Joint CPC Trainee Session
Billing and Coding

Joint CHEST/ATS Clinical Practice Committee Members

Disclaimers

- No conflicts

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 CHEST-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 CHEST-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 2012 American Medical Association.

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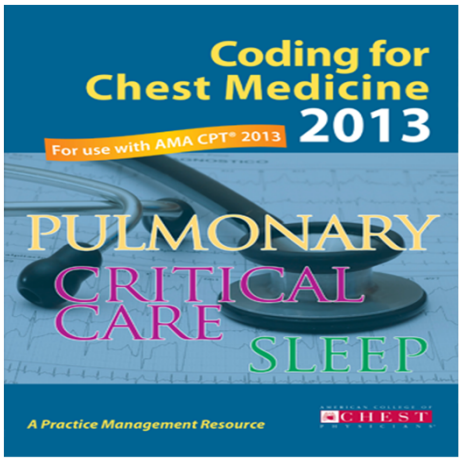

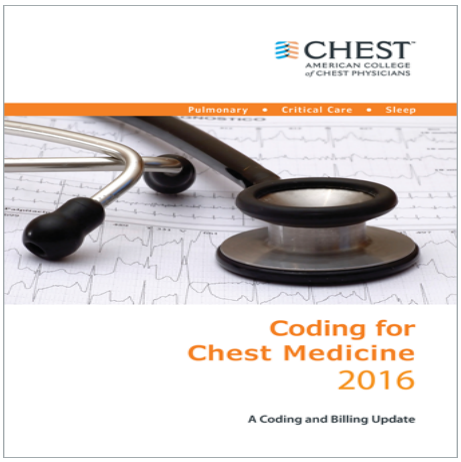

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Know Before You Code

- ICD-10 VS CPT (AMA)

International Classification of Disease (ICD) is the diagnosis and Current Procedural Terminology (CPT) is the procedure or care

- Document accurately – documentation should reflect level of work done -- code to that level
- Code as if every visit or procedure will be audited
- Code all activities where practical
- Be thorough, but not greedy
- Reimbursement largely dependent upon payer
- Be aware of local and carrier differences
- Can't discuss specific fees outside of your own entity
- Fees typically set to capture all code components
  - Global, Technical (TC), Professional (26)

DOCUMENT! DOCUMENT! DOCUMENT!

Evaluation and Management Coding

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October 7, 2018

Chest and American Thoracic Society Clinical Practice Committee

Disclaimer

Opinions rendered are my own

No warranty or guarantee of fitness is made or implied

Member of ATS clinical practice committee

No financial disclosures

Why Learn About Evaluation and Management Coding?

E & M occurs whenever a clinician sees a patient

E & M coding is the sole source of income for many clinicians

It translates patients encounters into a 5 digit code that facilitates billing and reimbursement

Patient encounters vary in levels of care, levels of documentation, and levels of reimbursement

Examples of E & M Coding

Within hospital follow up visits there are 3 levels of care

99231	"level 1 note"	0.76 work RVU's
99232	"level 2 note"	1.39 work RVU's
99233	"level 3 note"	2.00 work RVU's

In 2018, Medicare conversion factor is $36.00/RVU

https://www.ama-assn.org/practice-management/medicare-physician-payment-schedules

E & M = Cognitive Labor

E & M coding is how Clinician cognitive labor is translated into reimbursement

In order to get paid properly, documentation must be done correctly

So clinicians must understand the guidelines and the rules of the road for documentation and coding their work

The “rules of the road” are the E&M guidelines

The E&M Guidelines

Based on three “Key components”

1. History
2. Physical Exam
3. Medical Decision Making

Hospital Progress Notes				
MDM	E/M	Hx	Exam	Time*
SF/Low	99231	PF	PF	15
Mod	99232	EPF	EPF	25
High	99233	Det	Det	35
Requires 2/3 key components				

Time affects level when
Counseling and and/or
Coordination is >50% of total visit time

Medical Decision Making

The complexity of medical decision making (MDM) should drive the level of service

If MDM is simple, then a comprehensive history and physical exam should not translate to a high level of service

Three categories determine the level of MDM Complexity

1. **Number of diagnoses provider is managing (diagnosis points)**
2. **Amount and complexity of the data (data points)**
3. **Patient Risk**

Complexity	Dx/Tx Options Points	Data Points	Risk Level
Problem-focused	<1 (minimal)	<1 (minimal)	Minimal
Low	2 (limited)	2 (limited)	Low
Moderate	3 (multiple)	3 (multiple)	Moderate
High	4 (extensive)	4 (extensive)	High

Coding for Chest Medicine 2016-A Billing and Coding Update, Manaker, ACCP, 17th edition

Adding up Diagnosis points

Number of Diagnoses/Treatment Options	Points/Problems
Self-limited/minor problem (stable, improved, or worsening)	1 (maximum = 2 problems)
Established problem (stable or improving)	1
Established problem (worsening)	2
New problem, without additional workup	3 (maximum = 1 problem)
New problem, with additional workup planned	4

-A problem listed in the assessment without a plan is considered "history", not a diagnosis

- "New Problem" = New problem for the provider. Not necessarily new problem for the patient

