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Coding&Billing Quarterly

JANUARY 2018

In This Issue

Welcome to the January issue of the ATS Coding and Billing Quarterly. This issue covers a lot of new Medicare payment policies that will impact ATS members and their practices starting Jan. 1, 2018.

Medicare released the final rules for both the 2018 Medicare Physician Fee Schedule – which covers payment and coverage policies for physicians and other Medicare Part B providers – and the Medicare Hospital Outpatient Prospective Payment Rule – which deals with reimbursement for hospital outpatients services. While neither rule includes any major policy shifts that will directly impact ATS members, there are a number of reimbursement changes (positive and negative) that will affect procedure code families of interest to ATS members. This issue will both alert you to these payment changes and provide some background on why these reimbursement changes are happening.

The New Year will bring in some revised CPT codes of interest to the ATS community. This issue explains these revised CPT codes. Also covered in this edition is news about the revised ICD-10-CM codes for pulmonary hypertension. While the revised family of codes was in use starting Oct. 1, 2017, we are still receiving questions on the correct use of the new code family. This issue includes nomenclature for the revised coding family for pulmonary hypertension.

MACRA continues to be on our radar and this issue provides an update on MACRA driven reporting requirements for 2018 and how those reporting requirements will impact future payments.

This issue also answers member questions on correct billing, coding and regulatory compliance issues. As always, we welcome member questions on coding, billing and regulatory compliance issues for pulmonary, critical care and sleep medicine. Questions can be sent to codingquestions@thoracic.org. All member questions will receive a response.

Have a healthy and prosperous New Year.

Alan L. Plummer MD
Editor
ATS Coding and Billing Quarterly

Revised CPT Codes for 2018

There will be a number of changes to Current Procedural Terminology (CPT) codes of interest to pulmonary/critical care providers effective on Jan. 1, 2018. It is important to understand these changes as they describe commonly used procedures in pulmonary medicine.

There are two changes in the CPT codes for therapeutic bronchoscopy involving **31645** and **31646**. CPT code **31645** *with therapeutic aspiration of tracheobronchial tree, initial* describes a therapeutic bronchoscopy for removal of viscous, copious or tenacious secretions from the airways. It had previously included wording that suggested it was used for abscess drainage and this has been removed. CPT code **31646** *with therapeutic aspiration of tracheobronchial tree, subsequent, same hospital stay* describes the same procedure and is utilized when the procedure is repeated during the same hospital stay. This code, therefore, would not be appropriate to use for a procedure done in the outpatient setting. If a therapeutic bronchoscopy is done in the outpatient setting, CPT code **31645** should be used for each procedure.

CPT code **94620** *Pulmonary stress testing; simple (eg, 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry)* has been deleted and replaced by two new codes. CPT code **94617** *Exercise test for bronchospasm, including pre- and post-spirometry, electrocardiographic recording(s), and pulse oximetry* describes the procedure used to assess for exercise induced bronchospasm. CPT code **94618** *Pulmonary stress testing (eg, 6-minute walk test), including measurement of heart rate, oximetry, and oxygen titration, when performed* describes the typical simple pulmonary stress test. After Jan. 1, 2018, if CPT code **94620** is used, the claim will be denied. CPT code **94621** *Cardiopulmonary exercise testing, including measurements of minute ventilation, CO2 production, O2 uptake, and electrocardiographic recordings* has been reworded to describe the procedure of cardiopulmonary exercise testing more clearly. In addition to these changes, there are numerous parentheticals appended that list the CPT codes that may not be used in conjunction with **94617**, **94618** and **94621**. Please refer to the 2018 CPT manual for further information on these exclusions.

2018 Medicare Physician Fee Schedule

The CY 2018 physician fee schedule final rule, released on Nov. 2, 2017 contained final site-neutral policies mandated in Section 603 of the Bipartisan Budget Act of 2015. Section 603 is about "payment equalization" between free-standing physician offices and off-campus hospital owned, provider-based departments (PBDs.) Section 603 directed CMS to no longer pay the OPPS rate for services furnished in new off-campus PBDs (i.e., not billing as of Nov. 2,15) beginning Nov. 2, 2015, except under certain circumstances that the 21st Century Cures Act expanded to some degree. Providers in these hospitals owned as off-campus PBDs will append one of two modifiers, a PN or PO. Append a modifier PN - *Non-excepted*[1] *service provided at an off-campus, outpatient, provider-based department of a hospital* if you were a new PBD after Nov. 2, 2015. Append a modifier PO - **Excepted service** provided at an off-campus, outpatient, provider-based department **PBD** of a hospital. The PO modifier is for those sites that are grandfathered and it will not trigger a payment reduction. The PN modifier will result in a payment rate that is a 60 percent reduction to the OPPS payment rate as the final rules states it will pay 40 percent of the OPPS rate.

Codes with significant payment changes in the Medicare Physician Fee Schedule include:

Central Venous and Arterial Catheter Placement

A significant change in the physician work value for central venous catheter placement and arterial catheter placement will be in effect as of Jan. 1, 2018. CPT code **36556** (*insertion of a non-tunneled central venous catheter, ≥ 5 years old*) was identified by CMS as part of a screen of high expenditure procedures with Medicare allowed charges of $10 million or more. As part of the same code family, CPT codes **36555**, **36620**, and **93503** were added for review by the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC). Codes that are identified by the AMA high expenditure screen are subject to re-survey of the physician work value of the service.

The re-survey of the central venous catheter placement and arterial catheter placement code was driven largely

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[1] **Note:** This modifier required to be reported for non-excepted PBDs hospital is defined at 42 CFR 412.65, satellite facilities of a hospital defined at 42 CFR 412.22(h).

July 2017 Compared to Final 2018 Rates

Medicare Physician Fee Schedule (MPFS)

Endoscopy/Bronchoscopy, Pulmonary Diagnostic Testing & Therapies, Sleep Medicine Testing, Pulmonary Rehabilitation/Respiratory Therapy and Thoracentesis/Chest Tubes

			CY 2017 CF $35.8887	CY 2018 CF $35.9998	% Change	Dollar Change	CY 2017 CF $35.8887	CY 2018 CF $35.9998	% Change	Dollar Change
CPT/ HCPCS	Modifier or CY 2017 code	Short Description	2017 NF Allowable	2018 NF Allowable	NF Allowable	NF Allowable	2017 FAC Allowable	2018 FAC Allowable	FAC Allowable	FAC Allowable
31615		Visualization of windpipe	$171.91	$171.36	0%	($0.55)	$118.79	$118.08	-1%	($0.71)
31622		Dx bronchoscope/ wash	$246.20	$246.96	0%	$0.76	$136.74	$136.44	0%	($0.30)
31623		Dx bronchoscope/ brush	$276.34	$279.00	1%	$2.66	$138.89	$138.96	0%	$0.07
31624		Dx bronchoscope/ lavage	$258.40	$260.28	1%	$1.88	$140.68	$140.76	0%	$0.08
31625		Bronchoscopy w/biopsy(s)	$338.43	$340.20	1%	$1.77	$162.58	$162.36	0%	($0.22)
31626		Bronchoscopy w/markers	$858.46	$868.32	1%	$9.86	$206.72	$207.36	0%	$0.64
31627		Navigational bronchoscopy	$1,422.99	$1,436.75	1%	$13.77	$101.21	$101.16	0%	($0.05)
31628		Bronchoscopy/ lung bx each	$358.89	$361.80	1%	$2.91	$182.67	$183.24	0%	$0.57
31629		Bronchoscopy/ needle bx each	$443.58	$446.04	1%	$2.45	$194.52	$194.04	0%	($0.48)
31630		Bronchoscopy dilate/fx repr	$207.44	NA	NA	NA	$207.44	$207.00	0%	($0.44)
31631		Bronchoscopy dilate w/stent	$237.94	NA	NA	NA	$237.94	$237.24	0%	($0.70)
31632		Bronchoscopy/ lung bx addl	$66.04	$65.52	-1%	($0.52)	$50.96	$51.12	0%	$0.16
31633		Bronchoscopy/ needle bx addl	$82.19	$82.44	0%	$0.25	$65.68	$65.88	0%	$0.20
31634		Bronch w/ balloon occlusion	$1,826.02	$1,824.83	0%	($1.19)	$201.34	$195.48	-3%	($5.86)
31635		Bronchoscopy w/fb removal	$285.67	$288.00	1%	$2.32	$181.96	$182.16	0%	$0.20

