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# Coding & Billing Quarterly

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## Editor's Letter

Welcome to the June issue of the ATS Coding & Billing Quarterly. This issue covers a number of items of interest to ATS members including guidance on proper documentation for medical work performed by medical students, appropriate coding and billing practices when working in tandem with advance practice providers, plus a review article on the AMA Resource Based Relative Value Update System - better known as RUC – and why RUC is such an important part of physician reimbursement.



And, as always, we respond to your questions about coding, billing and regulatory compliance issues. If you have questions about these issues, we encourage you to send questions to [codingquestions@thoracic.org](mailto:codingquestions@thoracic.org).

Alan L. Plummer MD  
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## RUC Survey:

### What is it and Why is it important?

The short answer is, it is the beginning of the process that ultimately determines the RVU's for all CPT codes. Physician participation is essential in order to ensure that appropriate values are assigned. Think of it as being similar to casting your vote in an election.

Professional reimbursement in the US is dependent on submission of charges using Current Procedural Terminology or CPT codes for services provided. The value of each service or Relative Value Unit (RVU) is set by Centers for Medicare and Medicaid Services (CMS) with recommendations from the AMA Resource Based Relative Value Update Committee, better known as the AMA RUC. The RUC conducts 3 meetings a year to develop the lengthy list of reimbursement recommendations which then go to CMS for review and are finalized annually in the Medicare Physician Fee Schedule. ATS needs help from its membership to participate in this process to ensure that appropriate values are assigned.

In order for each new, revised or potentially mis-valued CPT code to go through the RUC process, ATS will ask its members to participate in a RUC Survey. The purpose of the survey is to determine the time, complexity of the work involved and an estimate of the RVU for the given procedure or service.

The request for a RUC survey is sent to a random sample of the membership in a window of time set by the AMA several months prior to the next RUC meeting. The online survey asks if the member performs the procedure or service and has familiarity with it. If the answer is yes, the survey will begin. The member is asked a series of questions, beginning with estimating the time it takes to perform the service. Time, in RUC terms is broken down into pre-service, intra-service and post-service work. Think of the pre-work as what is done to prepare for the procedure or service, the intra-work is the actual procedure and the post-work is what work is needed to complete reports and communicate results to others. There are detailed descriptions and instructions in the survey which help the respondent understand the differences. Next, the survey respondent is asked to select a comparison code to the survey code from a list of similar services or procedures

that have already been through the RUC process. This is the Reference Service List or RSL. This is a very important step as the survey respondent will use this select "reference service" to compare to the survey code in terms of intensity and complexity of work. Finally, the survey respondent is asked to estimate the physician work RVU for the survey code. This is perhaps the most important step. Completion of the survey takes about 20 minutes.

Once the surveys are completed and returned, the ATS staff compile the results and data. An expert panel of ATS as well as ACCP/CHEST advisors is convened to review the results, prepare the recommendations which are then submitted to the AMA in preparation for the RUC meeting. The more surveys returned, the more accurate the recommendations will be to the RUC and ultimately to CMS. It is critical that members participate in the process. So, the next time you receive an email for a RUC survey, please take the time to complete it.

For more information on how to fill out a RUC survey, please see <http://www.thoracic.org/professionals/clinical-resources/resources-for-practices/ats-coding-billing-issues/ama-cpt-coding-ruc-surveys.php>

Or read the AMA document which describes the RVS Update process:

[https://www.ama-assn.org/sites/default/files/media-browser/public/rbrvs/ruc-update-booklet\\_0.pdf](https://www.ama-assn.org/sites/default/files/media-browser/public/rbrvs/ruc-update-booklet_0.pdf)

Questions can be sent to [codingquestions@thoracic.org](mailto:codingquestions@thoracic.org)

## Medical Student Documentation

The Centers for Medicare & Medicaid Services (CMS) recently released a Change Request (CR) regarding medical student documentation. [CR 10412](#) is an update to previous policies on allowing the teaching physician to refer to and verify student documentation of components of Evaluation and Management (E/M) documentation for the purposes of billing for E/M services. As of the implementation date of March 5, 2018, teaching physicians can now use student documentation of E/M services and its components for billing purposes.

"The teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed, but may

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verify any student documentation of them in the medical record, rather than re-documenting this work.” This varies from the previous policy that teaching physicians could “not refer to a student’s documentation of physical examination findings or medical decision making in your personal note,” and required the teaching attending to “verify and redocument the history of present illness, and perform and redocument the physical examination and medical decision-making activities of the service.”