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Adding up Diagnosis points

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Amount and/or Complexity of Data Ordered/Reviewed	Points
Review and/or order of clinical test(s)	1
Review and/or order of test(s) in the pathology/laboratory section of CPT	1
Review and/or order of test(s) in the radiology section of CPT	1
Review and/or order of test(s) in the medicine section of CPT	1
Decision to obtain old records and/or obtain history from someone other than the patient	1
Review and summarize old records and/or obtain the history from someone other than the patient and/or discussing the case with another health-care provider	2
Independent visualization of actual image, tracing, or specimen	2

-Only one point per category
-You get 2 points for medical record review and/or discussing case if you document details. Just writing that it happened is not sufficient

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Adding up Data Points

Amount and/or Complexity of Data Ordered/Reviewed	Points
Review and/or order of clinical test(s)	1
Review and/or order of test(s) in the pathology/laboratory section of CPT	1
Review and/or order of test(s) in the radiology section of CPT	1
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Decision to obtain old records and/or obtain history from someone other than the patient	1
Review and summarize old records and/or obtain the history from someone other than the patient and/or discussing the case with another health-care provider	2
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High	4 (extensive)	4 (extensive)	High

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Assessing Risk

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	• One self-limited or minor problem (eg, cold, insect bite, tinea corporis)	• Laboratory tests requiring venipuncture • Chest radiographs • ECG/EEG • Urinalysis • Ultrasound (eg, echocardiography) • KOH preparation	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness (eg, well-controlled hypertension, noninsulin-dependent diabetes, cataract, BPH) • Acute uncomplicated illness or injury (eg, cystitis, allergic rhinitis, simple sprain)	• Physiologic tests not under stress (eg, pulmonary function tests) • Noncardiovascular imaging studies with contrast (eg, barium enema) • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives

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Assessing Risk

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Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis (eg, lump in breast) • Acute illness with systemic symptoms (eg, pyelonephritis, pneumonitis, colitis) • Acute complicated injury (eg, head injury with brief loss of consciousness)	• Physiologic tests under stress (eg, cardiac stress test, fetal contraction stress test) • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors (eg, arteriogram, cardiac catheterization) • Obtain fluid from body cavity (eg, lumbar puncture, thoracentesis, culdocentesis)	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation

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Assessing Risk

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Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
High	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that pose a threat to life or bodily function (eg, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure) • An abrupt change in neurologic status (eg, seizure, TIA, weakness, sensory loss)	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

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Assessing Risk

The highest single bulleted item in any risk category determines the patient's risk level

Stratify risk based on the presenting problems, diagnostic procedures or management options selected

Minimal Risk	Low Risk	Moderate Risk	High Risk
•One self-limited or minor problem (e.g., cold, insect bite, tinea corporis) •Labs •EKG •EEG •CXR •UA •Ultrasound •Echo •KOH prep •Rest •Gargles •Elastic bandages •Superficial dressings	•Two or more self-limited or minor problems •One stable chronic illness, (e.g., well controlled HTN, DM2) •Acute uncomplicated illness or injury (e.g., cystitis/rhinitis) •Physiologic tests without stress •Non-cardiovascular imaging with contrast •Skin or superficial needle biopsy •ABG •Over the counter drugs •Minor surgery without risk factors •PT/OT •IV fluids without additives	•One or more chronic illness, with mild exacerbation or progression •Two or more stable chronic illnesses •Undiagnosed new problem with uncertain prognosis (e.g., lump in breast) •Acute illness with systemic symptoms (e.g., pyelonephritis, colitis) •Physiologic tests with stress •Endoscopy without known risk factors •Deep needle/incisional biopsy •Cardiovascular imaging with contrast without risk factors (arteriogram/cath) •Fluid from body cavity (LP, thoracentesis, paracentesis, etc.) •Prescription drug management •Minor surgery with risk factors •Elective major surgery without risk factors •IV fluids with additives •Closed treatment of fracture or dislocation	•Chronic illness with severe exacerbation or progression •Illness with threat to life or bodily function (MI, ARF, PE) •Abrupt change in neurological status (TIA, weakness) •Cardiovascular imaging with contrast (arteriogram, cardiac cath) with risk factors •EP studies •Endoscopy with risk factors •Discography •Elective major surgery with risk factors • Emergency surgery •Parenteral controlled substances •Drugs requiring intensive monitoring for toxicity •Decision for DNR or to de-escalate care

It only takes **ONE** item from the above table to qualify for any level of risk. Use highest risk present.

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How to Determine Level of Complexity

Complexity	Dx/Tx Options Points	Data Points	Risk Level
Problem-focused	<1 (minimal)	<1 (minimal)	Minimal
Low	2 (limited)	2 (limited)	Low
Moderate	3 (multiple)	3 (multiple)	Moderate
High	4 (extensive)	4 (extensive)	High

-Final result of complexity is based on the two highest valued categories
-The "second weakest link" determines the level of complexity

"I don't want to calculate points every time I write a note"

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- Explain what would happen to the patient if you weren't there
- If you can explain why patient could have a poor outcome without you, then you've documented a high complex patient
- Describe decisions you made after conversations with another health care provider → 2 points for data review
- Remind yourself that your medical decision making reflects your cognitive skill, not always your cognitive labor
- Don't be afraid to write in the 1st person ("I lowered the dose of prednisone to 20 mg a day")

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All Three Key Components must be met for New Outpatients

