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DECEMBER 2018

Coding & Billing Quarterly



Editor's Letter

The Centers for Medicare and Medicaid Services (CMS) released the final Medicare Physician Fee Schedule for 2019 and it includes some major policy changes for the entire physician community – but in most cases implementation of major policy changes are delayed until after 2019. This article will discuss the proposals in detail, those that are finalized in this rule and those that will likely be brought back in future CMS proposed rules. For those looking for a quick summary:

E/M Office visits – CMS has effectively created three payment levels for new and established patient office visits; level 1, levels 2,3 and 4 are combined and level 5. This is a hybrid of the original proposal to create two levels; level 1 and a combination of levels 2-5. However, this policy will not be implemented until 2021, giving the community time to prepare for this major policy shift.

MPPR – Multiple Procedures Payment rule – CMS did not finalize its proposal for multiple services provided on the same day as an E/M service, to reduce payment for the least costly service by 50 percent. However they are seeking additional comment on this proposal, which is a strong hint that CMS will likely try to implement this policy at some point in the near future.

Specialty Care Payments – CMS is finalizing add-on payments for specialty and primary care, but they are not limiting it to specific specialties as originally proposed in the CMS-proposed rule.

DME Supplemental Oxygen - In a separate rule, CMS has “paused” DME competitive bidding for two years, moved to and “any willing provider” model for DME services and made slight payment increases for liquid portable oxygen systems. CMS hopes that these changes will address access problems in the DME market (the patient and provider communities are skeptical these changes will improve DME access).

This issue covers each of these proposals in detail, both what is in the final rule and our expert predictions on how this will impact payment and practice patterns.

Also covered in this edition is coding advice for recently FDA approved bronchial valves for the treatment of COPD and how CMS's DRG placement of ECMO services will impact hospital payments.

As always, we welcome your questions on coding, billing and regulatory compliance matters. Questions can be sent to: codingquestions@thoracic.org.

Alan L. Plummer MD

Editor

ATS Coding and Billing Quarterly

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2019 Medicare Physician Fee Schedule: Final Rule

On Nov. 1, the Centers for Medicare and Medicaid Services released the final 2019 Medicare Physician Fee Schedule Rule, which covers payment and regulations for Medicare Part B providers. The final rule includes a number of important policy changes for pulmonary, critical care and sleep physicians. Below is a brief summary of major policy changes in the final rule.

Changes for 2019 and Beyond

Conversion Factor

The final conversion factor for 2019 physician services is \$36.04, which is a small increase over the 2018 conversion factor of \$35.99.

Documentation Requirements

CMS finalized several policies that will allow greater flexibility in how physicians choose to document patient encounters. For calendar years 2019 and 2020, physicians should continue to use either the 1995 or 1997 E/M documentation guidelines to document E/M office/outpatient visits for Medicare beneficiaries. CMS is also finalizing the following policies for 2019 and beyond:

- Elimination of the requirement to document medical necessity of a home visit in lieu of an office visit.
- For established patients' office visits or outpatient visits, when the relevant information is already in the medical record, physicians may choose to focus additional documentation on changes since the last visits or on key items that have not changed since the last visit. Physicians do not need to re-record the defined list of required elements if there is evidence that the physician appropriately reviewed the previous information and updated as needed. Physicians should still review prior data, update as needed and indicate in the medical record that they have done so.
- For E/M office/outpatient visits for new and established patients, CMS is clarifying that physicians do not need to re-enter in the medical record information on the patient's chief medical complaint and history if that information has already been put in the medical record by ancillary staff. The physician need only record that they reviewed and verified the information.
- Clarification of the requirement for medical documentation performed by residents and other members of the medical team for E/M services provided by teaching physicians.

Appropriate Use Criteria

CMS finalized its proposals for continued implementation of the AUC Program with little modification. Most notably, CMS finalized that AUC data will be reported by furnishing professionals on the Medicare claim form using a series of G-codes and modifiers — a proposal CMS previously abandoned. CMS acknowledged that the use of G-codes and modifiers may not be an ideal solution for reporting AUC data, but allows for program implementation to occur in 2020 as finalized. CMS also noted there are still technical issues that will need to be worked out with regard to G-codes. CMS has yet to propose how the transfer of AUC information will occur between the ordering and furnishing professions, or how it will identify outlier ordering professionals who will be subject to prior authorization.