The Clinical Practice Committee of the ATS is interpreting this change as largely bringing medical student documentation in parallel with resident physician documentation, allowing the teaching physician to refer to any available trainee documentation without having to redocument that information if the teaching physician has personally verified the information provided in the trainee’s documentation. E/M documentation guidelines for teaching physicians otherwise remain unchanged with requirements that: (1) you performed the service or were physically present during the critical or key portions of the service furnished by the resident, and (2) your participation in the management of the patient. For more information and details see <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R3971CP.pdf>

## Billing with Advance Practice Providers

Advanced Practice Providers (e.g. physician assistants, nurse practitioners, advanced practice nurses) and their collaborating physicians frequently care for the same patient in the intensive care unit on the same day. Navigating the relationship between the APP and the physician enables proper coding and billing of CPT codes 99291, 99292, and ICU procedures. Knowing the “rules of the road” facilitates a collaboration that benefits both groups of providers and helps avoid payment denials and other pitfalls.

Within the walls of the ICU, not every patient is “critically ill”. Only patients who have an illness or an injury that “acutely impairs one or more vital organ systems, with a high probability of imminent or life-

threatening deterioration”<sup>i</sup> are eligible for 99291/99292. Providers who should bill 99291/99292 are those who employ “high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or prevent further life-threatening deterioration of the patient’s condition”. If it takes longer than 30 minutes to perform these activities, then 99291/99292 can be submitted.

When an advanced practice provider and physician care for the same critically ill patient on the same day, CPT code 99291 can be used if a single provider spent at least 30 minutes giving personal attention to the patient. Documenting this encounter should describe why the patient met criteria for critical illness, what the provider did about it, and how long it took. Critical care service cannot be representative of a combined service between a physician and a qualified APP. If the APP spent 20 minutes in the morning and the intensivist spent 10 minutes later that day, then 99291 should not be used. Rather, evaluation and management (E/M) codes would be appropriate. Also, a physician may not bill for supervising a procedure performed by an APP<sup>ii</sup>. The APP should submit the bill.

If either the APP or the physician provides 99291 level of care, and a physician or qualified APP in the same specialty provides follow up care after the first hour (30-74 minutes) of critical care service, then the follow-up APP/physician should bill 99292. Providers in the same group practice who have the same specialty may not each report 99291 for critical care services to the same patient on the same day. Rather, these individuals must bill 99292 for each additional 30 minute time period spent caring for the patient on the same day after the initial 99291 service. Physicians in the same group practice who have different medical specialties may bill and be paid without regard to membership in the same group. But both providers cannot be caring for the patient at the same time. If providers from different specialties are both submitting 99291, then they should clearly document they cared for the patient at different times during the day. Also, two or more providers in the same group

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<sup>i</sup> <https://www.cms.gov/Regulations-and-guidance/Guidance/Manuals/downloads/clm104c12.pdf>. Chapter 12, 30.6.12. Accessed May 31, 2018

<sup>ii</sup> McCarthy C, O’Rourke NC, Madison JM. Integrating Advanced Practice Providers Into Medical Care Teams. *Chest* 2013; 143(3):847-850.

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who have different specialties need to provide care that is unique to their own specialty in order for both to bill 99291.

For encounters in the ICU involving either patients who are not critically ill, did not require highly complex decision making, or took less than 30 minutes, evaluation and management (E/M) codes (e.g. 99221-99223 or 99231-99233) should be reported. For E/M codes, both the physician and the APP may render portions of the service. If this occurs with an APP and physician belonging to the same group practice, then “shared/split” billing guidelines apply. In shared/split billing, the APP and physician may see the patient concurrently or at separate times during the same day.<sup>iii</sup> In either case, the physician must have a face-to-face encounter with the patient. Without this interaction, the APP must report the service as an independent provider. If the APP appears on the Medicare claim, reimbursement typically occurs at 85% of the Medicare Physician Fee Schedule. The documentation for shared/split services must identify the providers involved and include evidence of the physician’s participation. The physician should refer to the APP portion of service in the physician’s documentation.

There are many other permutations when examining the relationship between the APP and the physician. In some settings the APP is employed by the physician, in others both are employed by the same group, and in other settings the APP and the physician are employed by different groups but share the same specialty. Because of these variations, different Medicare administration contractors have developed different policies for physicians and APP’s submitting critical care bills for the same patient on the same day. Private payers and Medicaid may also have different rules. Physicians, APP’s, and their billing companies should contact their carrier to clarify 99291/99292 payment rules when APP’s and physicians are seeing the same patient on the same day.