New Patient Visit	History	Examination	MDM	Time
99201 0.48 wRVU	Problem-focused	Problem-focused	Straightforward	10 min
99202 0.93 wRVU	Expanded problem-focused	Expanded problem-focused	Straightforward	20 min
99203 1.42 wRVU	Detailed	Detailed	Low	30 min
99204 2.43 wRVU	Comprehensive	Comprehensive	Moderate	45 min
99205 3.17 wRVU	Comprehensive	Comprehensive	High	60 min

Two of Three Key components must be Met for Established Outpatient

Established Patient Visit		History	Examination	MDM	Time
99211	0.18 wRVU	N/A	N/A	N/A	5 min
99212	0.48 wRVU	Problem-focused	Problem-focused	Straightforward	10 min
99213	0.97 wRVU	Expanded problem-focused	Expanded problem-focused	Low	15 min
99214	1.50 wRVU	Detailed	Detailed	Moderate	25 min
99215	2.11 wRVU	Comprehensive	Comprehensive	High	40 min

https://www.aapc.com/practice-management/rvu-calculator.aspx

Consults Require three out of three key components

Work RVU's	Office (9924x) & Inpatient (9925x) Consults				
	MDM	E/M	Hx	Exam	Time*
0.64 /1.00	SF	99241/99251	PF	PF	15/20
1.34/1.50	SF	99242/99252	EPF	EPF	30/40
1.88/2.27	Low	99243/99253	Det	Det	40/55
3.02/3.29	Mod	99244/99254	Comp	Comp	60/80
3.77/4.00	High	99245/99255	Comp	Comp	80/110

https://learn.emuniversity.com/file.php/5/Coding_Guides/Specialty_Guide_Pulmonary.pdf

Initial Hospital Care requires three of three key elements

Work RVU's	MDM	E/M	Hx	Exam	Time*
1.92	SF/Low	99221	Det	Det	30
2.61	Mod	99222	Comp	Comp	50
3.86	High	99223	Comp	Comp	70

https://learn.emuniversity.com/file.php/5/Coding_Guides/Specialty_Guide_Pulmonary.pdf

Hospital follow up note requires 2 of 3 elements

Work RVU's	MDM	E/M	Hx	Exam	Time*
0.76	SF/Low	99231	PF	PF	15
1.39	Mod	99232	EPF	EPF	25
2.00	High	99233	Det	Det	35

https://learn.emuniversity.com/file.php/5/Coding_Guides/Specialty_Guide_Pulmonary.pdf

Final Complexity

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Final Result for Complexity					
A	Number diagnoses or treatment options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
B	Highest Risk	Minimal	Low	Moderate	High
C	Amount and complexity of data	≤ 1 Minimal or low	2 Limited	3 Multiple	≥ 4 Extensive
Type of decision making		STRAIGHT-FORWARD	LOW COMPLEX.	MODERATE COMPLEX.	HIGH COMPLEX.

Complexity of Data

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Amount and/or Complexity of Data Reviewed	
Reviewed Data	**Points**
Review and/or order of clinical lab tests	(1)
Review and/or order of tests in the radiology section of CPT	(1)
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	(2)
TOTAL	4

Decision Risk

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Use the risk table below as a guide to assign risk factors. It is understood that the table below does not contain all specific instances of medical care; the table is intended to be used as a guide. Circle the most appropriate factor(s) in each category. The overall measure of risk is the highest level circled. Enter the level of risk identified in Final Result for Complexity (table below).

Risk of Complications and/or Morbidity or Mortality

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	• One self-limited or minor problem, e.g., cold, insect bite, tinea corporis	• Laboratory tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound, e.g., echo • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness, e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, e.g.,pulmonary function tests • Non-cardiovascular imaging studies with contrast, e.g., barium enema • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis • Acute complicated injury, e.g., head injury with brief loss of consciousness	• stress test, isk factors • Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
High	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure • An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic with identified risk factors) • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

Final Complexity

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Final Result for Complexity					
A	Number diagnoses or treatment options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
B	Highest Risk	Minimal	Low	Moderate	High
C	Amount and complexity of data	≤ 1 Minimal or low	2 Limited	3 Multiple	≥ 4 Extensive
Type of decision making		**STRAIGHT-FORWARD**	**LOW COMPLEX.**	**MODERATE COMPLEX.**	**HIGH COMPLEX.**

Case 1

Cc: Hospital follow up for COPD exacerbation

History: He has shortness of breath with walking to the bathroom, sputum is lighter yellow but still thick, he is less dyspneic with duonebs, his cough has improved

ROS: He is wheezing; no fever, no chills

Case 1

Exam: Hr 90, BP 130/80, RR is 12; AOx3, HEENT: eyes normal; neck is supple; regular rate and rhyth, no JVD, lungs with rhonchi at the bases; normal bowel sounds; no clubbing, cyanosis, or edema

CXR images reviewed, agree with radiologist that there are no infiltrates. WBC 9.0

Assessment: COPD exacerbation. Improving slowly

Plan: I discussed with primary attending that should be ok to lower prednisone dose to 40 mg daily. Continue duonebs. Attending and I also agreed to finish course of ceftriaxone since sputum less purulent.

How would you audit this note?