In the final rule CMS clarified that:

- Independent Diagnostic Testing Facilities are an applicable setting, meaning that providers who furnish advanced diagnostic imaging in those settings will need to meet AUC Program requirements.
- Consultation of AUC may be performed by clinical staff under the direction of the ordering professional.
- Claims from both furnishing professionals and facilities must include AUC consultation information.
- G-codes and modifiers will be used to report consultation information on claims.

Telehealth Services

In 2019, CMS has finalized new telehealth codes:

- HCPCS code **G0513** (prolonged service first 30 minutes)
- HCPCS code **G0514** (prolonged services, additional 30 minutes)

Payment for these codes is approximately \$66.95 in the non-facility setting (not including Medicare geographic payment adjustments).

CMS Recognizes New Technology Interprofessional Internet Consultation (CPT codes 99451, 99452, 99446, 99447, 99448, and 99449)

In 2019, CMS has re-evaluated past decisions not to pay for interprofessional internet consultations and established rates for existing CPT codes. CMS states, “in light of changes in medical practice and technology, we [CMS] proposed to change the procedure status for CPT codes **99446, 99447, 99448, and 99449** from B (bundled) to A (active). We [CMS] also proposed the RUC re-affirmed work RVUs of 0.35 for CPT code **99446**, 0.70 for CPT code **99447**, 1.05 for CPT code **99448**, and 1.40 for CPT code **99449**.”

Additionally, new in 2019, CMS is establishing codes and rates for:

HCPCS code G2010 Remote pre-recorded services

G2010 Remote evaluation of recorded video and/or images submitted by the patient (e.g., store and forward), including interpretation with verbal follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment), **2019 rate \$12.61 Non-facility.**

HCPCS Code G2012 Brief Communication Technology-based Service, e.g. Virtual Check-in

G2012 Brief communication- technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion **2019 rate is \$14.78 Non-facility.**

Reimbursement for Pulmonary, Critical Care and Sleep Services

Attached are two spread sheets that list the 2019 versus 2018 payment rates for high volume pulmonary, critical care and sleep services for both physician schedule and hospital outpatient reimbursement.

Bronchoscopy – in general, bronchoscopic services saw 1 percent to 5 percent reimbursement reductions driven by CMS’s decision to reduce practice expense inputs for

bronchoscopic services. However, bronchoscopic EBUS sampling 1st and 2nd lymph node or station (CPT **31652**) and 3rd lymph node or station (CPT **31653**) saw significant increases due to ATS efforts to improve physician work and practice expense values.

Pulmonary Function Tests – PFTs saw payment variation largely due to small changes in practice expense costs and time inputs for these codes.

Sleep Tests – unattended sleep tests saw large reductions driven by CMS decision to reduce practice physician work associated with code and the RUC decisions to reduce time and equipment inputs for these services.

Hospital Outpatient Payment – payment for pulmonary, critical care and sleep services in the hospital outpatient prospective payment rule were generally positive with either increases or no changes for most services. However, two services, exhaled carbon dioxide gas test (CPT **94770**) and multiple sleep latency test (CPT **95805**) were reduced by 45 percent and 50 percent, respectively, due to changes in their ambulatory payment classification (APC) category group assigned by CMS as a result of hospital cost data changes.

Changes Finalized for 2021

E/M Office Visits – Combining E/M Levels 2-4 into a Single Payment Level

Starting in 2021, CMS finalized policy will combine payment for level 2-4 E/M office and outpatient visit into a single payment - effectively moving from five levels for E/M office/outpatient visits to three levels. The level 5 E/M office/outpatient visit has been retained.

E/M Documentation and Level Selection Criteria

Also starting in 2021, physicians can choose to document E/M office/outpatient visits for levels 2 through 5 using medical decision-making, time, 1995 or 1997 framework. Further, CMS will apply the minimum documentation standard associated with a level 2 visit. Physicians can use medical decision-making, time, 1995 or 1997 guidelines for choosing the appropriate level of an E/M services.