## Endobronchial Ultrasound: Are you getting paid?

Kevin L Kovitz, MD, MBA and Kim D French, MHSA, CAPP

Endobronchial Ultrasound (EBUS) was given new Current Procedural Terminology (CPT) codes and relative value unit (RVU) valuation by the AMA effective January 2016. CPT codes, descriptors, and values were assigned for needle sampling of 2 or fewer nodes/stations (31652), 3 or more nodes/stations (31653), and when sampling is directed with radial probe peripheral ultrasound guidance add-on code (31654).

Lost in the change, however, was that some commercial carriers may not have adopted the new EBUS codes and valuations at the time they became effective. So some are inadvertently and inappropriately denying coverage and/or underpaying claims for this standard of care service. A carrier may have policies based on out of date literature or may have failed to implement the new standards. Without careful review, a denial may be overlooked because other components of the bronchoscopy may have been reimbursed (e.g. bronchoalveolar lavage or transbronchial biopsy) and the EBUS denial was lost in the overall reimbursement. Having a process in place for appealing an underpaid claim or denial is strongly recommended. This problem is carrier- and perhaps region-dependent so every practice should review bronchoscopy claims for this potential problem.

Common reasons for denials or underpayments include that blind transbronchial needle sampling, transthoracic sampling, or mediastinoscopy should have been attempted initially or even that EBUS is not indicated for benign disease such as sarcoidosis, among others. Each of these reasons is not reflective of the standard of care and the carriers should be alerted to this.

Our largest commercial carrier was in fact denying EBUS claims erroneously. With the following steps in place we were able to update their EBUS Coverage Policy successfully and appeal the denials. The following steps should be utilized for those encountering denials:

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<sup>iii</sup> Pohlig C. Nonphysician Providers in Your Practice. In: Manaker S, ed. *Coding for Chest Medicine*. Northbrook, IL: American College of Chest Physicians; 2013: 287-289.

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## 1. Be aware of the issues on your end.

- a. Do your notes reflect the procedure accurately, including describing why your choice of procedure fits the standard?
- b. Can the service be billed in combination with any other codes used or not?
- c. Have you submitted your claim in a timely manner?
- d. Are you aware you have been denied and do you have an appeal process in place?
- e. Is the volume of the service and the reimbursement under appeal worth the cost of the appeal itself in staff time?

## 2. Appeal the denial to your carrier.

- a. Use their process – often a carrier web link is available to upload documents.
- b. Submit full documentation if electronic submission is denied.
- c. Submit literature supporting that you have taken a standard of care approach.
- d. Appeal in writing to the medical director of the carrier(s) involved and/or with a personal meeting if needed. There might be local, regional or national directors to address broader scale concerns.

## 3. Elevate your concerns to your national societies

- a. ATS offers a question section of the CBQ that will elevate the question to the appropriate individuals and committees.

## Q&A

**Q:** How do we bill for a provider interpretation of overnight pulse oximetry?

**A:** Code 94762 (noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring [separate procedure]) should be used to bill for this service. Medicare should reimburse for 94762, including interpretation, only if that is the sole service billed for the patient on that date. If 94762 is billed with any other outpatient service on the same date, it will be bundled into that service and not paid for separately. Other payers may follow the same procedure or elect not to pay for 94762. You should check with these payers to find out what will be reimbursed for this service. While you may try to code it with 94762-26, that would be inaccurate as 94762 is a global code and does not have a PC-TC split billing. Another option could be to bill using an unlisted code 94799 and provide a detailed report of the service provided. This is likely to fail since a CPT code already exists for this service.

**Q:** We understand there are no specific ICD-10-CM codes to report for the use of e-cigarettes in 2018. In the absence of a specific code what should I report?

**A:** You are correct, presently there is no unique code(s) to document e-cigarette use. Absent a unique code, the ATS recommends F17.200 because the use of e-cigarettes is in patients who are nicotine dependent. We also believe that new ICD-10-CM codes to document e-cigarette use are necessary and the ATS has submitted a proposal for a new set of ICD-10-CM codes to document the use of e-cigarettes and/or electronic nicotine delivery systems (ENDS). The proposed codes work in parallel structure with the existing tobacco and nicotine codes. The ATS is optimistic that our proposed codes will be adopted soon.