MDM: 5 points for data review (2 pts for discussing case with another health care provider, 2 points for looking at image, 1 point for reviewing WBC). Max points is 4

1 point for established problem, improving

Moderate risk level (one or more chronic illness with mild exacerbation, Rx drug mgmt)

-Final result of complexity is based on the two highest valued categories

Complexity	Dx/Tx Options Points	Data Points	Risk Level
Problem-focused	<1 (minimal)	<1 (minimal)	Minimal
Low	2 (limited)	2 (limited)	Low
Moderate	3 (multiple)	3 (multiple)	Moderate
High	4 (extensive)	4 (extensive)	High

History Level and Exam Level

→HPI was extended (≥4 elements)

→Problem Pertinent ROS

→PFSH is not necessary in subsequent hospital care

→Exam was comprehensive

History Level	HPI	ROS	PFSH
Problem-focused	Brief (≤3)	N/A	N/A
Expanded problem-focused	Brief (≤3)	Problem-pertinent (1)	N/A
Detailed	Extended (≥4)	Extended (2–9)	Pertinent (1)
Comprehensive	Extended (≥4)	Complete (≥10)	Complete (2 or 3)*

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Hospital follow up note require 2 of 3 elements

MDM	E/M	Hx	Exam	Time*
SF/Low	99231	PF	PF	15
Mod	99232	EPF	EPF	25
High	99233	Det	Det	35

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Questions?

Bronchoscopy

Considered an inherently bilateral procedure

Surgical bronchoscopy always includes diagnostic bronchoscopy when performed by the same physician

Common CPT Codes - Bronchoscopy

Bronch-Diagnostic	31622
Bronch-Brush	31623
Bronch-BAL	31624
Bronch-EBBX (all sites)	31625
Bronch-TBBX (1 lobe)	31628
Bronch-TBNA (1 lobe)	31629
Additional TBBX Site	31632
Additional TBNA Site	31633
Bronch-removal foreign body	31635
Therapeutic Aspiration-initial	31645
Therapeutic Aspiration-subsequent	31646
Bronch Thermoplasty 1 lobe	31660
Bronch Thermoplasty 2+ lobes	31661

Common CPT Codes-Bronchoscopy

31652 Endobronchial Ultrasound (EBUS) with transbronchial needle aspiration (TBNA) of 2 or fewer mediastinal or hilar nodes or stations

31653 Endobronchial Ultrasound with transbronchial needle aspiration of 3 or more mediastinal or hilar nodes or stations

(TBNA is included. Not billed separately as 31629 or 31633)

31654 Endobronchial Ultrasound using Radial Probe. **ADD ON** (Use of this in addition to above OK if associated with a specific diagnostic bronch code. i.e 31629 or 31628 or others)

ZZZ "Add-On" Codes

(Cannot be billed as a Stand-Alone)

31654 EBUS Radial Probe (use with 31622-46)

31632 TBBX additional (use with 31628 tbbx)

31633 tbna additional (use with 31629 tbna)

Moderate sedation

Total Intra Service Time		(1st Bronchoscopist)	(2nd/different)
Less Than 10 Min	not billable		
15-22 Min	<5 y.o.	99151	99155
	>5	99152	99156
23-37 Min	<5	99151+99153	99155+99157
	>5	99152+99153	99156+99157

Be careful about billing 23-37 min – several carriers will not cover and may deny your base claim

Common Modifiers

22 Increased Procedural Service

24 Unrelated E/M by same physician during 10/90 day global

25 Separate E/M by same physician same day as another service

26 Professional Component (e.g. ultrasound by physician with unit in hospital)

50 Bilateral Procedure (e.g. bilateral chest tubes, 2 reports)

51 Multiple Procedures

52 Reduced Services

53 Discontinued Services

59 Distinct Procedural Service

76 Repeat Procedure by same physician

Diagnostic Endoscopies
31615-31661 (DIAGNOSTIC AND THERAPEUTIC Bronchoscopies

Zero Global Period (Medicare, 2002)

Includes bronchoscope and **related** preoperative and postoperative care on the **SAME DAY** of the procedure

E /M services provided on the **SAME DAY** of the procedure may be appropriate and necessary – append E /M with 25 modifier, code procedure in standard format

Multiple Endoscopy Rule

Typical bronchoscopy includes multiple procedures

Report all procedures in descending order of complexity eg; 31629 31233 31625…

Reimbursement is for most complex plus the sum of the differences between the rest and the basic bronchoscopy 31622 – excluding ZZZ codes

Multiple Procedure Rule

- Multiple procedures, other than bronchoscopy in same setting
- Full payment is made for the procedure with the highest Practice Expense (PE) payment. For subsequent procedures, same patient - same day, decreased amounts
- Modifier 51 denotes multiple procedures and may be carrier dependent

Common Pleural Procedures – Part I

(billable, if performed with E/M or CC add 25 modifier to E/M or CC code)

32550 indwelling pleural catheter

32551 chest tube open

32552 removal of indwelling pleural catheter

32554 thoracentesis without imaging

32555 thoracentesis with imaging

Common Pleural Procedures – Part II
(billable, if performed with E/M or CC add 25 modifier to E/M or CC code)

32556 pleural drainage, percutaneous, with insertion of indwelling catheter, without imaging

32557 pleural drainage, percutaneous, catheter with imaging

32560 chemical pleurodesis includes thoracentesis but not chest tube use 32551 separately (Use HCPCS code for agent)

32561, 32562 fibrinolysis initial, subsequent days via Chest Tube – report only once per calendar day

Guidance associated

76604.26 – US, chest scan only

76942-26 – US Guidance for Needle Bx & Indwelling Catheter

Case example

75 yo woman. Hemoptysis *(R04.2)*. CT and PET show hilar and mediastinal adenopathy *(R59.0)*. RUL mass *(R91.8)*.