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			CY 2017 CF $35.8887	CY 2018 CF $35.9998	% Change	Dollar Change	CY 2017 CF $35.8887	CY 2018 CF $35.9998	% Change	Dollar Change
CPT/ HCPCS	Modifier or CY 2017 code	Short Description	2017 NF Allowable	2018 NF Allowable	NF Allowable	NF Allowable	2017 FAC Allowable	2018 FAC Allowable	FAC Allowable	FAC Allowable
31636		Bronchoscopy bronch stents	$228.61	NA	NA	NA	$228.61	$229.68	0%	$1.07
31637		Bronchoscopy stent add-on	$76.80	NA	NA	NA	$76.80	$77.04	0%	$0.24
31638		Bronchoscopy revise stent	$260.55	NA	NA	NA	$260.55	$259.56	0%	($0.99)
31640		Bronchoscopy w/tumor excise	$261.99	NA	NA	NA	$261.99	$261.00	0%	($0.99)
31641		Bronchoscopy treat blockage	$267.37	NA	NA	NA	$267.37	$267.12	0%	($0.25)
31643		Diag bronchoscope/ catheter	$183.75	NA	NA	NA	$183.75	$183.96	0%	$0.21
31645		Bronchoscopy clear airways	$260.19	$265.68	2%	$5.49	$154.68	$152.28	-2%	($2.40)
31646		Bronchoscopy reclear airway	$234.35	NA	NA	NA	$132.07	$147.24	11%	$15.17
31647		Bronchial valve init insert	$218.92	NA	NA	NA	$218.92	$220.68	1%	$1.76
31648		Bronchial valve remov init	$199.90	NA	NA	NA	$199.90	$202.32	1%	$2.42
31649		Bronchial valve remov addl	$72.14	$70.20	-3%	($1.94)	$72.14	$70.20	-3%	($1.94)
31651		Bronchial valve addl insert	$77.16	$77.04	0%	($0.12)	$77.16	$77.04	0%	($0.12)
31652		Bronch ebus samplng 1/2 node	$842.67	$850.68	1%	$8.01	$230.41	$230.40	0%	($0.01)
31653		Bronch ebus samplng 3/> node	$891.83	$899.28	1%	$7.44	$255.17	$255.60	0%	$0.43
31654		Bronch ebus ivntj perph les	$128.84	$128.88	0%	$0.04	$70.34	$70.20	0%	($0.14)
31660		Bronch thermoplsty 1 lobe	$203.13	NA	NA	NA	$203.13	$202.68	0%	($0.45)
31661		Bronch thermoplsty 2/> lobes	$214.26	NA	NA	NA	$214.26	$214.56	0%	$0.30
32554		Aspirate pleura w/o imaging	$206.00	$208.08	1%	$2.08	$92.95	$93.24	0%	$0.29

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			CY 2017 CF $35.8887	CY 2018 CF $35.9998	% Change	Dollar Change	CY 2017 CF $35.8887	CY 2018 CF $35.9998	% Change	Dollar Change
CPT/ HCPCS	Modifier or CY 2017 code	Short Description	2017 NF Allowable	2018 NF Allowable	NF Allowable	NF Allowable	2017 FAC Allowable	2018 FAC Allowable	FAC Allowable	FAC Allowable
32555		Aspirate pleura w/ imaging	$295.72	$297.36	1%	$1.64	$116.64	$115.92	-1%	($0.72)
32556		Insert cath pleura w/o image	$563.81	$572.40	2%	$8.59	$127.76	$127.44	0%	($0.32)
32557		Insert cath pleura w/ image	$521.10	$523.44	0%	$2.33	$158.99	$158.04	-1%	($0.95)
94002		Vent mgmt inpat init day	$94.39	NA	NA	NA	$94.39	$94.68	0%	$0.29
94003		Vent mgmt inpat subq day	$68.19	NA	NA	NA	$68.19	$68.40	0%	$0.21
94010		Breathing capacity test	$36.25	$36.72	1%	$0.47	$36.25	NA	NA	NA
94010	26		$8.61	$8.64	0%	$0.03	$8.61	$8.64	0%	$0.03
94010	TC		$27.63	$28.08	2%	$0.45	$27.63	NA	NA	NA
94011		Spirometry up to 2 yrs old	$93.67	NA	NA	NA	$93.67	$88.92	-5%	($4.75)
94012		Spirmtry w/ brnchdil inf-2 yr	$150.73	NA	NA	NA	$150.73	$144.72	-4%	($6.01)
94013		Meas lung vol thru 2 yrs	$20.46	NA	NA	NA	$20.46	$19.80	-3%	($0.66)
94014		Patient recorded spirometry	$57.42	$57.60	0%	$0.18	$57.42	NA	NA	NA
94015		Patient recorded spirometry	$31.58	$31.68	0%	$0.10	$31.58	NA	NA	NA
94016		Review patient spirometry	$25.84	$25.92	0%	$0.08	$25.84	$25.92	0%	$0.08
94060		Evaluation of wheezing	$61.73	$61.92	0%	$0.19	$61.73	NA	NA	NA
94060	26		$13.28	$13.32	0%	$0.04	$13.28	$13.32	0%	$0.04
94060	TC		$48.45	$48.60	0%	$0.15	$48.45	NA	NA	NA
94070		Evaluation of wheezing	$61.01	$61.92	1%	$0.91	$61.01	NA	NA	NA
94070	26		$29.43	$29.52	0%	$0.09	$29.43	$29.52	0%	$0.09
94070	TC		$31.58	$32.40	3%	$0.82	$31.58	NA	NA	NA
94150		Vital capacity test	$25.48	$26.28	3%	$0.80	$25.48	NA	NA	NA
94150	26		$3.95	$3.96	0%	$0.01	$3.95	$3.96	0%	$0.01
94150	TC		$21.53	$22.32	4%	$0.79	$21.53	NA	NA	NA

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			CY 2017 CF $35.8887	CY 2018 CF $35.9998	% Change	Dollar Change	CY 2017 CF $35.8887	CY 2018 CF $35.9998	% Change	Dollar Change
CPT/ HCPCS	Modifier or CY 2017 code	Short Description	2017 NF Allowable	2018 NF Allowable	NF Allowable	NF Allowable	2017 FAC Allowable	2018 FAC Allowable	FAC Allowable	FAC Allowable
94200		Lung function test (MBC/MVV)	$26.20	$28.08	7%	$1.88	$26.20	NA	NA	NA
94200	26		$5.74	$5.76	0%	$0.02	$5.74	$5.76	0%	$0.02
94200	TC		$20.46	$22.32	9%	$1.86	$20.46	NA	NA	NA
94250		Expired gas collection	$26.92	$28.80	7%	$1.88	$26.92	NA	NA	NA
94250	26		$5.74	$5.76	0%	$0.02	$5.74	$5.76	0%	$0.02
94250	TC		$21.17	$23.04	9%	$1.87	$21.17	NA	NA	NA
94375		Respiratory flow volume loop	$40.20	$40.68	1%	$0.48	$40.20	NA	NA	NA
94375	26		$15.07	$15.12	0%	$0.05	$15.07	$15.12	0%	$0.05
94375	TC		$25.12	$25.56	2%	$0.44	$25.12	NA	NA	NA
94400		CO2 breathing response curve	$57.78	$59.04	2%	$1.26	$57.78	NA	NA	NA
94400	26		$20.10	$20.16	0%	$0.06	$20.10	$20.16	0%	$0.06
94400	TC		$37.68	$38.88	3%	$1.20	$37.68	NA	NA	NA
94450		Hypoxia response curve	$70.34	$73.08	4%	$2.74	$70.34	NA	NA	NA
94450	26		$20.46	$20.52	0%	$0.06	$20.46	$20.52	0%	$0.06
94450	TC		$49.89	$52.56	5%	$2.67	$49.89	NA	NA	NA
94452		Hast w/report	$58.50	$59.04	1%	$0.54	$58.50	NA	NA	NA
94452	26		$14.71	$14.76	0%	$0.05	$14.71	$14.76	0%	$0.05
94452	TC		$43.78	$44.28	1%	$0.50	$43.78	NA	NA	NA
94453		Hast w/oxygen titrate	$81.11	$81.72	1%	$0.61	$81.11	NA	NA	NA
94453	26		$19.38	$19.44	0%	$0.06	$19.38	$19.44	0%	$0.06
94453	TC		$61.73	$62.28	1%	$0.55	$61.73	NA	NA	NA
94610		Surfactant admin thru tube	$57.06	NA	NA	NA	$57.06	$57.24	0%	$0.18
I94617		Exercise tst brncspsm	$57.06	$97.20	70%	$40.14	$57.06	NA	NA	NA
I94617-26	26		$31.22	$34.20	10%	$2.98	$31.22	$34.20	10%	$2.98
I94617-TC	TC		$25.84	$63.00	144%	$37.16	$25.84	NA	NA	NA
I94618		Pulmonary stress testing	$57.06	$34.92	-39%	($22.14)	$57.06	NA	NA	NA