When physicians use time for documentation, they must document the medical necessity of the visit and that the billing physician personally spent the required amount of time face-to-face with the patient.

New Add-On Codes for Level 2-4 E/M office/outpatient visits

Implementation of add-on codes that describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care, though they would not be restricted by physician specialty. These codes would only be reportable with E/M office/outpatient level 2-4 services, and their use generally would not impose new per-visit document requirements. Further, in 2021 CMS intends to adopt a new “extended visit” add-on code for use only with E/M office/outpatient level 2-4 visits to account for the additional resources required when physicians need to spend extended time with a patient.

Policies Not Adopted

The final rule is also significant for policy proposals that CMS did not move forward with, including the Multiple

Procedures Payment Reduction proposed rule. CMS had initially proposed a new policy that – when an E/M service and additional procedure or procedures are offered on the same day – CMS would automatically reduce payment for the least expensive service offered by 50 percent. If implemented, physicians would have been stuck with either absorbing significant payment reductions for services provided to Medicare beneficiaries or forcing patients to return for multiple office visits or to receive treatment or testing on different days. Neither option was in the best interest of patient care.

Fortunately, CMS listened to the universal opposition from the physician community on the MPPR proposal and did not finalize this policy. However, it is clear that CMS may return to this policy at some point in the near future. ■

2019 PAYMENT TABLES FOR PULMONARY, CRITICAL CARE AND SLEEP SERVICES

American Thoracic Society
October 2018 Compared to Final 2019 Rates Medicare Physician Fee Schedule (MPFS)
Endoscopy/Bronchoscopy, Pulmonary Diagnostic Testing & Therapies, Sleep Medicine Testing, Pulmonary Rehabilitation/Respiratory Therapy and Thoracostomy/Chest Tubes
Click here for Link to Reference: CMS Website MPFS CY 2019 October Release (Web Version) (PDF)
August 3, 2018 MPFS File for October 2018 & November 1, 2018 for Final 2019 MPFS Files

CPT/HCPCS Code	Short Description	2018 Rate	2019 Rate	% Change	Dollar Change	2018 Rate	2019 Rate	% Change	Dollar Change
31615	Mucoscopy	\$174.30	\$174.30	0%	\$0.00	\$174.30	\$174.30	0%	\$0.00
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31631	Endoscopic examination	\$240.00	\$240.00	0%	\$0.00	\$240.00	\$240.00	0%	\$0.00
31632	Endoscopic examination	\$240.00	\$240.00	0%	\$0.00	\$240.00	\$240.00	0%	\$0.00
31633	Endoscopic examination	\$240.00	\$240.00	0%	\$0.00	\$240.00	\$240.00	0%	\$0.00
31634	Endoscopic examination	\$240.00	\$240.00	0%	\$0.00	\$240.00	\$240.00	0%	\$0.00
31635	Endoscopic examination	\$240.00	\$240.00	0%	\$0.00	\$240.00	\$240.00	0%	\$0.00
31636	Endoscopic examination	\$240.00	\$240.00	0%	\$0.00	\$240.00	\$240.00	0%	\$0.00
31637	Endoscopic examination	\$240.00	\$240.00	0%	\$0.00	\$240.00	\$240.00	0%	\$0.00
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31639	Endoscopic examination	\$240.00	\$240.00	0%	\$0.00	\$240.00	\$240.00	0%	\$0.00
31640	Endoscopic examination	\$240.00	\$240.00	0%	\$0.00	\$240.00	\$240.00	0%	\$0.00
31641	Endoscopic examination	\$240.00	\$240.00	0%	\$0.00	\$240.00	\$240.00	0%	\$0.00
31642	Endoscopic examination	\$240.00	\$240.00	0%	\$0.00	\$240.00	\$240.00	0%	\$0.00
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Medicare DME Competitive Bidding Program Final Rule

Last week, CMS also released the final rule for the Medicare DME Competitive Bidding program. The major policy announcement is that CMS is effectively “pausing” the competitive bidding program for two years and will not engage in new rounds of competitive bids or awarding contracts for DME services. In the two-year pause period, CMS will instead operate on an “any willing provider” model, meaning DME products can be provided by any qualified supplier who is willing to accept the Medicare payment rate. CMS hopes that temporarily moving to an “any willing provider” model will address some of the quality and access problems currently seen in the competitive bidding process.

