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Coding&Billing Quarterly

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In This Issue

Letter from the Editor

This fall physicians across the U.S. will need to transition to ICD-10, beginning October 1, 2015. Hopefully you and your practice are well on you way to preparing for the ICD-10 transition, coding and billing software systems have been upgraded, encounter forms with ICD-10 codes have been created and physician and coding staff have been trained on the new system. For those looking for a bit of last minute preparation, this edition of the ATS Coding and Billing Quarterly will provide some useful information, including an article on ICD-10 coding for the interstitial lung diseases and news about ATS-sponsored webinars on ICD-10 coding.

This edition also has information about the Centers for Medicare and Medicaid Services proposed hospital outpatient rule and physician fee schedule rule for 2016. The proposed rules include several policy measures that, if adopted, will significantly impact the pulmonary, critical care and sleep communities. This edition summarizes some of those key issues and outlines the ATS response to CMS's proposal.

This edition also includes coding, billing and regulation questions submitted by ATS members and answered by ATS experts. As always, we welcome your questions. Please submit your questions to (codingquestions@thoracic.org).

Sincerely,

Alan L. Plummer, MD
Editor

ATS Hosts ICD-10 Webinars

The ATS will hold 3 webinars to provide information to ATS members on ICD-10 coding for pulmonary, critical care and sleep medicine. The webinars are free for ATS members and are expected to last about 60 minutes each. Webinars will be held:

Wednesday September 9 – Pulmonary Medicine Coding with Dr. Katina Nicolacakis
Register here: Pulmonary Medicine ICD-10 Coding

Wednesday September 16 – Critical Care Medicine Coding with Dr. Stephen Hoffmann
Register here: Critical Care ICD-10 Coding

Wednesday September 23 – Sleep Medicine Coding presented by Dr. Michael Nelson
Register here: Sleep Medicine ICD-10 Coding

CMS PROPOSES HOSPITAL OUTPATIENT RULE FOR 2016

This summer, CMS issued the proposed 2016 rule for the Hospital Outpatient Prospective Payment System. The rule touched on a number of areas of interest to ATS members. Below is a quick summary of key issues:

Pulmonary Rehabilitation and Respiratory Therapy Codes

On the plus side, CMS is proposing to increase the payment for pulmonary rehabilitation (G0424) and respiratory therapy codes (G0237, G0238, G0239) provided in hospital outpatient departments for 2016.

Code	Description	Proposed 2016 Medicare Payment	% Increase
G0237	Therapeutic procd strg endur	$93.27	78%
G0238	Oth resp proc, indiv	$56.70	8%
G0239	Oth resp proc, group	$31.30	6%
G0424	Pulmonary rehab w exer	$56.70	8%

APC Consolidation

CMS is proposing to consolidate the Ambulatory Payment Classification (APC) across a broad range of outpatient hospital services, including services that impact interventional bronchoscopy procedures, pulmonary function tests and sleep testing. The proposed APC consolidation will likely create payment "winners and losers" in each of the impacted APC categories. However, the proposed rule initiates so many proposed policy changes it is difficult to estimate the magnitude of impact caused by APC consolidation. While estimating the exact impact is challenging, it appears the overall impact on payments for pulmonary and sleep services will be minimal.

Chronic Care Codes

In the proposed rule CMS issued a clarification on the appropriate use of chronic care codes (CPT 99490) but did not propose to allow providers to use complex chronic care codes (CPT 99487/99489).

Lung Cancer Screening Shared Decision Making Visit Code

Also in the proposed CMS Hospital Outpatient Prospective Payment rule is CMS's proposal for coding the "shared decision making visit" needed for CT lung cancer screening. As you may recall, CMS issued coverage policy for CT lung cancer screening earlier this year. One of the requirements for lung cancer screening was a "shared decision making visit" for patients and providers to discuss the risks and benefits of lung cancer screening. However, in issuing the coverage policy, CMS did not outline how to code and bill for the shared decision making visit.

In the proposed rule, CMS has created new G codes for the shared decision making. Each visit is proposed by CMS to be approximately 15 minutes long with a work RVU of 0.52 therefore an approximate payment of $20.00. What is unclear in the CMS proposal is whether thecode can be used with an E&M service or whether CMS envisions the code as a stand-alone service only. The ATS believes the code should be available in both situations, as a stand-alone service or in combination with an E&M service.

