



## Editor

### **Katina Nicolacakis, MD**

Member, Joint ATS/CHEST  
Clinical Practice Committee,  
ATS RUC Advisor

## Advisory Board Members

### **Kevin Kovitz, MD**

Member, Joint ATS/CHEST  
Clinical Practice Committee

### **Stephen P. Hoffmann, MD**

Member, Joint ATS/CHEST  
Clinical Practice Committee,  
ATS CPT Advisor

### **Michael Nelson, MD**

Member, Joint ATS/CHEST  
Clinical Practice Committee,  
ATS Alternate CPT Advisor

### **Steve G. Peters, MD**

Member, Joint ATS/CHEST  
Clinical Practice Committee,  
CHEST CPT Advisor

## Editor's Letter

Welcome to the September edition of the ATS Coding and Billing Quarterly. This edition will focus primarily on the proposed Medicare rules for 2024 covering physician reimbursement and hospital outpatient reimbursement. As is common with most proposed Medicare rules, there is a mix of encouraging policy and some concerning policy for pulmonary, critical care, and sleep providers. The articles below will highlight some of the proposed changes and will provide some context for what is driving the policy and payment changes.

This edition also features an article from Raj Desai, MD, on proper documentation for bronchoscopy procedures. Appropriate documentation is an essential part of successful coding and reimbursement for the work physicians do. Additionally, Mike Nelson, MD, has provided an article on correct billing for bronchoscopy codes (CPT **31628**, **31629**), addressing the persistent confusion many physicians, coding staff, and insurers have on how those two codes interact.

Lastly, this edition responds to questions submitted by ATS members. If you would like to submit a question on coding, billing, or regulatory concerns, please send it to [codingquestions@thoracic.org](mailto:codingquestions@thoracic.org).

### **Katina Nicolacakis, MD**

Editor, ATS Coding & Billing Quarterly

---

## In this Issue

Proposed 2024 Medicare Physician Fee Schedule **2**

Medicare Part B Payment for Preventive Vaccine Administration Services **3**

Interventional Pulmonology and Advanced Bronchoscopy Operative Documentation Best Practices **4**

Correct Coding – Bronchoscopic Codes 31628 & 31629 **9**

Coding and Billing Questions **9**

# CMS Releases Proposed 2024 Medicare Physician Fee Schedule

Gary Ewart, MHS, Denise Merlino, MBS, CNMT, FSNMT, CPC, Katina Nicolacakis, MD

In July, the Centers for Medicare and Medicaid Services released the proposed Medicare Physician Fee Schedule for calendar year 2024. It includes payment rates for Medicare physician services for 2024, as well as a number of policy changes that impact pulmonary, critical care, and sleep physicians. Below is a brief summary of payment and policy changes that are of interest to ATS members:

## Conversion Factor

For 2024, CMS is proposing a conversion factor of \$32.75, a cut of \$1.14 (-3.34 percent). CMS has no discretion in adjusting the annual conversion factor as the formula is dictated by Congressional law and is explicitly designed to reduce overall Medicare expenditures. The new cut in the conversion factor is disappointing. However, CMS has proposed additional policies, discussed below, that may provide increased reimbursement to physicians who frequently provide E/M services.

## Anticipated Cumulative Financial Impacts for Pulmonary, Critical Care, and Sleep Providers from the Proposed Rule

If implemented as proposed, the American Medical Association estimates that pulmonary specialists will submit approximately \$1.3 billion in Medicare claims in 2024 and will see an estimated -1.09 percent cut in Medicare reimbursements. The Medicare reimbursement reduction for pulmonary services is largely driven by the 3.34 percent cut in the conversion factor, with compensating offsets from pulmonologists' use of a new add-on G-code for E/M visits to account for complex patients.

AMA estimates that critical care intensivists bill a total of \$388 million Medicare claims and see a 2.51 percent cut in Medicare reimbursements. The cut is driven largely by the 3.34 percent cut in the Medicare conversion factor.