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			CY 2017 CF $35.8887	CY 2018 CF $35.9998	% Change	Dollar Change	CY 2017 CF $35.8887	CY 2018 CF $35.9998	% Change	Dollar Change
CPT/ HCPCS	Modifier or CY 2017 code	Short Description	2017 NF Allowable	2018 NF Allowable	NF Allowable	NF Allowable	2017 FAC Allowable	2018 FAC Allowable	FAC Allowable	FAC Allowable
l94618-26	26		$31.22	$23.40	-25%	($7.82)	$31.22	$23.40	-25%	($7.82)
l94618-TC	TC		$25.84	$11.52	-55%	($14.32)	$25.84	NA	NA	NA
94620		Pulmonary stress test/ simple	$57.06	Deleted. Replaced with 94617 & 94618	NA	NA	$57.06	Deleted. Replaced with 94617 & 94618	NA	NA
94620	26		$31.22	NA	NA	NA	$31.22	NA	NA	NA
94620	TC		$25.84	NA	NA	NA	$25.84	NA	NA	NA
p94621		Pulm stress test/ complex	$165.09	$168.48	2%	$3.39	$165.09	NA	NA	NA
p94621	26		$70.34	$70.56	0%	$0.22	$70.34	$70.56	0%	$0.22
p94621	TC		$94.75	$97.92	3%	$3.17	$94.75	NA	NA	NA
94640		Airway inhalation treatment	$18.66	$19.08	2%	$0.42	$18.66	NA	NA	NA
94642		Aerosol inhalation treatment	$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00
94644		Cbt 1st hour	$44.86	$46.08	3%	$1.22	$44.86	NA	NA	NA
94645		Cbt each addl hour	$14.71	$16.56	13%	$1.85	$14.71	NA	NA	NA
94660		Pos airway pressure cpap	$64.60	$66.24	3%	$1.64	$39.12	$39.24	0%	$0.12
94662		Neg press ventilation cnp	$35.89	NA	NA	NA	$35.89	$37.08	3%	$1.19
94664		Evaluate pt use of inhaler	$17.59	$17.64	0%	$0.05	$17.59	NA	NA	NA
94667		Chest wall manipulation	$26.92	$27.36	2%	$0.44	$26.92	NA	NA	NA
94668		Chest wall manipulation	$29.79	$32.76	10%	$2.97	$29.79	NA	NA	NA
94680		Exhaled air analysis o2	$57.78	$59.76	3%	$1.98	$57.78	NA	NA	NA
94680	26		$12.92	$12.96	0%	$0.04	$12.92	$12.96	0%	$0.04
94680	TC		$44.86	$46.80	4%	$1.94	$44.86	NA	NA	NA
94681		Exhaled air analysis o2/co2	$54.91	$58.32	6%	$3.41	$54.91	NA	NA	NA
94681	26		$10.41	$10.44	0%	$0.03	$10.41	$10.44	0%	$0.03

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			CY 2017 CF $35.8887	CY 2018 CF $35.9998	% Change	Dollar Change	CY 2017 CF $35.8887	CY 2018 CF $35.9998	% Change	Dollar Change
CPT/ HCPCS	Modifier or CY 2017 code	Short Description	2017 NF Allowable	2018 NF Allowable	NF Allowable	NF Allowable	2017 FAC Allowable	2018 FAC Allowable	FAC Allowable	FAC Allowable
94681	TC		$44.50	$47.88	8%	$3.38	$44.50	NA	NA	NA
94690		Exhaled air analysis	$52.04	$56.88	9%	$4.84	$52.04	NA	NA	NA
94690	26		$3.95	$3.96	0%	$0.01	$3.95	$3.96	0%	$0.01
94690	TC		$48.09	$52.92	10%	$4.83	$48.09	NA	NA	NA
94726		Pulm funct tst plethysmograp	$53.47	$56.16	5%	$2.69	$53.47	NA	NA	NA
94726	26		$12.56	$12.60	0%	$0.04	$12.56	$12.60	0%	$0.04
94726	TC		$40.91	$43.56	6%	$2.65	$40.91	NA	NA	NA
94727		Pulm function test by gas	$42.71	$45.00	5%	$2.29	$42.71	NA	NA	NA
94727	26		$12.56	$12.60	0%	$0.04	$12.56	$12.60	0%	$0.04
94727	TC		$30.15	$32.40	7%	$2.25	$30.15	NA	NA	NA
94728		Pulm funct test oscillometry	$40.20	$42.12	5%	$1.92	$40.20	NA	NA	NA
94728	26		$12.92	$12.96	0%	$0.04	$12.92	$12.96	0%	$0.04
94728	TC		$27.28	$29.16	7%	$1.88	$27.28	NA	NA	NA
94729		Co/membane diffuse capacity	$55.27	$55.80	1%	$0.53	$55.27	NA	NA	NA
94729	26		$9.33	$9.36	0%	$0.03	$9.33	$9.36	0%	$0.03
94729	TC		$45.94	$46.44	1%	$0.50	$45.94	NA	NA	NA
94750		Pulmonary compliance study	$80.03	$84.24	5%	$4.21	$80.03	NA	NA	NA
94750	26		$11.13	$11.16	0%	$0.03	$11.13	$11.16	0%	$0.03
94750	TC		$68.91	$73.08	6%	$4.17	$68.91	NA	NA	NA
94760		Measure blood oxygen level	$3.23	$2.88	-11%	($0.35)	$3.23	NA	NA	NA
94761		Measure blood oxygen level exercise	$4.67	$4.68	0%	$0.01	$4.67	NA	NA	NA
94762		Measure blood oxygen level	$24.76	$25.20	2%	$0.44	$24.76	NA	NA	NA
94770		Exhaled carbon dioxide test	$7.54	NA	NA	NA	$7.54	$7.56	0%	$0.02
94772		Breath recording infant	$0.00	$0.00	NA	$0.00	$0.00	NA	NA	NA

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			CY 2017 CF $35.8887	CY 2018 CF $35.9998	% Change	Dollar Change	CY 2017 CF $35.8887	CY 2018 CF $35.9998	% Change	Dollar Change
CPT/ HCPCS	Modifier or CY 2017 code	Short Description	2017 NF Allowable	2018 NF Allowable	NF Allowable	NF Allowable	2017 FAC Allowable	2018 FAC Allowable	FAC Allowable	FAC Allowable
94772	26		$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00
94772	TC		$0.00	$0.00	NA	$0.00	$0.00	NA	NA	NA
94774		Ped home apnea rec compl	$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00
94775		Ped home apnea rec hk-up	$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00
94776		Ped home apnea rec downld	$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00
94777		Ped home apnea rec report	$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00
94780		Car seat/bed test 60 min	$60.29	$53.28	-12%	($7.01)	$25.12	$24.48	-3%	($0.64)
94781		Car seat/bed test + 30 min	$23.33	$21.24	-9%	($2.09)	$8.97	$8.64	-4%	($0.33)
94799		Pulmonary service/ procedure Unlisted	$0.00	$0.00	NA	$0.00	$0.00	NA	NA	NA
94799	26		$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00
94799	TC		$0.00	$0.00	NA	$0.00	$0.00	NA	NA	NA
95782		Polysom <6 yrs 4/> paramtrs	$1,035.39	$935.63	-10%	($99.75)	$1,035.39	NA	NA	NA
95782	26		$128.84	$129.24	0%	$0.40	$128.84	$129.24	0%	$0.40
95782	TC		$906.55	$806.40	-11%	($100.15)	$906.55	NA	NA	NA
95783		Polysom <6 yrs cpap/bilvl	$1,176.79	$997.91	-15%	($178.88)	$1,176.79	NA	NA	NA
95783	26		$146.43	$140.76	-4%	($5.67)	$146.43	$140.76	-4%	($5.67)
95783	TC		$1,030.36	$857.16	-17%	($173.21)	$1,030.36	NA	NA	NA
95800		Slp stunattended	$180.88	$180.72	0%	($0.16)	$180.88	NA	NA	NA
95800	26		$53.12	$53.28	0%	$0.16	$53.12	$53.28	0%	$0.16
95800	TC		$127.76	$127.44	0%	($0.32)	$127.76	NA	NA	NA
95801		Slp stdy unatnd w/anal	$92.23	$92.52	0%	$0.29	$92.23	NA	NA	NA
95801	26		$50.24	$50.40	0%	$0.16	$50.24	$50.40	0%	$0.16

