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Coding&Billing Quarterly

OCTOBER 2016

In This Issue

Letter from the Editor

Welcome to October issue of the ATS Coding and Billing Quarterly.

The physician community is waiting on a number of important final rules from CMS that will significantly impact medicine in 2017 and beyond. Just before this issue went to press, CMS released the final rule on MACRA (Medicare Access and CHIP Authorization Act) – a small acronym that will usher in large changes in the U.S health system. As we reported in the June issue of the ATS Coding and Billing Quarterly, MACRA will bring significant short and long term changes to the physician community by requiring most physicians who participate in the Medicare program to participate in either Advanced Alternative Payment Models (APMs – essentially risk sharing payment arrangements) or participate in MIPS (Merit-based Improvement System – a combined system that include quality measures, practice improvement activities and certified EHR use). Since the final rule was only just released, this issue provides only a cursory overview of the final MACRA rule. The January 2017 issue of the ATS Coding and Billing Quarterly will provide a more comprehensive review of the MACRA rule.

We are also awaiting publication of the final Medicare Physician Fee Schedule which will provide important guidance on payment rates, new procedure codes and changes to quality measures. Please see our January issue for a full detailing of both these pending rules.

In the meantime, this issue will provide you with updates on ATS efforts to improve the ICD-10-CM nomenclature for pulmonary hypertension. It also notes changes in G codes for reporting smoking cessation counseling, revisions to COPD/bronchodilator use quality measures and addresses the continued confusion on appropriate coding for EBUS procedures.

As always, we welcome your suggestions for future articles and any coding, billing or regulatory compliance issues you may have.

Sincerely,

Alan L. Plummer, MD
Editor

ATS REQUESTS REVISED ICD-10 CODES FOR PULMONARY HYPERTENSION

The ATS is petitioning the ICD-10 Coding Update and Coordination Committee to revise the existing ICD-10 for pulmonary hypertension. The current ICD-10 codes use the terms primary and secondary to delineate different categories of pulmonary hypertension, however, the terms primary and secondary have been largely superseded by a more recent terminology based on WHO classifications. These categories are:

Group 1: Pulmonary Arterial Hypertension
Group 2: Pulmonary Hypertension due to left heart disease
Group 3: Pulmonary Hypertension due to lung disease and/or hypoxia
Group 4: Chronic Thromboembolic Pulmonary Hypertension
Group 5: Pulmonary Hypertension with unclear multifactorial mechanisms

At a recent meeting of the ICD-10 Update and Coordination Committee, ATS member Scott Manaker MD presented the rationale for revising ICD-10 codes to follow the more current nomenclature. In his presentation to the committee, Dr. Manaker noted that both drug treatment and surgical interventions rely on the WHO categories.

While the outcome of the edit process is not yet complete, the ATS expects that the ICD-10 Update and Coordination Committee will accept most of our recommendation. Assuming the pulmonary hypertension codes are amended, the revised codes would be available for use starting October 1, 2017.

CMS RELEASES FINAL MACRA RULE

The Centers for Medicare and Medicaid Services (CMS) recently released the final rule to implement the Medicare Access and CHIP Reauthorization Act – better known as MACRA. The final MACRA rule will implement significant changes to Medicare reimbursement for Part B services by requiring nearly all Part B providers (physicians, physician assistants, nurse practitioners and other Part B providers) to participate in CMS Quality Payments Programs. Providers with less than $30,000.00 in Medicare Part B reimbursements or fewer than 100 Medicare beneficiaries will initially be exempt from participating in the CMS Quality Payments Program. CMS estimates 32.5% of providers will meet the above participation exemptions.

Physicians can participate in the CMS Quality Payments Program two ways:

Participating in an Advanced Alternative Payment Model (APM). APMs include a variety of CMS approved payment models that require some form of risk sharing, incorporation of electronic medical records and quality improvement activities. Provider who successfully participate in APMs in 2017 are eligible for up to a 5% bonus payments in 2019.

Participating in Merit-based Incentive Pay System (MIPS). Under MIPS, providers will be required to report on quality measures, practice improvement activities and use of certified EHR technology.

Providers who do not successfully participate in either program in 2017 will be subject to a 4% cut in 2019. Providers who successfully submit at least 90 continuous days of data for 2017 encounters in the MIPS program, at a minimum, will avoid the -4% cut in 2019 and may be eligible for a positive bonus. Full year MIPS participants will be eligible for bonus payments in 2019 based on 2017 reported data.

To learn more about the final rule, please visit the CMS Quality Payment Programs http://www.hhs.gov/aboutnews/2016/10/14/hhs-finalizes-streamlined-medicare-payment-system-rewards-clinicians-quality-patient-care.html website.

The ATS will closely review the final rule and provide a more detailed analysis in the January 2017 issue of ATS Coding and Billing Quarterly.

CMS CEASES USE OF HCPCS G CODES FOR SMOKING CESSATION

Effective on or after Oct. 1, 2016 the Center for Medicare and Medicaid Services (CMS) will no longer allow use of Healthcare Common Procedural Coding System (HCPCS) codes **G0436** *Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minute*s and **G0437** Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes. Instead, CMS will utilize the existing CPT codes developed for the Current Procedural Terminology (CPT) code set.