Procedure: EBUS TBNA R paratracheal 4R, subcarinal 7, Left paratracheal 4L *(31653)*. TBBX *(31628)* and TBNA *(31629)* RUL nodule with radial probe *(31654)* and fluoroscopic image guidance *(not separately billable)*.

Case Example 2

83 y.o. with screening CT showing mediastinal and hilar *(R59.0)* adenopathy (4 R and 11 R) and well as peripheral Right lower lobe SOLITARY nodule (R91.1) . PET + in these areas only. Patient not interested in surgery but will consider treatment if cancer found.

Procedure: EBUS TBNA 4R and 11 R *(31652)*. No other enlarged nodes seen. ROSE shows lymphocytes. Navigational bronchoscopy *(31627)* to peripheral lesion not successful. Immediate navigation/image guided TTNA *(32405.51)*performed. Dx made of lung cancer *(C34.90)*. Pneumothorax *(J93.81)* post procedure requires catheter over a wire and patient sent home *(32556)*.

Returns to office 3 days later for chest tube/catheter removal.

(E & M 99212-99215)

Note: US peripheral, CT Guidance, Fluoro guidance, or Navigational guidance have different coding concerns)

Case Example 3

80 y.o. with multiple comorbidities presents with fever *(R50.81)*, purulent sputum and pleurisy *(R09.1)*. CXR shows large left effusion *(J90)*. Thoracentesis *(32555)* with imaging yields pus. Patient diagnosed with empyema *(J86.9)*. Open chest tube placed *(32551)*.

Followed daily. Decision made on day 2 to use fibrinolytics BID for next 3 days. *(E&M level 99231-99233 .25 modifier + 32561 x 1, 32562 x 1, 32562 x 1 Only one a day)*

Drainage improved and chest tube removed day after *(E&M 99231-99233)*.

CHEST AMERICAN COLLEGE of CHEST PHYSICIANS

Critical Care

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CPT Editorial Panel, ATS Advisor

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Disclaimer

- Opinions rendered are my own.
- No warranty or guarantee of fitness is made or implied.

Critical Care – Definition of Service

- The direct delivery of medical care for a critically ill /injured patient.
- "A critical illness/injury acutely impairs one or more vital organ systems such that there is a **high probability of imminent or life threatening deterioration in the patient's condition"**.
- "Involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition".
  - Examples include, but are not limited to: CNS failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure.
  - Typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s) – but not required
  - "May be provided on multiple days, even if no changes are made in the treatment rendered to the patient, provided that the patient's condition continues to require the level of attention described above".
- Usually, but not always, given in a critical care area.
  - Services for a patient who is not critically ill but happens to be in a critical care unit are reported using other appropriate E/M codes.

Critical Care – Time Based

- Report the total duration of time spent in provision of critical care services to a critically ill/injured patient, even if the time is not continuous.
  - For any given period of time spent providing critical care services, must devote full attention to the patient
    - Cannot provide services to any other patient during the same period of time.
  - Time should be recorded in the patient's record.
  - Time spent engaged in work directly related to the individual patient's care whether that time was spent at the immediate bedside or elsewhere on the floor or unit.
- Time spent in activities that occur outside of the unit or off the floor may not be reported as critical care since the individual is not immediately available to the patient.
  - eg, telephone calls whether taken at home, in the office, or elsewhere in the hospital
- Time spent in activities that do not directly contribute to the treatment of the patient may not be reported as critical care, even if performed in the critical care unit
  - eg, participation in administrative meetings or telephone calls to discuss other patients.
- Time spent performing separately reportable procedures or services should not be included as critical care time.

Critical Care – The Codes

99291

Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

99292 (Add-On)

Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

Critical Care Time

Start/Stop Time OR Total Time

Total Duration of Critical Care	Codes
<30 min	• appropriate E/M codes
30-74 min(30 -74 min)	• 99291 X 1
75-104 min (1 hr 15 min - 1 hr 44 min)	• 99291 X 1 & 99292 X 1
105-134 min (1 hr 45 min - 2 hr 14 min)	• 99291 X 1 & 99292 X 2
135-164 min (2 hr 15 min - 2 hr 44 min)	• 99291 X 1 & 99292 X 3

CRITICAL CARE TIME
TYPE OF WORK

Type of Work

- Must be on patient floor/unit – must be available to be at the bedside
  - Entire time need not be at patient bedside.
- Reviewing patient monitoring data/laboratory tests/radiographs
- Discussing care with nurses and other MDs
- Reviewing consultations – notes in Epic
- Reviewing telemetry
- Family meeting – patient unable to provide input
- Writing progress notes and orders
- If patient lacks capacity to participate in discussions:
  - Time spent with family members or surrogate decision makers obtaining a medical history, reviewing the patient's condition or prognosis, or discussing treatment or limitation(s) of treatment may be reported as critical care, provided that the conversation bears directly on the management of the patient.