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			CY 2017 CF $35.8887	CY 2018 CF $35.9998	% Change	Dollar Change	CY 2017 CF $35.8887	CY 2018 CF $35.9998	% Change	Dollar Change
CPT/ HCPCS	Modifier or CY 2017 code	Short Description	2017 NF Allowable	2018 NF Allowable	NF Allowable	NF Allowable	2017 FAC Allowable	2018 FAC Allowable	FAC Allowable	FAC Allowable
95801	TC		$41.99	$42.12	0%	$0.13	$41.99	NA	NA	NA
95803		Actigraphy testing	$142.84	$146.16	2%	$3.32	$142.84	NA	NA	NA
95803	26		$44.50	$45.00	1%	$0.50	$44.50	$45.00	1%	$0.50
95803	TC		$98.34	$101.16	3%	$2.82	$98.34	NA	NA	NA
95805		Multiple sleep latency test	$433.89	$440.64	2%	$6.74	$433.89	NA	NA	NA
95805	26		$60.29	$60.48	0%	$0.19	$60.29	$60.48	0%	$0.19
95805	TC		$373.60	$380.16	2%	$6.56	$373.60	NA	NA	NA
95806		Sleep study unatt & resp efft	$171.91	$173.52	1%	$1.61	$171.91	NA	NA	NA
95806	26		$62.45	$62.64	0%	$0.19	$62.45	$62.64	0%	$0.19
95806	TC		$109.46	$110.88	1%	$1.42	$109.46	NA	NA	NA
95807		Sleep study attended	$471.58	$469.80	0%	($1.78)	$471.58	NA	NA	NA
95807	26		$63.52	$63.72	0%	$0.20	$63.52	$63.72	0%	$0.20
95807	TC		$408.05	$406.08	0%	($1.98)	$408.05	NA	NA	NA
95808		Polysom any age 1-3> param	$648.87	$714.96	10%	$66.09	$648.87	NA	NA	NA
95808	26		$90.08	$90.72	1%	$0.64	$90.08	$90.72	1%	$0.64
95808	TC		$558.79	$624.24	12%	$65.45	$558.79	NA	NA	NA
95810		Polysom 6/> yrs 4/> param	$631.28	$639.00	1%	$7.71	$631.28	NA	NA	NA
95810	26		$124.17	$124.56	0%	$0.38	$124.17	$124.56	0%	$0.38
95810	TC		$507.11	$514.44	1%	$7.33	$507.11	NA	NA	NA
95811		Polysom 6/>yrs cpap 4/> parm	$663.22	$671.04	1%	$7.81	$663.22	NA	NA	NA
95811	26		$129.20	$129.60	0%	$0.40	$129.20	$129.60	0%	$0.40
95811	TC		$534.02	$541.44	1%	$7.41	$534.02	NA	NA	NA
99151	99151	Mod sed same phys/qhp <5 yrs	$78.24	$79.20	1%	$0.96	$24.05	$25.20	5%	$1.15
99152	99152	Mod sed same phys/qhp 5/>yrs	$52.04	$52.56	1%	$0.52	$12.56	$12.96	3%	$0.40
99153	99153	Mod sed same phys/qhp ea	$11.13	$11.16	0%	$0.03	$11.13	NA	NA	NA
99155	99155	Mod sed oth phys/qhp <5 yrs	$94.39	NA	NA	NA	$94.39	$98.64	5%	$4.25

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			CY 2017 CF $35.8887	CY 2018 CF $35.9998	% Change	Dollar Change	CY 2017 CF $35.8887	CY 2018 CF $35.9998	% Change	Dollar Change
CPT/ HCPCS	Modifier or CY 2017 code	Short Description	2017 NF Allowable	2018 NF Allowable	NF Allowable	NF Allowable	2017 FAC Allowable	2018 FAC Allowable	FAC Allowable	FAC Allowable
99156	99156	Mod sed oth phys/qhp 5/>yrs	$77.16	NA	NA	NA	$77.16	$77.40	0%	$0.24
99157	99157	Mod sed other phys/qhp ea	$58.50	NA	NA	NA	$58.50	$59.04	1%	$0.54
99291		Critical care first hour	$278.14	$279.36	0%	$1.22	$226.82	$226.80	0%	($0.02)
99292		Critical care each add 30 min	$124.53	$124.92	0%	$0.39	$113.77	$113.76	0%	($0.01)
99406		Behav chng smoking 3-10 min	$14.71	$14.76	0%	$0.05	$12.56	$12.60	0%	$0.04
99407		Behav chng smoking > 10 min	$28.35	$28.44	0%	$0.09	$26.20	$26.28	0%	$0.08
99483		Assmt & care pln pt cog imp	NA	$241.92	NA	NA	NA	$178.92	NA	NA
99484		Care mgmt svc bhvl hlth cond								
99487		Cmplx chron care w/o pt vsit	$93.67	$94.68	1%	$1.01	$52.76	$53.28	1%	$0.52
99489		Complx chron care addl 30 min	$47.01	$47.16	0%	$0.15	$26.56	$26.64	0%	$0.08
99490		Chron care mgmt srvc 20 min	$42.71	$42.84	0%	$0.13	$32.66	$32.76	0%	$0.10
99495		Trans care mgmt 14 day disch	$165.45	$167.04	1%	$1.59	$111.97	$112.32	0%	$0.35
99496		Trans care mgmt 7 day disch	$233.99	$236.52	1%	$2.52	$162.22	$163.08	1%	$0.86
99497		Advncd care plan 30 min	$82.90	$86.04	4%	$3.14	$77.88	$80.64	4%	$2.76
99498		Advncd care plan addl 30 min	$72.50	$75.96	5%	$3.46	$72.50	$75.60	4%	$3.10
G0237		Therapeutic procd strg endur	$10.05	$10.08	0%	$0.03	$10.05	NA	NA	NA
G0238		Oth resp proc, indiv	$10.41	$10.44	0%	$0.03	$10.41	NA	NA	NA

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			CY 2017 CF $35.8887	CY 2018 CF $35.9998	% Change	Dollar Change	CY 2017 CF $35.8887	CY 2018 CF $35.9998	% Change	Dollar Change
CPT/ HCPCS	Modifier or CY 2017 code	Short Description	2017 NF Allowable	2018 NF Allowable	NF Allowable	NF Allowable	2017 FAC Allowable	2018 FAC Allowable	FAC Allowable	FAC Allowable
G0239		Oth resp proc, group	$13.28	$13.32	0%	$0.04	$13.28	NA	NA	NA
●G0296		Visit to determ LDCT elig	$28.71	$29.16	2%	$0.45	$26.92	$27.00	0%	$0.08
●G0297		LDCT for Lung CA screen	$256.25	$242.28	-5%	($13.97)	$256.25	NA	NA	NA
●G0297	26		$51.68	$52.56	2%	$0.88	$51.68	$52.56	2%	$0.88
●G0297	TC		$204.57	$189.72	-7%	($14.85)	$204.57	NA	NA	NA
G0379		Direct refer hospital observ	$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00
G0384		Lev 5 hosp type bed visit	$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00
G0390		Trauma respons w/hosp criti	$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00
G0398		Home sleep test/type 2 porta	$0.00	$0.00	NA	$0.00	$0.00	NA	NA	NA
G0398	26	Home sleep test/type 2 porta	$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00
G0398	TC	Home sleep test/type 2 porta	$0.00	$0.00	NA	$0.00	$0.00	NA	NA	NA
G0399		Home sleep test/type 3 porta	$0.00	$0.00	NA	$0.00	$0.00	NA	NA	NA
G0399	26	Home sleep test/type 3 porta	$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00
G0399	TC	Home sleep test/type 3 porta	$0.00	$0.00	NA	$0.00	$0.00	NA	NA	NA
G0424		Pulmonary rehab w exer	$30.15	$30.60	2%	$0.45	$14.00	$14.40	3%	$0.40
G0463		Hospital outpt clinic visit	$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00
G0501	G0501	Resource-inten svc during ov	$0.00	$0.00	NA	$0.00	$0.00	$0.00	NA	$0.00
G0500	G0500	Mod sedat endo service >5yrs	$59.22	$59.76	1%	$0.54	$5.74	$5.76	0%	$0.02
G0502	G0502	Init psych care manag, 70min	$142.84	NA	NA	NA	$90.08	NA	NA	NA
G0503	G0503	Subseq psych care man,60mi	$126.33	NA	NA	NA	$81.11	NA	NA	NA
G0504	G0504	Init/sub psych care add 30 m	$66.04	NA	NA	NA	$43.43	NA	NA	NA