AMA estimates sleep physicians will bill \$61 million in Medicare claims and see a 0.75 increase in Medicare reimbursements.

## Add-On Payment for E/M Visits

CMS is proposing to create an add-on G-code for selected E/M services. The proposed code (code **G2211**) is intended to recognize the inputs associated with E/M visits for primary care and the care for patients with chronic complex conditions. The code

can be used with outpatient visits. When implemented, CMS predicts the new G-code will redistribute significant Medicare funds from procedural services to E/M providers.

In 2021, CMS proposed a similar policy to use an add on G-code to increase overall payments for E/M services but was prevented by Congress from implementing the proposed G-code, largely at the request of the surgical specialties. The policy that CMS is proposing for 2024 would continue to have a redistributive effect between proceduralists and cognitive providers, but the redistribution will likely be less than the 2021 proposal.

## Split (or Shared) Evaluation and Management (E/M) Visits

CMS is once again proposing to delay implementation of changes to billing practices for split/shared E/M services.

For background, split/shared billing occurs when two providers (a physician and an NPP) from the same practice share the E/M service, which is subsequently billed under a single provider. Split/shared visits usually occur in the hospital or other institutional settings.

In prior years, CMS allowed the decision on who should bill the service to be based on either the components of an E/M service (history, exam, and/or medical decision making) or who provided more than half of the total time for the services. In 2022, CMS indicated they would change the rules for who bills the split/shared service to who provides the majority of time in the service. This change was delayed through 2023, and now again for 2024. The ATS and other societies have advocated for this to remain as is, as we feel that MDM should drive reimbursement. We are pleased that this is to remain the practice through 2024. As a reminder, since 2022, critical care services (**99291/99292**) may also be split/shared, however in this instance, billing is determined by time, only.

## Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Program

In another win from the physician community, CMS is proposing to stop the Appropriate Use Criteria program and rescind the underlying regulations regarding the AUC.

Congress created the AUC program to reduce the use of inappropriate diagnostic imaging services. Under the AUC program, physicians ordering diagnostic imaging were required to document

that they used a clinical decision support mechanism to ensure appropriate use of diagnostic imaging. However, the AUC program was not well-received by many providers and was viewed by many as inappropriate interference in the physician decision-making.

### Payment for Dental Services prior to Certain Cancer Treatments

CMS is proposing to offer select dental services to Medicare beneficiaries who are initiating cancer therapy. The proposed policy would expand on CMS's current dental coverage policy for patients receiving organ transplants and heart valve surgery.

### Telehealth Services Furnished in Teaching Settings

Under current regulatory policy, CMS stated that at the conclusion of the COVID-19 Public Health Emergency, teaching physicians must have a physical presence to bill for their services involving residents, including Medicare telehealth services. CMS finalized an exception for residency training sites located outside of a metropolitan statistical area (MSA), in which case the teaching physician could be present through audio/video real-time communications technology.

However, Congress intervened and enacted legislation to extend Medicare coverage of a range of telehealth services. To be consistent with the telehealth policies that were extended by Congress, CMS is proposing to allow teaching physicians to use audio/video real-time communications technology when the resident furnishes Medicare telehealth services in all residency training locations through the end of CY 2024. This virtual presence would meet the requirement that the teaching physician be present for the key portion of the service.

## Medicare Part B Payment for Preventive Vaccine Administration Services

In June 2021, CMS announced an additional payment for in-home COVID-19 vaccine administration, which was established on a preliminary basis during the PHE. Based on data that show that this payment has helped improve health care access to vaccines for underserved Medicare populations, CMS is proposing to maintain this additional payment for the administration of a COVID-19 vaccine in the home. CMS is also proposing to extend this in-home additional payment to the administration of the other three preventive vaccines included in the Part B preventive vaccine benefit — the pneumococcal, influenza, and hepatitis B vaccines — when provided in the home.