Details of Time

- Calendar day (MN →MN)
- Cumulative time
- No over-lap/carry over time
- Does not include time time from procedures billed separately
- Do include time from bundled procedures

CRITICAL CARE CODES

- **The following services are included in critical care services:**
  - Interpretation of
    - Cardiac output measurements
    - Chest X-rays
    - Pulse oximetry
    - Blood gases
    - Information data stored in computers (eg, ECGs, blood pressures, hematologic data
  - Procedures
    - Gastric intubation
    - Temporary transcutaneous pacing
    - Ventilatory management
    - Vascular access procedures
      - Venipuncture/Arterial puncture
- **Services performed not on this list should be reported separately.**

Critical Care Codes
Other Billable Services

Endotracheal intubation

Insertion/placement of pulmonary artery catheter

Cardiopulmonary resuscitation

Central venous lines

Arterial lines

Dialysis catheter

Ultrasound

Thoracentesis/Paracentesis

Separate Identifiable E&M Service
The -25 Modifier

Used for a procedure and a visit on same day

Requirements

- Procedure/service performed identified by a CPT code
- The visit (E&M service) SEPARATELY IDENTIFIABLE
- The visit must be beyond routine pre/post-procedure care
- Separate procedure note required
- Append -25 to the E&M code
- Appropriate ICD-10 codes (diagnosis) for E&M visit and procedure

Critical Care Documentation Checklist

- Pt is/remains critically ill, with…
  - List ≥ 1 critical care dx
- Relevant Hx, PE and Data
  - Good patient care, reduce malpractice and compliance liability
- What I thought….
  - Why are they critically ill
- I did…
  - What critical care service did you provide?
  - E.g., keep vent the same, continue to titrate drips, etc
- No overlap…
  - …with other providers; or …with separately billable services
- My time
  - Start/stop time(s) or total times

Case 1

Case

Patient in the ICU on vasopressors and a ventilator with hypotension and respiratory failure secondary to sepsis.

Note

Patient remains critically ill on mechanical ventilation for respiratory failure and vasopressors for septic shock. Remains sedated with versed. Blood cultures positive for gram negative cocci. Added cefepime for greater gram negative coverage. Will increase ventilator rate from 12-14 to increase minute ventilation due to increased PaCO2.

- I spent 35 minutes in the care of this critically ill patient, independent of time spent on procedures.
- Signed Dr. X

Code: 99291 (wRVU – 4.5) Correct or Incorrect?

Correct

Note Included why patient is critically ill, what you are doing and the time you participated.

Case 2

Case

Patient in the ICU on vasopressors and a ventilator with hypotension and respiratory failure secondary to sepsis.

Note

Patient remains critically ill on mechanical ventilation for respiratory failure and vasopressors for septic shock. Remains sedated with versed. Blood cultures positive for gram negative cocci. Added cefepime for greater gram negative coverage. Will increase ventilator rate from 12-14 to increase minute ventilation due to increased PaCO2.

- Signed Dr. X

Code: 99291 (wRVU - 4.5) Correct or Incorrect?

Incorrect

No time reported

Correct Code: 99231 (wRVU - .76)

Expanded problem focused HPI

No physical exam

Medical Decision Making – Low complexity

- 2 diagnoses
- 1 data element
- High risk

Case 3

Case

55 year old male admitted for cystoscopy procedure three days ago. Was doing well on the floor until he suddenly became hypotensive, febrile, tachycardia, SOB and lethargic. You are called to see him on the floor.

Note

Called to see patient on the floor. He was doing well post procedure then developed high fevers, lethargy, SOB followed by hemodynamic instability. He appears septic. I have given him three liters of NS and started him on norepinephrine. I placed him on high flow oxygen at 70% FIO2. I have ordered a set on blood cultures, an ABG, CBC and a Chem 7. I ordered broad spectrum antibiotics for septic shock.

- I spent 35 minutes in the care of this critically ill patient, independent of time spent on procedures.
- Signed Dr. X

Code: 99291 (wRVU - 4.5) Correct or Incorrect?

Correct

Note Included why patient is critically ill, what you are doing and the time you participated.

Location of service does not matter.

Case 4

Case

35 year old women admitted to the ICU 4 days ago on a ventilator for respiratory failure from pneumonia

- Extubated a day and a half ago.

Note

Patient remains in the MICU awaiting a bed on the floor. Still doing well after extubation 36 hours ago. Hemodynamically stable. Lungs clear. Continuing antibiotics for pneumonia.

- I spent 35 minutes in the care of this critically ill patient, independent of time spent on procedures.
- XXXXX

Code: CPT 99291 (wRVU - 4.5) Correct or Incorrect?

Incorrect

No evidence patient is critically ill, in fact patient appears very stable and well on the way to recovery.

Just because they are in the ICU does not make them critically ill or allow you to bill critical care time.

Correct Code: 99231 (wRVU - .76)

HPI - Expanded problem focused
Physical exam – Problem Focused
Medical Decision Making – Straight Forward

- 1 diagnoses
- 0 data element
- Moderate Risk

Case 5

Case

Patient in the ICU on vasopressors and a ventilator with hypotension and respiratory failure secondary to sepsis.

Note

Patient remains critically ill on mechanical ventilation for respiratory failure and vasopressors for septic shock. He worsened this morning with increased hemodynamic instability. I gave him three liters of NS to bring his MAP back to 60 mmHg. Remains sedated with propafol, but added NMB due to dis-synchrony with the ventilator. Blood cultures positive for gram negative cocci. Added cefepime for greater gram negative coverage. Will increase ventilator rate from 12-14 to increase minute ventilation due to increased PaCO2.