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			CY 2017 CF $35.8887	CY 2018 CF $35.9998	% Change	Dollar Change	CY 2017 CF $35.8887	CY 2018 CF $35.9998	% Change	Dollar Change
CPT/ HCPCS	Modifier or CY 2017 code	Short Description	2017 NF Allowable	2018 NF Allowable	NF Allowable	NF Allowable	2017 FAC Allowable	2018 FAC Allowable	FAC Allowable	FAC Allowable
G0505	G0505	Cog/func assessment outpt	$238.30	NA	NA	NA	$178.01	NA	NA	NA
G0506	G0506	Comp asses care plan ccm svc	$63.88	$64.44	1%	$0.56	$46.30	$46.44	0%	$0.14
G0507	G0507	Care manage serv minimum 20	$47.73	NA	NA	NA	$32.30	NA	NA	NA
G0508	G0508	Crit care telehea consult 60	$201.34	NA	NA	NA	$201.34	$204.12	1%	$2.78
G0509	G0509	Crit care telehea consult 50	$194.16	NA	NA	NA	$194.16	$197.28	2%	$3.12

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by responses from the radiology and anesthesiology community. The below table shows the resulting changes in physician work value from the re-survey effort:

CPT Code	Short Descriptor	CY 2017 wRVU	CY 2018 Proposed wRVU	CY 2018 Final wRVU
36555	Insert non-tunneled central venous cath, < 5yo	2.43	1.93	1.93
36556	Insert non-tunneled central venous cath, ≥ 5yo	2.50	1.75	1.75
36620	Arterial cath, percutaneous	1.15	1.00	1.00

Spirometry Codes (CPTs **94011**, **94012**, **94013**)

CMS did not specify in the rule why changes occurred to these services. However, after careful review by the ATS coding team, it appears that CMS also made changes to the spirometry codes during part of the RUC and practice expense review of the pulmonary stress testing codes. No changes were made to the physician work portion of these services, however the practice expense RVUs are down slightly, most likely due to changes in supply costs from the practice expense review of the pulmonary stress tests.

Pulmonary Stress Test (CPTs **94617**, **94618**)

CPT code **94620** was identified as part of a screen of high expenditure services with Medicare-allowed charges of $10 million or more that had not been recently reviewed. CPT code **94621** was added to the family for review. At the request of ATS, and jointly with CHEST, the CPT Editorial Panel deleted CPT code **94620** and split it into two new codes, CPT codes **94617** and **94618**, to describe two different tests commonly performed for evaluation of dyspnea. CMS agreed with the proposed ATS and RUC-recommended work RVUs of 1.42 for CPT code **94621**, 0.70 for CPT code **94617**, and 0.48 for CPT code **94618**. The surveys for the time the services are performed were

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updated per the society survey times for the equipment and practice expense, therefore we have some increases and decreases in the codes based on the changes to the work and practice expense from the RUC recommendations and CMS practice expense refinements.

Polysomnography (CPTs **95782**, **95783**, **95808**)

As a result of the PE updates to the Pulmonary Stress codes noted above, CMS also updated the payment rates for the costs of some supply items in these sleep codes. That resulted in a trickle-down effect for any other CPT codes that had the same supplies as the costs were updated in the practice expense for any services that contain the same supplies.

2018 Medicare Hospital Outpatient Prospective Payment Rule

Most services paid under the Medicare Hospital Prospective Payment Rule will see an increase in reimbursement for 2018. The across the board increase is a result of CMS's decision to change how they reimburse hospitals for drug costs – known as 340B discount drug program payments. Starting 2018, CMS's new drug reimbursement policy will reduce hospital payments by an estimated $1.6 billion with much of those cost savings being redistributed throughout other Medicare hospital outpatient service payments. Specifically, CMS will pay separately payable, non-pass-through drugs (other than vaccines) purchased through the 340B program at a rate of the manufacturers-submitted average sales price ***(ASP) minus 22.5 percent,*** rather than the 2017 rate of ***ASP plus 6 percent.*** Sole community hospitals in rural areas, PPS-exempt cancer hospitals and children's hospitals will be exempted from this policy for CY 2018. While the cuts in hospital drug cost reimbursements will extend beyond 2018, the additional payment for other hospital outpatient service payments is expected to be a one-time windfall.

Among other changes, the OPPS final rule reinstates for CYs 2018 and 2019 the moratorium on enforcement of the *direct supervision policy for outpatient therapeutic services for critical access hospitals and small rural hospitals with 100 or fewer beds.*

Some "winners" in the 2018 final OPPS rule include:

Respiratory Therapy Codes (**G0237**, **G0238**, **G0239**) received a 12 percent increase in reimbursements. The increase was driven by a combination of improved hospital cost reporting and the 340B payment windfall. Pulmonary rehabilitation code (**G0424**) saw a 3 percent increase that was driven by the 340B windfall.

Chest wall manipulation (CPT **94668**) will see a 93 percent increase in reimbursement, largely due to the code being moved into a higher Ambulatory Payment Classification (APC).

Unattended sleep study with analysis (CPT **95801**) will also see a 93 percent increase driven by the code's reassignments to a higher APC code.

Insertion of Catheter Pleura with Imaging (CPT **32557**) will see a 44 percent increase in reimbursement due to its placement in a higher APC code.

Payment "losers" in the OPPS rule include:

The Level 5 Hospital Bed visit (**G0384**) will see a 22 percent cut in reimbursement driven mostly by changes in hospital cost reporting.

Pleura Aspirate without imaging (CPT **32554**) and pleura aspirate with imaging (CPT **32555**) are both cut by 10 percent in 2018 due to changes in hospital cost reporting.

The table below includes an expanded list of services of interest to ATS members under the 2018 CMS Medicare Hospital Outpatient Prospective Payment Rule

2017 July Compared to Final 2018 Rates

Medicare Hospital Outpatient Prospective Payment System HOPPS (APC)

Endoscopy/Bronchoscopy, Pulmonary Diagnostic Testing & Therapies, Sleep Medicine Testing, Pulmonary Rehabilitation/ Respiratory Therapy and Thoracentesis/Chest Tubes

CPT/ HCPCS	CMS Short Description	Status		APC		JUL CY 2017	Final CY 2018	Dollar Change	Percent Change
		CY 2017	CY 2018	CY 2017	CY 2018	Payment Rate	Payment Rate		
31615	Visualization of windpipe	T	T	5162	5162	$442.62	$459.84	$17.22	4%
31620	Endobronchial us add-on	NA	NA	NA	NA	NA	NA	NA	NA
31622	Dx bronchoscope/wash	J1	J1	5153	5153	$1,269.79	$1,323.61	$53.82	4%
31623	Dx bronchoscope/brush	J1	J1	5153	5153	$1,269.79	$1,323.61	$53.82	4%
31624	Dx bronchoscope/lavage	J1	J1	5153	5153	$1,269.79	$1,323.61	$53.82	4%
31625	Bronchoscopy w/biopsy(s)	J1	J1	5153	5153	$1,269.79	$1,323.61	$53.82	4%
31626	Bronchoscopy w/markers	J1	J1	5155	5155	$4,362.95	$4,863.83	$500.88	11%
31627	Navigational bronchoscopy	N	N					NA	NA
31628	Bronchoscopy/lung bx each	J1	J1	5154	5154	$2,431.23	$2,616.39	$185.16	8%
31629	Bronchoscopy/needle bx each	J1	J1	5154	5154	$2,431.23	$2,616.39	$185.16	8%
31630	Bronchoscopy dilate/fx repr	J1	J1	5154	5154	$2,431.23	$2,616.39	$185.16	8%
31631	Bronchoscopy dilate w/stent	J1	J1	5155	5155	$4,362.95	$4,863.83	$500.88	11%
31632	Bronchoscopy/lung bx addl	N	N					NA	NA
31633	Bronchoscopy/needle bx addl	N	N					NA	NA
31634	Bronch w/balloon occlusion	J1	J1	5155	5155	$4,362.95	$4,863.83	$500.88	11%
31635	Bronchoscopy w/fb removal	J1	J1	5153	5153	$1,269.79	$1,323.61	$53.82	4%
31636	Bronchoscopy bronch stents	J1	J1	5155	5155	$4,362.95	$4,863.83	$500.88	11%
31637	Bronchoscopy stent add-on	N	N					NA	NA
31638	Bronchoscopy revise stent	J1	J1	5155	5155	$4,362.95	$4,863.83	$500.88	11%
31640	Bronchoscopy w/tumor excise	J1	J1	5154	5154	$2,431.23	$2,616.39	$185.16	8%
31641	Bronchoscopy treat blockage	J1	J1	5154	5154	$2,431.23	$2,616.39	$185.16	8%
31643	Diag bronchoscope/catheter	J1	J1	5153	5153	$1,269.79	$1,323.61	$53.82	4%
31645	Bronchoscopy clear airways	J1	J1	5153	5153	$1,269.79	$1,323.61	$53.82	4%
31646	Bronchoscopy reclear airway	T	T	5152	5152	$361.92	$375.44	$13.52	4%
31647	Bronchial valve init insert	J1	J1	5155	5155	$4,362.95	$4,863.83	$500.88	11%
31648	Bronchial valve remov init	J1	J1	5154	5154	$2,431.23	$2,616.39	$185.16	8%
31649	Bronchial valve remov addl	Q2	Q2	5153	5153	$1,269.79	$1,323.61	$53.82	4%
31651	Bronchial valve addl insert	N	N					NA	NA
31652	Bronch ebus samplng 1/2 node	J1	J1	5154	5154	$2,431.23	$2,616.39	$185.16	8%
31653	Bronch ebus samplng 3/> node	J1	J1	5154	5154	$2,431.23	$2,616.39	$185.16	8%
31654	Bronch ebus ivntj perph les	N	N					NA	NA
31660	Bronch thermoplsty 1 lobe	J1	J1	5155	5155	$4,362.95	$4,863.83	$500.88	11%
31661	Bronch thermoplsty 2/> lobes	J1	J1	5155	5155	$4,362.95	$4,863.83	$500.88	11%
32554	Aspirate pleura w/o imaging	T	T	5181	5181	$684.13	$612.53	($71.60)	-10%