Under this proposal, effective Jan. 1, 2024, the payment amount for administration of all four vaccines would be identical, that is, Medicare Part B will pay the same additional payment amount to providers and suppliers that administer a pneumococcal, influenza, hepatitis B, or COVID-19 vaccine in the home. This additional payment amount will be annually updated using the percentage increase in the Medicare Economic Index and adjusted to reflect geographic cost variations. CMS is proposing to limit the additional payment to one payment per home visit, even if multiple vaccines are administered during the same home visit. Every vaccine dose that is furnished during a home visit will still receive its own unique vaccine administration payment.

### Payment Variation for Pulmonary Rehabilitation Services

Medicare payment for pulmonary rehabilitation (**94625**, **94626**, **G0237**, **G0238**, and **G0239**) saw some variability under the Medicare Physician Fee Schedule, with the non-facility payment for **94625** increasing 24 percent while the non-facility payment for **94626** increased one percent. Non-facility payment for **G0237** increased three percent while **G0238** saw a three percent cut and **G0239** was cut by one percent.

### Medicare Physician Fee Schedule Payment Rates for Pulmonary Rehabilitation Services

CPT/ HCPCS	Short Description	CY 2023 CF	CY 2024 CF	% Change	Dollar Change
		\$33.8872	\$32.7476		
		2023 NF Allowable	2024 NF Allowable	NF Allowable	NF Allowable
<b>G0237</b>	Therapeutic procd strg endure	\$10.84	\$11.13	3%	\$0.29
<b>G0238</b>	Oth resp proc, indiv	\$10.51	\$10.15	-3%	(\$0.35)
<b>G0239</b>	Oth resp proc, group	\$12.88	\$12.77	-1%	(\$0.11)
<b>94625</b>	Phy/qhp op pulm rhb w/o mntr	\$58.62	\$72.70	24%	\$14.07
<b>94626</b>	Phy/qhp op pulm rhb w/ mntr	\$77.94	\$78.92	1%	\$0.98

The majority of pulmonary rehabilitation services are provided in outpatient programs and the Medicare Outpatient Prospective Payment System proposed rule has increases for outpatient pulmonary rehabilitation. **G0237** and **G0238** saw a six percent increase, and **G0239** a nine percent increase in the proposed rule, while **94625** and **94626** saw a modest one percent increase.

**Medicare Hospital Outpatient Prospective Payment Rates for Pulmonary Rehabilitation Services**

CPT/HCPCS	CMS Short Description	Status		APC		Final CY 2023	Final CN CY 2023	Final CN CY 2023
		CY 2023	CY 2024	CY 2023	CY 2024	Payment Rate	Single Frequency	Total Frequency
<b>G0237</b>	Therapeutic procd strg endur	S	S	5731	5731	\$24.96	20,580	56,601
<b>G0238</b>	Oth resp proc, indiv	S	S	5731	5731	\$24.96	51,631	53,613
<b>G0239</b>	Oth resp proc, group	S	S	5732	5732	\$33.96	195,715	201,167
<b>94625</b>	Phy/qhp op pulm rhb w/o mntr	S	S	5733	5733	no data	no data	no data
<b>94626</b>	Phy/qhp op pulm rhb w/mntr	S	S	5733	5733	\$57.48	3	3

## Interventional Pulmonology and Advanced Bronchoscopy Operative Documentation Best Practices

Neeraj R Desai, MD, MBA, FCCP, FACP, DAABIP  
 Member, Joint ATS/CHEST Clinical Practice Committee

Appropriate and timely documentation improves communication between providers, optimizes clinical care, allows optimal billing, and allows for appropriate support for risk management and medicolegal review. In a study of multispecialty surgical practice, 76 percent of operative notes contained one or more audit criteria deficiencies. The three most common deficiencies identified included an incomplete description of all surgical procedures performed (56 percent), an inadequate description of the indications for procedures (49 percent), and only 45 percent of the operative notes were dictated within 24 hours of the procedure<sup>1</sup>.