CMS has advised its Medicare contractors to replace code **G0436** with CPT code **99406** (*Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes*) and replace code **G0437** with CPT code **99407** (*Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes*). According to the Medicare National Coverage Determination Manual, tobacco cessation counseling is covered both for symptomatic and asymptomatic smokers. CMS will allow healthcare providers two attempts per year to encourage Medicare patients to cease tobacco use but does not define an attempt. Rather, either of the codes may be used up to four times per attempt; so **99406** and **99407** or a combination of these codes may be used up to 8 times in a 12 month period. These codes may be used either as a stand-alone or with an evaluation and management (E&M) service with appropriate documentation. Remember, however, if one uses these codes during an E&M visit, a **25** modifier will need to be appended to the E&M code.

CONFUSION IN EBUS CODING

There has been some confusion about appropriate coding using the new endobronchial ultrasound codes with some of the other bronchoscopy codes. Notably, when CPT code **31629** *bronchoscopy with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus* is appropriate to use with code **31652** *with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), one or two mediastinal and/ or hilar lymph node stations or structures* and **31654** code *with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), 3 or more mediastinal and/ or hilar lymph node stations or structures*. Both **31652** and **31653** include needle sampling as a part of the work and therefore, if the bronchoscopy involves only the sampling of the hilar/mediastinal node, it would be inappropriate to include **31629**.

However, mediastinal sampling is often done in conjunction with evaluation of a more peripheral lesion. If a bronchoscopy is performed with needle aspiration biopsy(ies) of a peripheral lesion and subsequently an EBUS scope is used to sample mediastinal or hilar lymph node stations, one could utilize **31629** as well as either **31652** or **31653**. If EBUS is used to localize the peripheral node, the **31654** can also be used.

As an illustrative example, a 75 year old male is found to have a 2 cm peripheral nodule in the anterior segment of the right upper lobe with enlarged right hilar and subcarinal lymph nodes on CT scan. Bronchoscopy is performed and initially the patient has a survey bronchoscopy along with brushings and washing of the airway using a non-EBUS scope. A radial ultrasound probe is used to help identify the peripheral lesion and multiple needle biopsies are performed as are brushings and washings. Subsequently, an EBUS scope is introduced and right hilar, right paratracheal and subcarinal needle aspiration biopsies are performed. The appropriate codes to utilize to describe the work done in this procedure include **31623**, **31629**, **31653** and **31654**. Had no peripheral needle biopsies been performed then code **31629** and **31654** would NOT be used.

Coming Soon: RUC Survey on Unattended Sleep Studies

In early 2017, the ATS and sister societies will participate in a joint RUC survey to collect information on physician time, intensity, medical decision making to perform and interpret unattended sleep studies (CPT **95800**, **95801**, **95806**). Randomly selected ATS members will be contacted by email to participate in this web based survey. Data from the survey will be used to inform the AMA RUC and CMS on the proper value of unattended sleep studies.

If you are asked to participate in the survey and are familiar with unattended sleep studies, we strongly urge you to take the time to accurately complete the RUC survey.

ATS REVISES COPD BRONCHODILATOR MEASURE

Starting January 1, 2017, the quality measure for COPD and bronchodilator use has been changed to require the prescription of long-acting bronchodilators to fulfill to quality measures. The new measure now reads:

Measure #52 (NQF XXXX): Chronic Obstructive Pulmonary Disease (COPD): Long-Acting Inhaled Bronchodilator Therapy – National Quality Strategy Domain: Effective Clinical Care

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of COPD (FEV1/FVC < 70%) and who have an FEV1 less than 60% predicted and have symptoms who were prescribed a **long-acting** inhaled bronchodilator (emphasis added).

The previous measure did not differentiate between short and long-acting inhaled bronchodilators. However, COPD treatment guidelines developed by the ATS and other professional organizations strongly recommend the use of long-acting bronchodilators for patients with COPD.

The ATS Quality Improvement and Implementation Committee worked with staff at CMS to update the measure to better align with clinical practice guidelines and to improve patient care. CMS has accepted the revision as an administrative change and will implement the revised measure starting January 1, 2017. Providers should make note of the change in the quality measure and ensure they are reporting the revised measure accurately.

Q&A

Pulmonary Stress Test and ECGs

Q. We perform an ECG with CPT **94620** *Pulmonary stress testing; simple (eg, 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry) or* **94621** *Pulmonary stress testing; complex (including measurements of CO2 production, O2 uptake, and electrocardiographic recordings)* Can we bill separately for the ECG and or stress test if performed with these services? Additionally, what if an ECG is done in the morning and then the test needs to be repeated. Are we able to bill and be paid for the ECG in that situation?

A. No, it is not appropriate to report and bill separately for an ECG as those services, when performed, would be inherent to either CPT **9460** and or **94621**. For a separate ECG performed at a separate time during the same date of service for either **94620** or **94621**, if medically necessary and separately ordered you may be paid by appending the modifier **59** or another appropriate modifier as requested by the payer. The modifier is necessary to designate this was a separate identifiable service.