- I spent 80 minutes in the care of this critically ill patient, independent of time spent on procedures.
- Signed Dr. X

Code: 99291 (wRVU – 4.5) and 99292 (wRVU – 2.25) Correct or Incorrect?

Correct

Total Duration of Critical Care	Codes
<30 min	• appropriate E/M codes
30-74 min(30 -74 min)	• 99291 X 1
75-104 min (1 hr 15 min - 1 hr 44 min)	• 99291 X 1 & 99292 X 1
105-134 min (1 hr 45 min - 2 hr 14 min)	• 99291 X 1 & 99292 X 2
135-164 min (2 hr 15 min - 2 hr 44 min)	• 99291 X 1 & 99292 X 3

ADVANCED PRACTICE PROVIDERS

Katina Nicolacakis, MD FCCP
Cleveland Clinic
CHEST
October 2018

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INDEPENDENT BILLING

- Balanced Budget Act (BBA) 1997
  - Expanded billing opportunities
  - Removed all setting restrictions (SNF)
- National Provider Identification (NPI)
- CMS recognized APPs consistently
  - Reimburses at 85%
- Physician need not be physically present
  - State laws may differ
- Documentation parallels physician requirements
- Co-signature not required for billing (may be by certain states)

WHAT IS A SHARED/SPLIT VISIT?

- E/M that is shared between the physician and an APP (NP, PA, CNS, or CNM)
- Billed under the physicians billing number
- Provided in a hospital inpatient, hospital outpatient, off campus hospital outpatient, or emergency room department
- NOT TO BE USED FOR CRITICAL CARE

ENCOUNTER EXAMPLES

APP sees the patient and writes a progress note in the morning during rounds. The physician sees the the patient in a face-to-face encounter later the same day

APP sees the patient in the pulmonary outpatient clinic and identifies a high-risk disease process. She/he discusses the case with one of the physicians in the office. The physicians then sees and examines the patient and documents a note clearly indicating a face-to-face encounter.

Shared/Split Billing Guidelines

- Services MUST occur on the same day, though may be same or separate times
- APP and Physician are in the same group practice/employed by the same employer
- Physician MUST have a face to face encounter
- Documentation must include evidence of physician and APP each performing a substantive portion of the E/M
- Each must sign the note and refer to the other
- Reimbursement depends on who's NPI is on the claim – can be either

DOCUMENTATION REQUIREMENTS

What does substantive mean?

Document face-to-face encounter

Physician must document at least one of the 3 components

- History
- Physical Exam
- Medical Decision Making

Cannot say “Agree with above” and sign

EXAMPLE

I have personally performed a face to face diagnostic evaluation on this patient. My findings are as follows: …Patient presents with cough, yellow sputum production and increased SOB for 3 days. Has tried using albuterol MDI more and guaifenesin for relief. Exam shows scattered expiratory wheezes with good air entry, started on azithromycin and prednisone burst for acute exacerbation of COPD. **Signed by treating physician**

EXAMPLE

I have personally performed a face to face diagnostic evaluation on this patient. I have reviewed and agree with the care plan. History and Exam by me shows: diffuse scattered expiratory wheezes without crackles or rhonchi. CXR negative for pneumonia. Albuterol nebulizer treatment giving with improved air entry and symptomatic relief. Patient prescribed azithromycin and prednisone burst.

Signed by treating physician

INADEQUATE DOCUMENTATION

"I have personally seen and examined the patient independently, reviewed the PA's History, exam and MDM and agree with the assessment and plan as written" signed by the physician

"Patient seen" signed by the physician

"Seen and examined" signed by the physician

"Seen and examined and agree with above (or agree with plan)" signed by the physician

"As above" signed by the physician

Documentation by the APP stating "The patient was seen and examined by myself and Dr. X., who agrees with the plan" with a co-sign of the note by Dr. X

No comment at all by the physician, or only a physician signature at the end of the not

SHARED/SPLIT BILLING

CMS updated billing policy Oct 2002

Expanded billing opportunities to inpatients, hospital outpatients, and ED patients

Medicare recognizes this policy

Some 3rd party payers do

Applies to specified E/M services

NOT Critical Care (99291/2) or procedures

NOT SNF

E/M EXAMPLES FOR SHARED/SPLIT

hospital admissions (99221-99223)

follow-up visits (99231-99233)

discharge management (99238-99239)

observation care (99217-99220, 99234-99236)

emergency department visits (99281-99285)

prolonged care (99354-99357)

hospital outpatient departments (provider-based visits) (99201-99215)

SHARED/SPLIT

If the documentation does not support the physician performed any part of the face-to-face components of an evaluation and management encounter, then the service must only be submitted under the APP's NPI.

For example, the documentation supports the physician participated only in the reviewing of the patient's record.