Operative and procedural notes are traditionally created after a procedure by the primary surgeon or proceduralist, who recalls the procedure and documents the details.

With the increasing adoption of electronic health record (EHR) systems, operative notes and other clinical documents are generated and immediately available. EHR systems also enable other mechanisms for note generation, including voice-to-text software, typed notes, synoptic reporting, and templated notes<sup>2</sup>.

Specific sections (these requirements may vary based on local or hospital policies)

### History and physical (H&P)

The H&P must be completed and documented no more than 30 days before or 24 hours after admission or registration. In all cases when it is determined that an H&P is required, except for emergencies, the H&P must be completed and documented before the surgery or procedure takes place, even if that surgery or procedure occurs less than 24 hours after admission or registration<sup>2</sup>.

### Consent

A well-designed informed consent process would include a discussion of the following elements:

- A description of the proposed surgery, including anesthesia.
- Risks and benefits for the patient related to the surgery and anesthesia, as informed by the responsible practitioner’s clinical judgment and existing standards.
- Treatment alternatives, including the attendant material risks and benefits.
- Who will conduct the surgical intervention and administer the anesthesia, and whether physicians other than the operating practitioner, including but not limited to residents or fellows or assistants, will be performing important tasks related to the surgery following the hospital’s policies<sup>2</sup>.

## Operative Report

*Required Elements of the operative report (CMS and Joint Commission)*

Traditionally operative notes are not covered by E/M, and the Joint Commission and Centers for Medicare & Medicaid Services (CMS) have specified criteria for operative notes, including information on suggested contents and note sections<sup>2,3,4</sup>.

### *Timing*

The report must be written or dictated immediately after an operation or other high-risk procedure and entered into the medical record. 'Immediately after surgery or procedure' is defined as, "upon completion of the procedure before the patient is transferred to the next level of care." For this requirement, The Joint Commission considers the Pre-Op, OR, and PACU the same level of care as the clinical team is essentially intact across these areas. If a brief progress note (brief op note) option is used, it must contain, at a minimum, the primary surgeon and assistants, procedures performed and description of each procedure finding, any estimated blood loss, any specimens removed, and the post operative diagnosis<sup>3</sup>.

*Components proposed by Joint Commission and other elements that help with appropriate coding and billing<sup>2,3,5</sup>*

- I. Preoperative Diagnosis(es)
- II. Postoperative Diagnosis(es)
- III. Anesthesia Type
- IV. Anesthesiologist/CRNA
- V. Proceduralist/Surgeon's Name
- VI. Resident or Fellow or Assistant
- VII. Procedures Performed
- VIII. Brief History and Indication
- IX. Full Description of the Procedure(s)
- X. Time Out
- XI. Details of the procedure(s), from start to end (e.g., scope in and scope out).
- XII. Specimens Collected
- XIII. Complications
- XIV. Estimated Blood Loss
- XV. Summary of Findings/ Impression
- XVI. Follow-up Plans:

5 Physician's Current Procedural Terminology (CPT®) codes, descriptions, and numeric modifiers are © 2022 by the American Medical Association. All rights reserved.

# ATS 2024

## Save the Date

San Diego, CA  
May 17-22

### BE THE FIRST TO KNOW



It is useful to include ICD-10 and CPT codes in the operative documentation. The ICD-10 and CPT codes that are utilized in coding are produced and copyrighted by the American Medical Association.

It is advisable to include detailed reasoning for the procedure which supports communication and necessary appeal or reviews.

If the operator performs moderate sedation document time from first medication under observation to the end of monitoring by the provider.

### Future Considerations

There is a need to develop educational programs and standardization of synoptic reporting especially as we increase our pulmonary procedural armamentarium. Standardized operative report structure and synoptic reporting when procedures are performed for cancer should be similar to other oncology specimen reporting<sup>6,7,8</sup>.