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CPT/ HCPCS	CMS Short Description	Status		APC		JUL CY 2017	Final CY 2018	Dollar Change	Percent Change
		CY 2017	CY 2018	CY 2017	CY 2018	Payment Rate	Payment Rate		
32556	Insert cath pleura w/o image	J1	J1	5302	5302	$1,334.83	$1,427.29	$92.46	7%
32557	Insert cath pleura w/ image	T	T	5181	5182	$684.13	$982.90	$298.77	44%
94002 Single Code	Vent mgmt inpat init day (Single Code APC Assignment & Rate)	Q3	Q3	5801	5801	$423.95	$460.67	$36.72	9%
94002 Composite	Vent mgmt inpat init day (Composite APC Assignment & Rate)	S	S	5041	5041	$687.17	$733.58	$46.41	7%
94002 Composite	Vent mgmt inpat init day (Composite APC Assignment & Rate)	S	S	5045	5045	$872.07	$957.50	$85.43	10%
94003 Single Code	Vent mgmt inpat subq day (Single Code APC Assignment & Rate)	Q3	Q3	5801	5801	$423.95	$460.67	$36.72	9%
94003 Composite	Vent mgmt inpat subq day (Composite APC Assignment & Rate)	S	S	5041	5041	$687.17	$733.58	$46.41	7%
94003 Composite	Vent mgmt inpat subq day (Composite APC Assignment & Rate)	S	S	5045	5045	$872.07	$957.50	$85.43	10%
94010	Breathing capacity test	Q1	Q1	5721	5721	$127.10	$136.31	$9.21	7%
94011	Spirometry up to 2 yrs old	Q1	Q1	5721	5721	$127.10	$136.31	$9.21	7%
94012	Spirmtry w/brnchdil inf-2 yr	Q1	Q1	5722	5722	$232.31	$248.81	$16.50	7%
94013	Meas lung vol thru 2 yrs	S	S	5723	5723	$415.87	$444.36	$28.49	7%
94014	Patient recorded spirometry	Q1	Q1	5735	5735	$263.61	$329.99	$66.38	25%
94015	Patient recorded spirometry	Q1	Q1	5722	5722	$232.31	$248.81	$16.50	7%
94016	Review patient spirometry	A	A					NA	NA
94060	Evaluation of wheezing	S	S	5722	5722	$232.31	$248.81	$16.50	7%
94070	Evaluation of wheezing	S	S	5722	5722	$232.31	$248.81	$16.50	7%
94150	Vital capacity test	Q1	Q1	5721	5721	$127.10	$136.31	$9.21	7%
94200	Lung function test (MBC/MVV)	Q1	Q1	5734	5734	$100.02	$105.03	$5.01	5%
94250	Expired gas collection	Q1	Q1	5733	5733	$54.55	$55.96	$1.41	3%
94375	Respiratory flow volume loop	Q1	Q1	5722	5722	$232.31	$248.81	$16.50	7%
94400	CO2 breathing response curve	Q1	Q1	5721	5721	$127.10	$136.31	$9.21	7%
94450	Hypoxia response curve	Q1	Q1	5721	5721	$127.10	$136.31	$9.21	7%
94452	Hast w/report	Q1	Q1	5734	5734	$100.02	$105.03	$5.01	5%
94453	Hast w/oxygen titrate	Q1	Q1	5734	5734	$100.02	$105.03	$5.01	5%
94610	Surfactant admin thru tube	Q1	Q1	5791	5791	$162.08	$186.36	$24.28	15%
94620	Pulmonary stress test/simple	Q1	D	5734		$100.02		NA	NA
94621	Pulm stress test/complex	S	S	5722	5722	$232.31	$248.81	$16.50	7%
94617	Exercise tst brncspsm	Q1	Q1	5734	5734	$100.02	$105.03	$5.01	5%
94618	Pulmonary stress testing	Q1	Q1	5734	5734	$100.02	$105.03	$5.01	5%
94640	Airway inhalation treatment	Q1	Q1	5791	5791	$162.08	$186.36	$24.28	15%
94642	Aerosol inhalation treatment	Q1	Q1	5791	5791	$162.08	$186.36	$24.28	15%
94644	Cbt 1st hour	Q1	Q1	5734	5734	$100.02	$105.03	$5.01	5%
94645	Cbt each addl hour	N	N					NA	NA

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CPT/ HCPCS	CMS Short Description	Status		APC		JUL CY 2017	Final CY 2018	Dollar Change	Percent Change
		CY 2017	CY 2018	CY 2017	CY 2018	Payment Rate	Payment Rate		
94662 Single Code	Neg press ventilation cnp (Single Code APC Assignment & Rate)	Q3	Q3	5801	5801	$423.95	$460.67	$36.72	9%
94662 Composite	Neg press ventilation cnp (Composite APC Assignment & Rate)	S	S	5041	5041	$687.17	$733.58	$46.41	7%
94662 Composite	Neg press ventilation cnp (Composite APC Assignment & Rate)	S	S	5045	5045	$872.07	$957.50	$85.43	10%
94664	Evaluate pt use of inhaler	Q1	Q1	5791	5791	$162.08	$186.36	$24.28	15%
94667	Chest wall manipulation	Q1	Q1	5734	5734	$100.02	$105.03	$5.01	5%
94668	Chest wall manipulation	Q1	Q1	5733	5734	$54.55	$105.03	$50.48	93%
94680	Exhaled air analysis o2	Q1	Q1	5721	5721	$127.10	$136.31	$9.21	7%
94681	Exhaled air analysis o2/co2	Q1	Q1	5722	5722	$232.31	$248.81	$16.50	7%
94690	Exhaled air analysis	Q1	Q1	5732	5732	$28.38	$31.80	$3.42	12%
94726	Pulm funct tst plethysmograp	Q1	Q1	5722	5722	$232.31	$248.81	$16.50	7%
94727	Pulm function test by gas	Q1	Q1	5721	5721	$127.10	$136.31	$9.21	7%
94728	Pulm funct test oscillometry	Q1	Q1	5722	5722	$232.31	$248.81	$16.50	7%
94729	Co/membane diffuse capacity	N	N					NA	NA
94750	Pulmonary compliance study	Q1	Q1	5721	5721	$127.10	$136.31	$9.21	7%
94760	Measure blood oxygen level	N	N					NA	NA
94761	Measure blood oxygen level	N	N					NA	NA
94762 Single Code	Measure blood oxygen level (Single Code APC Assignment & Rate)	Q3	Q3	5721	5721	$127.10	$136.31	$9.21	7%
94762 Composite	Measure blood oxygen level (Composite APC Assignment & Rate)	S	S	5041	5041	$687.17	$733.58	$46.41	7%
94762 Composite	Measure blood oxygen level (Composite APC Assignment & Rate)	S	S	5045	5045	$872.07	$957.50	$85.43	10%
94770	Exhaled carbon dioxide test	S	S	5722	5722	$232.31	$248.81	$16.50	7%
94772	Breath recording infant	S	S	5723	5723	$415.87	$444.36	$28.49	7%
94774	Ped home apnea rec compl	B	B					NA	NA
94775	Ped home apnea rec hk-up	S	S	5721	5721	$127.10	$136.31	$9.21	7%
94776	Ped home apnea rec downld	S	S	5721	5721	$127.10	$136.31	$9.21	7%
94777	Ped home apnea rec report	B	B					NA	NA
94780	Car seat/bed test 60 min	Q1	Q1	5732	5732	$28.38	$31.80	$3.42	12%
+ 94781	Car seat/bed test + 30 min	N	N					NA	NA
94799	Pulmonary service/procedure Unlisted	Q1	Q1	5721	5721	$127.10	$136.31	$9.21	7%
# 95782	Polysom <6 yrs 4/> paramtrs	S	S	5724	5724	$864.54	$902.91	$38.37	4%
# 95783	Polysom <6 yrs cpap/bilvl	S	S	5724	5724	$864.54	$902.91	$38.37	4%
# 95800	Slp stdy unattended	S	S	5721	5721	$127.10	$136.31	$9.21	7%
# 95801	Slp stdy unatnd w/anal	Q1	Q1	5733	5734	$54.55	$105.03	$50.48	93%
95803	Actigraphy testing	Q1	Q1	5733	5733	$54.55	$55.96	$1.41	3%
95805	Multiple sleep latency test	S	S	5724	5724	$864.54	$902.91	$38.37	4%