CMS PROPOSES 2016 MEDICARE PHYSICIAN FEE SCHEDULE RULE

In related news, CMS released the proposed 2016 Medicare Physician Fee Schedule rule that proposes payment rates and policies for physicians and other Part B providers for the coming year. The rule covers a number of areas of interest to the ATS including:

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Potentially Mis-valued Services Under the Physician Fee Schedule

CMS has identified a number of CPT codes as "potentially mis-valued." That means CMS is requesting/requiring the provider community to resurvey these codes to ensure they have the appropriate relative values within the overall coding system. The ATS is concerned that CMS's selection is driven more by cost saving potential than actual selection of mis-valued codes. If CMS moves forward with its plan to resurvey the identified codes, many codes of interest to ATS members will be affected, including:

31575	Diagnostic laryngoscopy
31579	Diagnostic laryngoscopy
31600	Incision of windpipe
33518	Cabg artery-vein two
36215	Place catheter in artery
36556	Insert non-tunnel cv cath
36595	Insert picc cath
36620	Insertion catheter artery
94010	Breathing capacity test
94620	Pulmonary stress test/simple

Practice Expense, Malpractice Expense, and Physician Work Values

CMS has proposed to accept the practice expense values and malpractice values for a number of recently surveyed pulmonary codes. This is welcome news. However, CMS has rejected work values for the new endobronchial ultrasound codes. The ATS is concerned that CMS rejected the physician work values recommended by the ATS and the AMA RUC. ATS will provide comments to CMS supporting our recommended work values.

Elimination of Refinement Panels

In related news, CMS has proposed eliminating the "Refinement Panel". These panels allow an appeal by the physician community with CMS for any code value lowered from the RUC recommendations. The refinement panels, while cumbersome, have been the physician communities' only means of appealing CMS's decisions on work values. The ATS strongly opposed CMS's proposal to eliminate the refinement panels.

Advance Care Planning

The ATS strongly supports CMS's proposal to pay for voluntary Advance Care Planning services (CPT 99497 and 99498). CMS finalized and later rescinded a similar policy in the 2011 final rule, bending to the political firestorm created by "death panel" demagoguery. While the ATS is disappointed it took CMS 4 years to move forward with this proposal, we are pleased that it has finally arrived. Allowing physicians and Medicare beneficiaries to voluntarily discuss and plan the care for life-threatening and end-of-life situations will improve care outcomes and reduce emotional stress on Medicare beneficiaries, their families and medical staff.

Quality Measures

The proposed rule also included small changes to a number of physician quality measures that touch on pulmonary diseases. Below is a quick summary of the proposed quality measures impacting pulmonary and critical care medicine;

NQF/PQRS 0028/226 –Preventive Care: Tobacco Use: Screening and Cessation Intervention –The ATS notes this measure has been included in several measures groups for 2016 and beyond including Cardiovascular Prevention Measures Group, Diabetes Retinopathy Measures Group, Diabetes Measures Group and the Preventive Care Measures Group.

Coordinating Care: Emergency Department Referrals: CMS is proposing to measure emergency department efforts to contact the patient's primary care physician in cases of asthma exacerbation and chest pain that do not result in an inpatient stay. While the ATS is generally supportive of quality measures to document and improve the effective coordination of care between the emergency room and primary care provider, we are concerned the proposed measure is not NQF endorsed (or endorsed by any other quality organization).

Post-Anesthetic Transfer of Care Measure: Use of Checklist or Protocol for Direct Transfer of Care from Procedure Room to Intensive Care Unit (ICU): CMS is proposing to include the "checklist" measure for transfer of patients to intensive care units. . While we are generally supportive of quality measures to document and improve the effective transfer of care within a hospital, we are concerned the proposed measure is not NQF endorsed (or endorsed by any other quality organization). We are unaware of any studies that demonstrate quality improvements with the adoption of checklists for transfer of patients to the ICU.

Tuberculosis Prevention for Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis Patients on a Biological Immune Response Modifier: CMS is proposing to adopt a TB prevention measure for patients on biological immune response modifiers.

ICD-10-CM CODING FOR INTERSTITIAL LUNG DISEASES

Since 2014, CBQ has been reviewing the new ICD-10-CM codes for many pulmonary diseases. To review these articles access CBQ on the ATS website at **www.thoracic.org/about/newsroom/newsletters/coding-and-billing/**.