## Example Template

*(If using templates, attention should focus on proper editing of details and customizing it based on system and equipment use. Avoid simple cut and paste. Template includes a full range of procedures and codes that require editing to reflect the actual procedures performed).*

Robotic Navigational Bronchoscopy + EBUS TBNA (Diagnosis and Staging)

### Date of Surgery

#### Preoperative Diagnoses (ICD-10)

1. Lung nodule (R 91.1)
2. Adenopathy (R 59.0)

#### Postoperative Diagnoses (ICD-10)

1. Lung nodule (R 91.1)
2. Adenopathy (R 59.0)
3. ....

#### Procedure Performed

Robotic Navigational bronchoscopy (CPT 31627)  
 Fluoroscopy guided Transbronchial biopsy x 1 lobe \_ (CPT 31628)  
 \*Fluoroscopy guided transbronchial biopsy – each additional lobe \_ (CPT 31632)  
 Transbronchial Needle Aspiration of lung nodule x 1 site \_ (CPT 31629)  
 \*Transbronchial Needle Aspiration of lung nodule (each additional site) \_ (CPT 31632)  
 Transbronchial Brushings (CPT 31623)  
 Bronchoalveolar lavage (CPT 31624)  
 Radial (peripheral) endobronchial ultrasound (CPT 31654)  
 Bronchoscopy guided fiducial marker placement (CPT 31626)

#### Endobronchial ultrasound for LN sampling:

Bronchoscopy with endobronchial ultrasonography (EBUS)-guided needle aspiration/biopsy 1 or 2 lymph node stations or structures (CPT 31652) OR  
 Bronchoscopy with endobronchial ultrasonography (EBUS)-guided needle aspiration/biopsy 3 or more lymph node stations or structures (CPT 31653)



**Type of Anesthesia**

General. Please see separate flow sheet.

If the proceduralist or their team provides anesthesia, detail it and code for it (>5yr old first 15 minutes of moderate sedation--minimum 10 minutes (CPT 99152. Each additional 15 minutes--minimum 8 minutes (CPT 99153).

**Indications**

The patient is a @AGE@ -year-old @CAPSEX@, who was found to have \*\*\*. Differential diagnosis, risks, benefits, and alternatives were discussed at length. Alternatives such as mediastinoscopy and or \*\*\* needle biopsy discussed. Endobronchial ultrasound guided transbronchial needle aspiration superior to blind transbronchial needle aspiration in diagnostic yield and today's procedure is undertaken for diagnostic purposes and \*\*\* mediastinal staging.

**Surgeon(s)****Fellows or Assistant(s)****Anesthesiologist/ CRNA****Technique/Description of Procedure****EQUIPMENT:**

7.5 MHz endobronchial ultrasound bronchoscope with dedicated \*\*\*-gauge needle.

20 MHz radial probe, endobronchial ultrasound

Adult therapeutic video bronchoscope (or specific type)

Robotic navigation software and Robotic Bronchoscopy device (specify type)

Standard C-arm fluoroscope.

Standard forceps and brush

19 G or 21 Gauge needle

**CONSENT:**

Informed consent obtained after discussing risks, benefits, and alternatives. Details of procedure and anesthesia were reviewed with the patient. Consent placed in chart.

All questions were answered and the patient was agreeable.

**PROCEDURE:**

Time out was done prior to the start procedure.

The patient's CT scan and 3-dimensional DICOM format was loaded into the planning system. Target points T1 in the \*\*\* was marked and measured at \*\*\*mm. T2 was marked in the \*\*\*, measuring \*\*\*mm. Virtual pathways were created to these lesions. This information was stored in a USB drive and loaded onto the controller software in the bronchoscopy suite.

The patient was placed in a supine position, anesthesia administered, ETT was placed. Flexible Bronchoscope was inserted and airway inspection was performed down to the subsegmental levels. \*\*\* No endobronchial lesions were seen.