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CPT/ HCPCS	CMS Short Description	Status		APC		JUL CY 2017	Final CY 2018	Dollar Change	Percent Change
		CY 2017	CY 2018	CY 2017	CY 2018	Payment Rate	Payment Rate		
95807	Sleep study attended	S	S	5723	5723	$415.87	$444.36	$28.49	7%
95808	Polysom any age 1-3> param	S	S	5724	5724	$864.54	$902.91	$38.37	4%
95810	Polysom 6/> yrs 4/> param	S	S	5724	5724	$864.54	$902.91	$38.37	4%
95811	Polysom 6/>yrs cpap 4/> parm	S	S	5724	5724	$864.54	$902.91	$38.37	4%
99291 Single Code	Critical care first hour (Single Code APC Assignment & Rate)	J2	J2	5041	5041	$687.17	$733.58	$46.41	7%
99291 Comprehesive	Critical care first hour (Comprehensive APC Assignment & Rate)	S	S	8011	8011	$2,222.64	$2,349.66	$127.02	6%
99292	Critical care each add 30 min	N	N					NA	NA
99406	Behav chng smoking 3-10 min	S	S	5821	5821	$25.23	$30.41	$5.18	21%
99407	Behav chng smoking > 10 min	S	S	5821	5821	$25.23	$30.41	$5.18	21%
99487	Cmplx chron care w/o pt vsit	S	S	5822	5822	$70.26	$71.94	$1.68	2%
99489	Complx chron care addl30 min	N	N					NA	NA
99490	Chron care mgmt srvc 20 min"	S	S	5822	5822	$70.26	$68.92	($1.34)	-2%
99495	Trans care mgmt 14 day disch	V	V	5012	5012	$106.61	$109.58	$2.97	3%
99496	Trans care mgmt 7 day disch	V	V	5012	5012	$106.61	$109.58	$2.97	3%
99497	Advncd care plan 30 min	Q1	Q1	5822	5822	$70.26	$68.92	($1.34)	-2%
99498	Advncd care plan addl 30 min	N	N					NA	NA
99490	Chron care mgmt srvc 20 min"	S	S	5822	5822	$70.26	$71.94	$1.68	2%
99495	Trans care mgmt 14 day disch	V	V	5012	5012	$106.61	$113.68	$7.07	7%
99496	Trans care mgmt 7 day disch	V	V	5012	5012	$106.61	$113.68	$7.07	7%
99497	Advncd care plan 30 min	Q1	Q1	5822	5822	$70.26	$71.94	$1.68	2%
99498	Advncd care plan addl 30 min	N	N					NA	NA
G0237	Therapeutic procd strg endur	S	S	5732	5732	$28.38	$31.80	$3.42	12%
G0238	Oth resp proc, indiv	S	S	5732	5732	$28.38	$31.80	$3.42	12%
G0239	Oth resp proc, group	S	S	5732	5732	$28.38	$31.80	$3.42	12%
G0296	Visit to determ LDCT elig	S	S	5822	5822	$70.26	$71.94	$1.68	2%
G0297	LDCT for Lung CA screen	S	S	5521	5521	$59.86	$62.11	$2.25	4%
G0379 Single Code	Direct refer hospital observ (Single Code APC Assignment & Rate)	J2	J2	5025	5025	$488.74	$520.81	$32.07	7%
G0379 Comprehensive	Direct refer hospital observ (Comprehensive APC Assignment & Rate)	S	S	8011	8011	$2,222.64	$2,349.66	$127.02	6%
G0384 Comprehensive	Lev 5 hosp type bed visit (Composite/Comphrensive APC Assignment & Rate)	S	S	8011	8011	2222.64	$2,349.66	$127.02	6%
G0390	Trauma respons w/hosp criti	S	S	5045	5045	$872.07	$957.50	$85.43	10%
G0398	Home sleep test/type 2 porta	S	S	5721	5721	$127.10	$136.31	$9.21	7%
G0399	Home sleep test/type 3 porta	S	S	5721	5721	$127.10	$136.31	$9.21	7%

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CPT/ HCPCS	CMS Short Description	Status		APC		JUL CY 2017	Final CY 2018	Dollar Change	Percent Change
		CY 2017	CY 2018	CY 2017	CY 2018	Payment Rate	Payment Rate		
G0508	Crit care telehea consult 60	B	B					NA	NA
G0509	Crit care telehea consult 50	B	B					NA	NA
G0463 Single Code	Hospital outpt clinic visit (Single Code APC Assignment & Rate)	J2	J2	5012	5012	$106.61	$113.68	$7.07	7%
G0463 Comprehensive	Hospital outpt clinic visit (Composite/Comprehensive APC Assignment & Rate)	S	J2	8011	8011	2222.64	$2,349.66	$127.02	6%
C-APC	Comprehensive Observation Services	S	J2	8011	8011	2222.64	$2,349.66	$127.02	6%

Definitions: Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is typically reported with multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, a single payment is made for all of the codes as a whole, rather than paying each code individually. The grouping process is described in the CMS Internet-Only Manual (IOM) Pub. 100-04, Chapter 4, Section 10.2.1 Use of the comment indicator "CH" in association with a new or composite/comprehensive APC indicates that the APC assignment or configuration of the composite APC has been changed for CY 2016.

Disclaimer: The information provided herein was current at the time of this communication. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference. The opinions referenced are those of the members of the ATS Clinical Practice Committee and their consultants based on their coding experience. They are based on the commonly used codes in pulmonary, sleep and the critical care sections in CPT and HCPCS level II, which are not all inclusive. Always check with your local insurance carriers as policies vary by region. The final decision for the coding of a procedure must be made by the physician considering regulations of insurance carriers and any local, state or federal laws that apply to the physicians practice. The ATS and its representatives disclaim any liability arising from the use of these opinions. ®CPT is a registered trademark of the American Medical Association, CPT only copyright 2015 American Medical Association.

MACRA 2018

On November 2, 2017, the Centers for Medicare and Medicaid Services (CMS) released the final Quality Payment Program ("QPP") Rule for 2018 and an overview, https://www.cms.gov/Medicare/Quality-Payment-Program/resource-library/QPP-Year-2-Final-Rule-Fact-Sheet.pdf. As expected, the increases to the low volume threshold for the MIPS track were retained from the proposed rule, and approximately 540,000 clinicians will be excluded from the program. The 2018 rule raises the low volume Medicare threshold to $90,000 Medicare Part B charges and 200 patients annually. Unexpectedly, CMS increased the weight of the Cost Category from 0 percent in the proposed rule to 10 percent in the final rule. Cost scores will be determined by using the Medicare Spending Per Beneficiary, Total Per Capita Cost Measures, and additional episode-based cost measures that are in development. In 2018, there will be a corresponding decrease in the quality score from 60 percent to 50 percent. Unfortunately, the use of multiple submission mechanisms to report for MIPS was not finalized for 2018, but CMS predicts multiple submission methods will be available for the 2019 performance period. Similarly, hospital-based clinicians will not be able to use facility-based measurements based on the Hospital Value-Based Purchasing program. CMS intends this reporting pathway will be available to hospital-based clinicians in 2019. CMS was excited to announce the inclusion of "Virtual Groups" as another participation option for year two of MIPS. A Virtual Group is a combination of two or more Taxpayer Identification Numbers (TINs) made up of solo practitioners and groups of 10 or fewer clinicians who exceed the low volume thresholds (eligible clinicians). Virtual groups can cross specialties and cross geographic borders. CMS addresses extreme and uncontrollable circumstances for both the 2017 transition year and the 2018 MIPS performance period by accepting applications for hardship exceptions. If a MIPS eligible clinician's Certified Electronic Health Record Technology (CEHRT) is unavailable due to circumstances such as hurricane, natural disaster, or public health emergency, then eligible clinicians should apply for reweighing of the Advancing Care Information (Meaningful Use) performance category by Dec. 31, 2017. And in 2018, the minimum amount of MIPS points needed to avoid a penalty is increasing from 3 points to 15 points. Measurement of performance in MIPS will be publicly reported on the Physician Compare website. Underlying all these changes regarding calculations of the MIPS score is a slow shift away from "fee for service" and toward value-based reimbursement.