Supplemental Oxygen – in both the proposed rule and the final rule, CMS recognized problems in the Medicare oxygen market, but failed to take meaningful action to address oxygen problems. CMS did provide a small increase in payments for liquid oxygen portable systems – which were offset by reductions in payments for other portable oxygen systems – in attempts to address access to liquid oxygen systems. However, the ATS is greatly concerned that the payment increases are insufficient to encourage DME companies to provide liquid portable systems to Medicare beneficiaries. We are also concerned that the DME providers are no longer under contractual obligation to provide a wide range of oxygen modalities so access to appropriate oxygen systems may further erode. Even with the contractual obligation, it was clear many DME companies were NOT supplying portable liquid oxygen as required by contract – so the contracts may only be of limited value.

In related news, CMS is also proposing to include ventilator equipment into the competitive bidding contracting process once the program completes its two year “pause.” The ATS is extremely concerned with this proposal and notes that ventilators are literal life-lines for many patients and require frequent servicing and emergency response service. Ventilators are not commodity products that can be purchased based solely on lowest bid proposal. ■

ECMO – CMS Splits ECMO Into Multiple DRGs

The use of Extracorporeal Membrane Oxygenation (ECMO) as a means to support lung and heart failure continues to grow across the country. Based upon the Extracorporeal Life Support Organization (ELSO) registry there were approximately 5500 cases of ECMO support in adults in the United States in 2017 with 58 percent of patients needing cardiac support and 42 percent respiratory support. Peripheral access was used in approximately 89 percent of patients.¹

Recently, the Center for Medicare and Medicaid Services (CMS) made a coverage decision in which Diagnostic Related Group (DRG) assignments (i.e. hospital reimbursement) for ECMO support were changed (see table I). Historically, all ECMO patients were assigned **DRG 003**, but now patients are stratified into different DRG groups based upon their mode of cannulation and indication for support. The modification in the ECMO International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) codes involved switching from a single code (**5A1522F**) to three separate PCS codes differentiated by the mode of vascular cannulation (central or peripheral) and the indication (cardiac or respiratory support). MS-DRG assignment for ECMO support will now be predicated upon those codes, resulting in a differential reimbursement based on the cannulation approach. Effective Oct. 1, 2018, peripheral ECMO ICD-10 PCS codes will be **5A1522G** (VA ECMO) and **5A1522H** (VVECMO) and are classified as non-surgical procedures with their DRG assignment based on the diagnosis and configuration (see table I)². Central ECMO cannulation **5A1522F** will still be considered to be an operating room procedure and remain in **DRG 003**. Approximately 10 percent of adult ECMO cases are over age 65 (covered by CMS) so the overall impact on ECMO reimbursement will be small at present. However, most insurance carriers follow the CMS coding and reimbursement decisions, hence this policy will affect all hospitals, patients, and clinicians.

Multiple medical specialty societies including the American Thoracic Society have joined together to ask CMS to consider a way to mitigate the negative financial

impact of these changes for FY 2019. In a letter to CMS, the societies have asked for reassignment of all ECMO ICD-10 PCS codes (5A1522F, 5A1522G and 5A1522H), regardless of the cannulation method, to Pre-MDC MS-DRG 003 for FY 2020 as well as the opportunity to meet and discuss the ramifications of differentiating ECMO based on cannulation. ■

TABLE 1

PCS Code 2018	Description	DRG	Base \$
5A1522 ³	ECMO	003	101,892
PCS Code Oct 1st 2018			
2018	Description	DRG	Base \$
5A1522F Central	ECMO	003	101,892
5A1522G	Peripheral VA ECMO		
	Heart Failure Shock	291	7,492
	Cardiac Arrest	296	8,551
	VA ECMO plus pVAD	215	71,759
5A1552H	Peripheral VV ECMO		
	Vent Support 96 hrs	207	31,165
	Sepsis with vent support	870	35,057
	VV ECMO plus pVAD	215	71,759

pVAD is peripheral ventricular device (Impella)