The scope was then withdrawn. Robotic bronchoscope was introduced via the swivel adaptor in the ETT tube.

Registration was performed and confirmed with acceptable divergence. Using robotic bronchoscopy guidance, \*\*\* lesion was located within the \*\*\* subsegment. Subsequently radial probe ultrasound was introduced through the robotic device confirming appropriate positioning. Using additional fluoroscopic guidance, transbronchial needle aspiration x \*\*\* was performed. Transbronchial biopsies x \*\*\* and brushings x \*\*\* were performed. Bronchoalveolar lavage was performed, instilling \*\*\*cc with \*\*\*cc aspirated. There was no evidence of active bleeding. Robotic bronchoscope was withdrawn.

Linear ultrasound bronchoscope was inserted via the swivel adaptor attached to the ETT. Ultrasound examination revealed a \*\*\*mm lymph node in the 11L left infra hilar location, \*\*\*mm lymph node in the 10L left hilar location a \*\*\*mm lymph node in the 7 subcarinal location, a \*\*\*mm lymph node in the 4L left paratracheal location, a \*\*\*mm lymph node in the 4R right paratracheal location, a \*\*\* mm lymph node in the 2R, a \*\*\* mm lymph node in the 2L, \*\*\*mm lymph node in the 10L right hilar location and a \*\*\*mm lymph node in the 11R infra hilar location. \*\*\* passes were taken at the \*\*\* location, with \*\*\* pass(es) given to the cytotechnician for screening, and the others placed into CytoLyt for processing.



Bronchoscope was withdrawn and procedure was concluded. Patient tolerated the procedure well. Post-procedure fluoroscopy of the patient's \*\*\*apex was negative for pneumothorax, however, dedicated chest-ray is pending at the time of this note.

#### Implants and Devices

#### Estimated Blood Loss

Less than \_ ml

#### Unanticipated Events/Complications

1. None immediate (CXR Pending)

#### Patient Condition/Disposition

1. Stable
2. Further delineation of care will be based on the results of this procedure.
3. Follow up in IP clinic in \_\_\_ days

#### References:

1. Flynn MB, Allen DA. The operative note as billing documentation: a preliminary report. *Am Surg.* 2004 Jul;70(7):570-4; discussion 574-5. PMID: 15279177.
2. Centers for Medicare & Medicaid Services (CMS) Operative Note
3. Requirements: Survey Protocol, Regulations and Interpretive Guidelines for Hospitals: A-0396 §482.51. [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_a\\_hospitals.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf). Accessed March 2nd 2023.
4. Operative and High-Risk Procedure Reports - Timeframe of Dictation or Written. <https://www.jointcommission.org/standards/standard-faqs/ambulatory/record-of-care-treatment-and-services-rc/000001698>. Accessed March 2, 2023
5. Writing an operative note *BMJ* 2005; 330 doi: <https://doi.org/10.1136/bmj.330.7492.s116-a> (Published 19 March 2005) Cite this as: *BMJ* 2005;330:s116
6. Melton GB, Wang Y, Arsoniadis E, Pakhomov SV, Adam TJ, Kwaan MR, Rothenberger DA, Chen ES. Analyzing Operative Note Structure in Development of a Section Header Resource. *Stud Health Technol Inform.* 2015;216:821-6.
7. Dumitra S, Wong SM, Meterissian S, Featherstone R, Barkun J, Fata P. The operative dictation: a review of how this skill is taught and assessed in surgical residency programs. *J Surg Educ.* 2015 Mar-Apr;72(2):321-9.
8. Novitsky YW, Sing RF, Kercher KW, Griffo ML, Matthews BD, Heniford BT. Prospective, blinded evaluation of accuracy of operative reports dictated by surgical residents. *Am Surg.* 2005 Aug;71(8):627-31;
9. Swigert NB. Clinical documentation, coding, and billing. *Semin Speech Lang.* 2006 May;27(2):101-18. doi: 10.1055/s-2006-939942. PMID: 16673258.