This article continues the series with ICD-10-CM coding for the idiopathic interstitial lung diseases (ICD 9-CM: **515-516.9**; ICD-10-CM: **J84-J84.9**) and systemic diseases with lung involvement (ICD-9-CM: **135**, **517.8** and **710-710.9**; ICD-10-CM: **D86.1-D86.3**, **M05.10-M05.19**; **M32.10-M35.02** and **J99**). The ICD-9 and ICD-10-CM coding for the idiopathic interstitial lung diseases was revised shortly before the last update on ICD-9-CM which occurred October 1, 2011. As a result there have been few changes in the code descriptors for the idiopathic interstitial lung diseases in ICD-10-CM.

ICD-9-CM code **515** for post inflammatory pulmonary fibrosis will be replaced by two codes, pulmonary fibrosis, unspecified, **J84.10**, or other specified interstitial pulmonary disease, **J84.89** (Table One). The first code should be used if there is no known cause or disease associated with the pulmonary fibrosis, and the second code if there seems to be a cause or disease associated with the pulmonary fibrosis which is not captured by another pulmonary ICD-10-CM code.

There have been a few changes in the coding structure for several of the idiopathic interstitial lung diseases. Lymphoid interstitial pneumonia, **J84.2**, has been removed from the list of idiopathic interstitial pneumonias, **J84.11**, and placed under other pulmonary diseases with fibrosis, **J84.1**. Similarly surfactant mutations of the lung, **J84.83**, has been moved from under other interstitial lung diseases of childhood, **J84.84**, and placed under other specified interstitial pulmonary diseases, **J84.8** (Table One). Chest x-ray or chest CT findings, pulmonary function test results and lung biopsy results should be described in the patient's record to document the presence of the idiopathic interstitial lung diseases.

TABLE ONE: IDIOPATHIC INTERSTITIAL LUNG DISEASES*

IDC-9-CM	DESCRIPTOR	IDC-10-CM	DESCRIPTOR
515	Post inflammatory pulmonary fibrosis	J84.10	Pulmonary fibrosis, unspecified
		J84.89	Other specified interstitial pulmonary disease
516.0	Pulmonary alveolar proteinosis	J84.01	Alveolar proteinosis
516.1	Idiopathic pulmonary hemosiderosis	J84.03	Idiopathic pulmonary hemosiderosis
516.2	Pulmonary alveolar microlithiasis	J84.02	Pulmonary alveolar microlithiasis
516.30	Idiopathic interstitial pneumonia, NOS	J84.111	Idiopathic interstitial pneumonia, NOS
516.31	Idiopathic pulmonary fibrosis	J84.112	Idiopathic pulmonary fibrosis
516.32	Idiopathic non-specific inter. pneumo	J84.113	Idiopathic non-specific interstitial pneumonitis
516.33	Acute interstitial pneumonitis	J84.114	Acute interstitial pneumonitis
516.34	Respiratory bronchiolitis inter lung dis	J84.115	Respiratory bronchiolitis interstitial lung dis
516.35	Idiopathic lymphoid inter pneumonia	J84.2	Lymphoid interstitial pneumonia
516.36	Cryptogenic organizing pneumonia	J84.116	Cryptogenic organizing pneumonia
516.37	Desquamative interstitial pneumonia	J84.117	Desquamative interstitial pneumonia
516.4	Lymphangioleiomyomatosis	J84.81	Lymphangioleiomyomatosis
516.5	Adult pulm Langerhans cell histiocytos	J84.82	Adult pulmonary Langerhans cell histiocytosis
516.61	Neuroendocrine cell hyperpl of infancy	J84.841	Neuroendocrine cell hyperplasia of infancy
516.62	Pulmonary interstitial glycogenosis	J84.842	Pulmonary interstitial glycogenosis
516.63	Surfactant mutations of the lung	J84.83	Surfactant mutations of the lung
516.64	Alveol cap dysplasia w/vein misalign	J84.843	Alveolar cap dysplasia w/vein misalignment
516.69	Other interstitial lung dis of childhood	J84.848	Other interstitial lung diseases of childhood
516.9	Other nonspec alveol & parietoalveol pneumopathies	J84.9	Interstitial pulmonary disease, unspecified