1. www.ELSO.org. Registry data.
2. <https://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/Downloads/2018-03-06-Agenda.pdf>
3. <https://www.else.org/Portals/0/CMS%20Changes%20in%20ECMO%20reimbursements%20-%20ELSO%20Report.pdf>

ATS/CHEST Webinar 2019 Medicare Payments Rules



The ATS and CHEST will jointly host a webinar on Wednesday December 12 @ 2:00 pm eastern to give members of ATS and CHEST information about the Medicare payment rules for 2019 and which policies will likely have an impact on pulmonary, critical care and sleep providers.

Specific topics will include:

- E/M office visits – how combining office visits levels 2,3 &4 will impact providers in the future
- Revised documentation requirements for office visits
- Appropriate Use Criteria implementation
- How best to incorporate new technology/ telehealth services into your practice
- Specialty Care payments
- DME supplemental oxygen

Webinar participants will be able to submit questions on other billing, coding, and regulatory compliance issues.

Click HERE
to register for the
FREE webinar



BRONCHIAL VALVES

Question: We understand that the FDA recently approved an endobronchial valve for the bronchoscopic treatment of adult patients with hyperinflation associated with severe emphysema in regions of the lung that have little to no collateral ventilation. To determine or confirm no collateral ventilation, we use a quantitative CT analysis service that assesses emphysema destruction and fissure completeness. In other cases, a bronchial blocking system is used that detects airflow if collateral ventilation is present.

What CPT and ICD 10 codes would be appropriate to report these new services?

Answer: CPT codes typically are not product- or device-specific. The codes below apply to current and future FDA approved endobronchial valves with similar clinical indications and intent for the treatment of emphysema.

To be a candidate for the currently approved service, patients must have little to no collateral ventilation between the target and adjacent lobes. In some patients, this can be determined by a quantitative CT analysis service to assess emphysema destruction and fissure completeness. If there is radiographic evidence of a complete fissure and anatomic isolation of the treatment target, a bronchoscopy assessment may be made on the patient. A bronchial blocking balloon and flow detection system is used to confirm that the patient has little to no collateral ventilation.

If the bronchial blocking technique shows evidence of collateral ventilation, the patient would be discharged without valve placement. In that scenario, the appropriate CPT code would be **31634**.

Code	Description
31634	Bronchoscopy, rigid with balloon occlusion, with assessment of air leak or flexible, including fluoroscopic guidance, when performed; with administration of occlusive substance (eg, fibrin glue), if performed
	(Do not report 31634 in conjunction with 31647 , 31651 at the same session)

If the patient is determined not to have collateral ventilation, the valve placement would proceed, followed by a hospital inpatient stay to monitor for possible side effects.

The appropriate CPT codes for placing, and removing FDA approved valves are:

NOTE for Removal: If there is a clinical need to remove the valves, (eg, intractable pneumothorax, post obstructive pneumonia other complications or lack of benefit) the valves can be removed.

Possible CPT Codes for FDA Approved Valve Insertion/Removal Procedures

Code	Description
31647	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe
+31651	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (Use 31651 in conjunction with 31647)
31648	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe
+31649	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure) (Use 31649 in conjunction with 31648)

NOTE code combinations: **31651** is used with **31647** when you insert a valve in a second lobe, in the same session. If today you insert in lobe #1, and in a separate procedure tomorrow you insert a valve in lobe #2, you report **31647** both days.

The table below identifies potential ICD-10-CM diagnosis codes for emphysema. Applicability and usage of these codes may vary per case. Hospitals and physicians also should check and verify current policies and requirements with the payer for any patient who will be treated with endobronchial valves.

Emphysema ICD-10-CM Diagnosis Codes

Code	Description
J43.0	Unilateral pulmonary emphysema
J43.1	Panlobular emphysema
J43.2	Centrilobular emphysema
J43.8	Other emphysema
J43.9	Emphysema, unspecified