While a majority of eligible clinicians are participating in the Quality Payment Program via the MIPS pathway, CMS wants to see increased participation in the Advanced Alternative Payment Model (APM) pathway. The final rule adds another determination period for MIPS APMs. This adds an additional opportunity for Medicare Shared Savings Program clinicians to qualify as MIPS APMs and receive incentive payments. CMS will also include non-Medicare payers when calculating the percentage of revenue the clinician is risking by entering these alternative payment models. Clinicians need to risk 8 percent of their revenues from a given payer in order to meet the criterion to qualify as an Advanced APM.

While the transition year for QPP is ending, it is not too late to pick your measures and ask your EHR vendor for guidance on collecting 2017 data and the best way to submit it by March 31, 2018. An article in the Jan. 2017 edition of the CBQ, http://www.thoracic.org/about/newsroom/newsletters/coding-and-billing/resources/2017/CBQ_Jan_17.pdf, offered advice on selection of measures and a discussion of the Quality Payment Program. If you have not done so, go to this website https://qpp.cms.gov/participation-lookup and enter your NPI number to check if you need to submit data to MIPS.

PULMONARY HYPERTENSION – NEW ICD-10-CM CODES

New and revised ICD-10-CM coding effective for claims submitted with dates of service on or after Oct. 1, 2017

I27.0 Primary pulmonary hypertension

Primary Group 1 pulmonary arterial hypertension
Primary pulmonary hypertension
Excludes secondary pulmonary hypertension

I27.2 Other secondary pulmonary hypertension

I27.20 Pulmonary hypertension, unspecified

Pulmonary hypertension NOS

I27.21 Secondary pulmonary arterial hypertension

Drug, toxin-induced pulmonary arterial hypertension NOS
Drug, toxin-induced secondary Group 1 pulmonary hypertension
Code also: associated conditions if applicable, or adverse effects of drugs or toxins
Adverse effect of appetite depressants (**T50.5X5**)
Congenital heart disease (**Q20-Q28**)
HIV (**B20**)
Portal hypertension (**K76.6**)
Collagen vascular disease (**M33.2-, M34.-, M05.-**)
Schistosomiasis (**B65.-**)

I27.22 Pulmonary hypertension due to left heart disease

Group 2 pulmonary hypertension
Code also associated left heart disease, if known, such as:
Multiple valve disease (**I08.-**)
Rheumatic mitral valve diseases (**I05.-**)
Rheumatic aortic valve diseases (**I06.-**)

I27.23 Pulmonary hypertension due to lung diseases and hypoxia

Group 3 pulmonary hypertension
Code also associated lung disease, if known, such as:
Bronchiectasis (**J47.-**)
Cystic fibrosis with pulmonary manifestations (**E84.0**)
Interstitial lung disease (**J84.-**)
Pleural effusion (**J90**)
Sleep apnea (**G47.3-**)

I27.24 Chronic thromboembolic pulmonary hypertension

Group 4 pulmonary hypertension
Code also associated pulmonary embolism, if applicable (***I26.-, I27.82***)

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I27.29 Other secondary pulmonary hypertension

Group 5 pulmonary hypertension
Pulmonary hypertension with unclear multifactorial mechanisms
Pulmonary hypertension due to hematologic disorders
Pulmonary hypertension due to metabolic disorders
Pulmonary hypertension due to other systemic disorders
Code also other associated disorders, if known, such as:
Chronic myeloid leukemia (**C92.10-C92.22**)
Essential thrombocythemia (**D47.3**)
Gaucher disease (**E75.22**)
Hypertensive chronic kidney disease with end stage renal disease (**I12.0, I12.11, I13.2**)
Hyperthyroidism (**E05.-**)
Hypothyroidism (**E00-E03**)
Polycythemia vera (**D45**)
Sarcoidosis (**D86.-**)

I27.8 Other specified pulmonary heart diseases

I27.83 Eisenmenger's syndrome

Eisenmenger's complex
(Irreversible) Eisenmenger's disease
Pulmonary hypertension with right to left shunt related to congenital heart disease
Code also underlying heart defect, if known, such as:
Atrial septal defect (**Q21.1**)
Eisenmenger's defect (**Q21.8**)
Patent ductus arteriosus (**Q25.0**)
Ventricular septal defect (**Q21.0**)

I27.89 Other specified pulmonary heart diseases

Eisenmenger's complex
Eisenmenger's syndrome
Excludes Eisenmenger's defect (**Q21.8**)

Q&A

Q. We have some patients referred by their PCP for PFT testing only. We have been told repeatedly that under "incident to" billing structure, there is a requirement for physician supervision in the office suite for any PFT, including spirometry. This supervision cannot be accomplished with an advanced practice provider (APP, NP, PA). The information from our coding experts: "Per specific diagnostic coding guidelines, there has to be an MD (not a PA or NPP) in the office suite during the time that the PFT is done as it requires general supervision." Is this the correct interpretation of this requirement? We have times when a MD is at the hospital doing consults or out of the office (vacation, leave) and we're told that the PFT must have a MD on site in order to bill.

A. We believe that your coding experts are mixing the "incident to" policies with policies for other diagnostic or technical services. In general, the "incident to" rules apply to the PA, NP and APP, who is performing a service that a physician would normally perform. Services rendered in the office suite do apply to those technical services. We refer you to the CMS Medicare Learning Matters clarification and specific Question located on page three and copied below:

MLN Matters Number: SE0441

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf

Page 3: Must a supervising physician be physically present when flu shots, EKGs, Laboratory tests, or X-rays are performed in an office setting in order to be billed as "incident to" services?

These services have their own statutory benefit categories and are subject to the rules applicable to their specific category. They are not "incident to" services and the "incident to" rules do not apply.

While it is true that only MDs and DOs may provide supervision of the outpatient facility, see below:

Only MDs and DOs May Provide Supervision

For diagnostic services in an outpatient setting, the Social Security Act §1861(r) requires "a doctor of medicine or osteopathy legally authorized to practice medicine in his or her state of practice" to act as the supervisory physician. Midlevel providers "are not permitted to function as supervisory 'physicians' for the purposes of other hospital staff performing diagnostic tests," according to the Medicare Benefit Policy Manual, chapter 6, §20.4.3.

The additional details go on to say:

Supervision requirements apply only to the technical component—the actual test administration—of a particular service. A physician always must provide the professional component (reading/interpretation of the results) for all services.

Defining Supervision Levels

The Code of Federal Regulations (42 CFR 410.32) defines three levels of supervision, as follows:

1. General supervision: The service is furnished under the overall direction and control of the physician, **but his or her physical presence is not required during the procedure.**

Therefore, if you are asking about the performing of the technical service for a PFT or spirometry, which are both noted as general supervision for the technical component, neither would require physician presence during the performing of the procedure. If you are referring to the reading of the test, this can only be performed by a qualified physician.

How to Determine Supervision Requirements for Each Service/Procedure

The supervision requirement for each CPT and HCPCS Level II code is defined by a one or two character indicator, found in the "Physician Supervision of Diagnostic Procedures" column of the National Physician Fee Schedule Relative Value File (available as a free download on the Centers for Medicare & Medicaid Services (CMS) website: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html). Indicators pertinent to diagnostic procedures are as follows:

- **1.** Procedure must be performed under general supervision.
- **2.** Procedure must be performed under direct supervision.
- **3.** Procedure must be performed under personal supervision.
- **9.** Concept does not apply.

From the above link the TC components for CPT **94010**, **94014**, **94015**, **94150-94375** and **94620** (now **94617** and **94618**) all have supervision levels of "1". We encourage you to review all the CPT codes for the services you provide for the level of supervision required to perform. We hope you find this information helpful.