*2015 ICD-9-CM; Draft 2015 ICD-10-CM; 2015 ICD-10-CM Mappings

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Lung involvement can occur with sarcoidosis and other systemic diseases. Usually two ICD-9-CM codes are required to code for the systemic disease and the lung involvement. To code for pulmonary involvement in sarcoidosis for example, ICD-9-CM code **135**, sarcoidosis, is used along with **517.8**, lung involvement in other diseases classified elsewhere. For sarcoidosis in ICD-10-CM, **D86.0** is the code for sarcoidosis of the lung and D86.2 is the code for sarcoidosis of the lung and lymph nodes (Table Two). **D86.1** should be used for sarcoidosis of the lymph nodes seen in stage I sarcoidosis. It will be important for documentation using ICD-10-CM to describe the chest x-ray or chest CT findings along with pulmonary function studies in the patient's record as well as pathologic findings supporting sarcoidosis. For ICD-10-CM, lung involvement in systemic diseases will require only one code (Table Two) Rheumatoid lung disease was identified by only one code in ICD-9-CM, **714.81**, and, in ICD-10-CM, becomes **M05.10**, rheumatoid lung disease with rheumatoid arthritis of an unspecified site, or **M05.19**, rheumatoid lung disease with rheumatoid arthritis of multiple sites (Table Two). Rheumatoid lung disease codes for monoarticular rheumatoid arthritis (**M05.12-M05.17**) should be used when only monoarticular rheumatoid arthitis is present. Documentation for lung involvement in rheumatoid arthritis and other systemic diseases will require describing the chest x-ray or chest CT findings, pulmonary functions studies and any lung pathology results in the patient's record.

TABLE TWO: LUNG INVOLVEMENT IN SYSTEMIC DISEASES*

135/517.8	Sarcoidosis	D86.0	Sarcoidosis of the lung
		D86.1	Sarcoidosis of the lymph nodes
		D86.2	Sarcoidosis of the lung and lymph nodes
517.8	Lung involvement in other lung diseases classified elsewhere	J99	Respiratory disorders in diseases class ELSW
710.0/517.8	Pulmonary alveolar microlithiasis	M32.13	Lung involvement in SLE
710.1/517.8	Systemic sclerosis w lung involve	M34.01	Systemic sclerosis with lung involvement
		M33.01	Juvenile dermatopolymyositis w lung involve
710.2/517.8	Sicca syndrome w lung involve	M35.02	Sicca syndrome w lung involvement
710.3/517.8	Dermatomyositis w lung involve	M33.11	Other dermatopolymyositis w lung involve
		M33.91	Dermatopolymyositis, unsp w resp involve
710.4/517.8	Polymyositis w lung involvement	M33.21	Polymyositis with respiratory involvement
714.81	Rheumatoid lung disease	M05.01	Rheumatoid lung dis w RA of unspec site
		M05.11 - M05.17	Rhematoid lung dis w RA of spec site
		M05.19	Rheumatoid lung dis w RA of multiple sites

*2015 ICD-9-CM; Draft 2015 ICD-10-CM; 2015 ICD-10-CM Mappings

Q&A

Counting Time for Critical Care Outside the Unit

Q. Can I count my time towards critical care services that I spend talking to the unit when I am at home or in my office? I believe my time is necessary for the care of the patient in the unit.

A. CPT and Payers would not consider time where a physician is not immediately available to the patient as critical care services to the patient. This time is considered as pre service and post service work included in any E/M service.

Q. CMS and the AMA posted leniency guidance during the first year (October-1-2015 to September 30, 2016) implementation ICD-10-CM, does this guidance apply to all payers in all settings?

A. No, the official CMS/AMA Guidance only applies to Medicare fee-for-service claims from physician or other practitioner claims billed under the Medicare Fee-for-Service Part B physician fee schedule. Each commercial payer will have to determine whether it will offer similar audit flexibilities. Additionally, this Guidance does not apply to claims submitted for beneficiaries with Medicaid coverage, either primary or secondary.

For more details and ICD-10-CM Q&As regarding the CMS/AMA joint announcement go to https://www.cms.gov/Medicare/Coding/ICD10/Clarifying-Questions-and-Answers-Related-to-the-July-6-2015-CMS-AMA-Joint-Announcement.pdf