## Correct Coding – Bronchoscopic Codes 31628 & 31629

Mike Nelson MD, CHEST AMA CPT Representatives;  
Member, ATS/CHEST Joint Clinical Practice Committee

Pulmonary physicians and particularly interventional bronchoscopists have been receiving denials when CPT codes **31628** Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe and **31629** Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i) are billed during the same procedure. While the difference between a transbronchial forceps biopsy and transbronchial needle biopsy are obvious to bronchoscopists, there has been confusion with payers. This could have been partly on the basis of a CPT Assistant article from March 2021 describing the use of both codes that stated, “Note that performing two types of lung biopsy (forceps and needle aspiration) on the same lesion would be considered unusual and documentation of medical necessity should clearly describe why both types of biopsy were clinically necessary.” This may have been interpreted by coders and/or payers to mean that the two codes should be billed together rarely or not at all. It is also possible that computer-based coding programs (e.g., Optum/Encoder Pro, etc.) are responsible for these inappropriate denials. There are, however, no NCCI edits that disallow this nor was this the intent of the CPT codes when they were developed. The previous statement from the CPT Assistant article was clarified in the following sentences, “For example, if needle aspiration were performed and immediate screening of the sample were insufficient for diagnosis, a forceps biopsy would be appropriate and reported separately. On the other hand, if a physician performed a needle aspiration out of concern that the lesion was vascular and found that it was not and proceeded with a forceps biopsy, then the needle aspiration would be integral to the forceps biopsy and not separately reported.” Importantly, with the increasing use of navigational bronchoscopy and robotic bronchoscopy, these codes will be used together more frequently, appropriately, and correctly, especially on distal lesions. Remember, these codes are used for procedures in a single lobe. If multiple lobes are sampled then CPT codes **31632** and **31633** would be added to **31628** and **31629**, respectively. If one is receiving denials for these procedures, coders and payers should be notified of these errors and denials should be appealed.

## Coding and Billing Questions

**Question:** My practice is wondering if we can use the newer codes for online digital E/M services? We know they are time-based, but we are confused about when they cannot be used. Can you please help? For example, I had an established COPD patient send a message through the electronic health record’s patient portal reporting new symptoms of headache, cough, and sputum production. They asked me to review the chest x-ray that was done two days prior when they went to urgent care. The patient is asking for an assessment and management plan. We message back and forth over the next day for a total of 13 minutes. Three days later, the patient developed more symptoms and then scheduled an office visit. How would I bill for this? **99212-99215** (Established Office E/M) or **99422** (Online digital E/M 11-20 minutes)?

**Answer:** Online Digital E/M services (**99421, 99422, 99423**) are to be used for established patients, only. They are time-based codes and cumulative up to seven days. They are to be reported for asynchronous communication via HIPAA-compliance secure platforms, such as through the electronic health record portal, portal email, etc. They may not be reported if an E/M occurs within seven days before or after, though the time may be incorporated into the subsequent E/M. These codes are not to be used for communication of test results, scheduling of appointments, or other communication that does not include E/M. In your example, you would report the appropriate Office/Outpatient Established CPT code (**99212-99215**)

**99421** – Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes

**99422** - Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes

**99423** - Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

**Question:** Is Cardiopulmonary Resuscitation in the Intensive Care Unit considered to be part of Critical Care services? (**99291-99292**)? There appears to be confusion in our billing department on this issue.

**Answer:** **92959** Cardiopulmonary resuscitation is not bundled into **99291-99292**. Consider it as a procedure. To code for this service in addition to Critical Care, the time for the CPR must be separate from the time for Critical Care (**99291-99292**). A separate procedure note must also be documented. There is no minimum time for this service, and a 25 modifier must be included, as well. **92950** reimburses at 4.00 wRVUs and may be reported two times per calendar day. ●