73	\$348.60	\$45.87
95805	26	Multiple sleep latency test	\$92.92	\$61.84	(\$31.08)
95806		Sleep study unattend & resp effort	\$204.28	\$182.11	(\$22.17)
95806	TC	Sleep study unattend & resp effort	\$122.05	\$119.26	(\$2.79)
95806	26	Sleep study unattend & resp effort	\$82.23	\$62.86	(\$19.37)
95807		Sleep study attended	\$479.35	\$469.89	(\$9.46)
95807	TC	Sleep study attended	\$397.86	\$406.70	\$8.84
95807	26	Sleep study attended	\$81.49	\$63.20	(\$18.29)
95808		Polysomn 1-3 channels	\$668.87	\$649.63	(\$19.24)
95808	TC	Polysomn 1-3 channels	\$537.98	\$559.59	\$21.61
95808	26	Polysomn 1-3 channels	\$130.90	\$90.04	(\$40.86)
95810		Polysomnograph 4 or more	\$769.17	\$694.14	(\$75.03)
95810	TC	Polysomnograph 4 or more	\$596.60	\$568.76	(\$27.84)
95810	26	Polysomnograph 4 or more	\$172.57	\$125.37	(\$47.20)
95811		Polysomnography w/cpap	\$848.08	\$749.18	(\$98.90)
95811	TC	Polysomnography w/cpap	\$662.97	\$618.03	(\$44.94)
95811	26	Polysomnography w/cpap	\$185.10	\$131.15	(\$53.95)

CMS has provided the corrected values for the family of sleep codes. As you may recall, the Medicare Physician Fee Schedule Final Rule published by CMS contained a number of errors in the practice expense calculations for the unattended sleep codes. Additionally, at the time the December issue of the *ATS Coding & Billing Quarterly* was published, the final conversion factor for 2011 had not yet been determined by Congress.

The table above lists the payment rate for the family of sleep codes, using both the corrected practice expense values and the final 2011 Medicare conversion factor.

For 2011 the Medicare physician fee schedule update will be 0 percent. The Medicare Economic Index was

rebased from 2000 to 2006 resulting in increases to the practice expense and malpractice practice relative value units (RVUs). The CY 2011 conversion factor decrease was offset by the other reimbursement formula increases.

December 2010 Conversion Factor	\$36.8729
MMEA "Zero Percent Update"	0.0 percent (1.000)
CY 2011 RVU Budget Neutrality Adjustment	0.4 percent (1.0043)
CY 2011 Rescaling to Match MEI Weights Budget Neutrality Adjustment	-8.3 percent (0.9175)
CY 2011 Conversion Factor	\$33.9764

ATS OFFERING FREE CODING BILLING AND REGULATORY COMPLIANCE ASSISTANCE AT DENVER INTERNATIONAL CONFERENCE

The ATS is offering one-on-one coding, billing and regulatory compliance sessions at the ATS meeting in Denver. Diane Krier-Morrow, MBA, MPH, CCS-P—the ATS Consultant for Coding and Reimbursement—will be available in Denver for free one-on-one discussions about correct coding, billing and regulatory compliance issues. This is the fifth year the ATS has provided this service to conference attendees. Mrs. Krier-Morrow is available to provide guidance on correct coding and billing for pulmonary, critical care and sleep medicine procedures, give advice on participating in the various Medicare quality reporting programs and help resolve persistent problems with claims denials, and other regulatory compliance issues.

These sessions are by appointment only and will be held on:

Sunday, May 15 8 am-3 pm

Monday, May 16 8 am-2 pm

Tuesday, May 17 8 am-Noon

If you are interested in scheduling an appointment with Mrs. Krier-Morrow, please send an email to codingquestions@thoracic.org.

Q&A

continued from page 1 **A.** It is appropriate to report **96372** for omalizumab (generic Xolair) with **J2357** for the agent. It has been reported to us that some Medicare contractors and other third-party payers allow reporting of **96401**. If you do not have written instructions to report these injections with the chemotherapy code, we suggest reporting **96372**.

It is good that you asked. Just changing coding patterns on what you hear without checking it out and having documentation to support a change noted in your practice compliance plan can put a practice in an audit situation.

SLEEP DATA REVIEW SERVICES

Q. Our practice started getting contacted by nursing facilities housing patients who we have treated to evaluate their progress with CPAP therapy. These facilities have been taking the card, downloading and sending our physician the reports, which, in turn, the physician is reading, and then making the necessary changes. Interpreting the studies and making needed CPAP adjustments is consuming significant physician time and staff resources. Is there a CPT code that we could bill to help compensate for the time he spends analyzing these reports?

A. CPT **99091** collection and interpretation of physiologic data (e.g., ECG, blood pressure or glucose monitoring) digitally stored

and/or transmitted by the patient and/or caregiver to the physician or other qualified healthcare professional, requires a minimum of 30 minutes by the provider, is an example of a code that could be reported. Keep in mind, **99091** requires a minimum of 30 minutes by the provider and is not paid by Medicare and not paid by virtually anyone else, unless privately contracted. Previously, the doctor in question appropriately reviewed the SmartCard and any other data as part of a legitimate face-to-face E/M office encounter, as all physicians review data, and properly billed an office E/M for the service.

To the larger issue of getting paid for the work, nursing homes don't want to pay transportation costs and potentially the office visits too, if they are covered by any applicable capitation or global payment schemes. Further many nursing home patients are Medicaid beneficiaries, so the likelihood collecting co-pays from the patient is small.

To get paid for the work the physician is providing, you should consider entering a private contract with the nursing home for data review services. The only other option is to interpret data during a face-to-face visit using E/M codes to provide appropriate clinical context and correlation. Note this could be reported as a nursing home visit (**99307-99310**) or domiciliary/rest home visit (**99334-99337**) or office visits (**99201-99215**) if the patient is transported.