"INCIDENT TO" BILLING

Service rendered by APP is

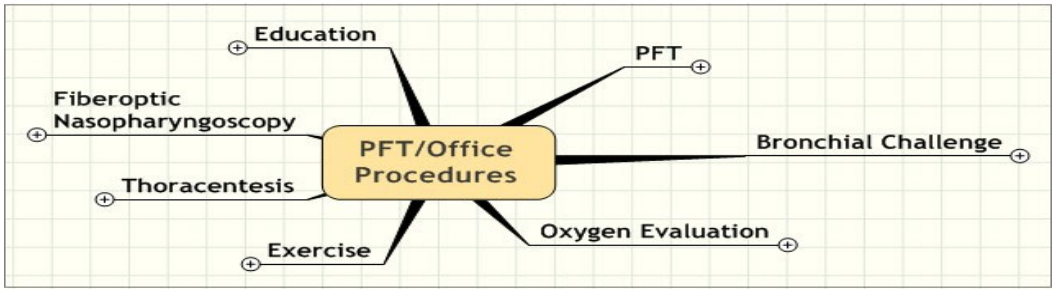
- Integral, though incidental part of physician's service
- Rendered without charge
- Commonly rendered in a private office,
- Does not apply in the hospital inpatient or outpatient setting
- Be furnished by under the physician's direct supervision
- Billing always reported under physician's name

APP DOCUMENTATION

- NOT the same as supervision of Residents and Fellows
- Each personally perform a substantive portion of E/M visit on the same day
- Physician must personally document at least one element of the face to face portion
- Whoever does the procedure must bill under their name (no physician supervision)
  - Supervision may be needed for hospital credentialing

PULMONARY FUNCTION LABORATORY

Pulmonary Diagnostics



Components of CPT Code

Global: (Technical and Professional Components Combined)

- Technical Portion and Professional Interpretation Included
- Usually a 5 digit CPT without a modifier
- A few code sets have stand-alone CPT for Technical vs Professional, eg: patient-initiated spirometric recording
- (94014 global, 94015 technical, 94016 professional interpretation)

Technical: (Facility Portion)

- Typically ends with TC; 94620 TC

Professional: (Professional Interpretation)

- Typically uses -26 modifier; 94617 - 26
- Pulmonary testing codes that are global only: 95012 eNO, 94760 pulse oximetry, 94761 exercise oximetry, 94762 overnight oximetry

Global (Technical and Professional Combined):

- Own the equipment, space and staff to bill global CPT (no modifier)
- Place of Service 11(Office)

Technical (Hospital):

- Hospital owns equipment and bills for technical component (modifier TC – even if physician owns equipment)
- Place of Service 21 (Inpatient Hospital)
- Place of Service 22 (Outpatient Hospital)

Professional (Provider Interpretation):

- Professional component only (modifier 26)
- Place of Service 21 or 22
- Occasionally Place of Service 11

IMPORTANT REMINDER: coding must coincide with Hospital submission!

Evaluation and Management Modifier – 25

- Typically used in outpatient E & M services when performed on same day as the pulmonary diagnostic test - same rule applies to inpatient E & M under other procedural circumstance
- Append 25 modifier, separately identifiable service done by the same physician on the same day, to the appropriate level of E & M service provided, never append 25 modifier on any other type of CPT code:

Outpatient Consultation 99241 – 99245

Outpatient New Visit 99201- 99205

Outpatient Established Visit 99211- 99215

Non-Physician Providers (NPP's)

- Medicare, to report a diagnostic test under a physicians name, federal regulations require supervision by the physician (MD or DO)
- APP's (APN, NP, PA) may perform, order, and interpret diagnostic testing and submit the claim in their own name; however, they cannot supervise performance of diagnostic testing (ie: by an RN or RT) with claim reporting under the physicians name
- Billing APP services to third party payers is dependent upon contractual obligations

Oximetry Evaluation – Global Code Only

- 94760 Pulse Oximetry – cannot report with any other service on same day by same provider (CCI Edit)
- 94761 Exercise Oximetry – cannot report with any other service on same day by same provider (CCI Edit)
- 94762 Continuous Overnight Oximetry – cannot report with any other service on same day by same provider (CCI Edit)

High Altitude Simulation

- 94452 without oxygen titration
- 94453 with oxygen titration
- 36600 Arterial Puncture
- 82803 Arterial Blood Analysis

94620 SIMPLE PULMONARY STRESS TEST – DELETED CODE : REPLACED BY 94617 and or 94618

94617 Exercise Test for Bronchospasm, including PRE and POST spirometry, EKG, recordings, and pulse oximetry

94618 Pulmonary Stress Test (eg 6 min walk test) including measurement of heart rate, oximetry, and oxygen titration, when performed

94621 Complex Pulmonary Stress Test

93015 Cardiac Stress Test , requires Cardiac diagnosis

Flow Volume Loop/Spirometry

- 94010 Spirometry
- 94060 Bronchospastic Spirometry
- 94375 Flow Volume loop
  (The above 3 codes are bundled and cannot be billed together)
- 94200 MVV (can be billed with 94375 only)

Lung Volumes*

- 94726 Plethysmography- do not report in conjunction with 94727, 94728
- 94727 Gas Dilution or Washout
- 94728 Airway Resistance by Impulse Oscillometry
- 94729 Diffusing Capacity – report 94729 in conjunction with 94010, 94060, 94070, 94375, 94726, 94727, 94728

Bronchial Challenge

- 94070 Multiple PFTs
- 95070 Inhalation Challenge
- J7674 HCPCS for Drug

* New methodologies are available for Lung Volume measurement (FRC, TLC) Suggest evaluation whether the CPT codes support the new technologies.

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New ATS Recommendations for Standardized PFT Report

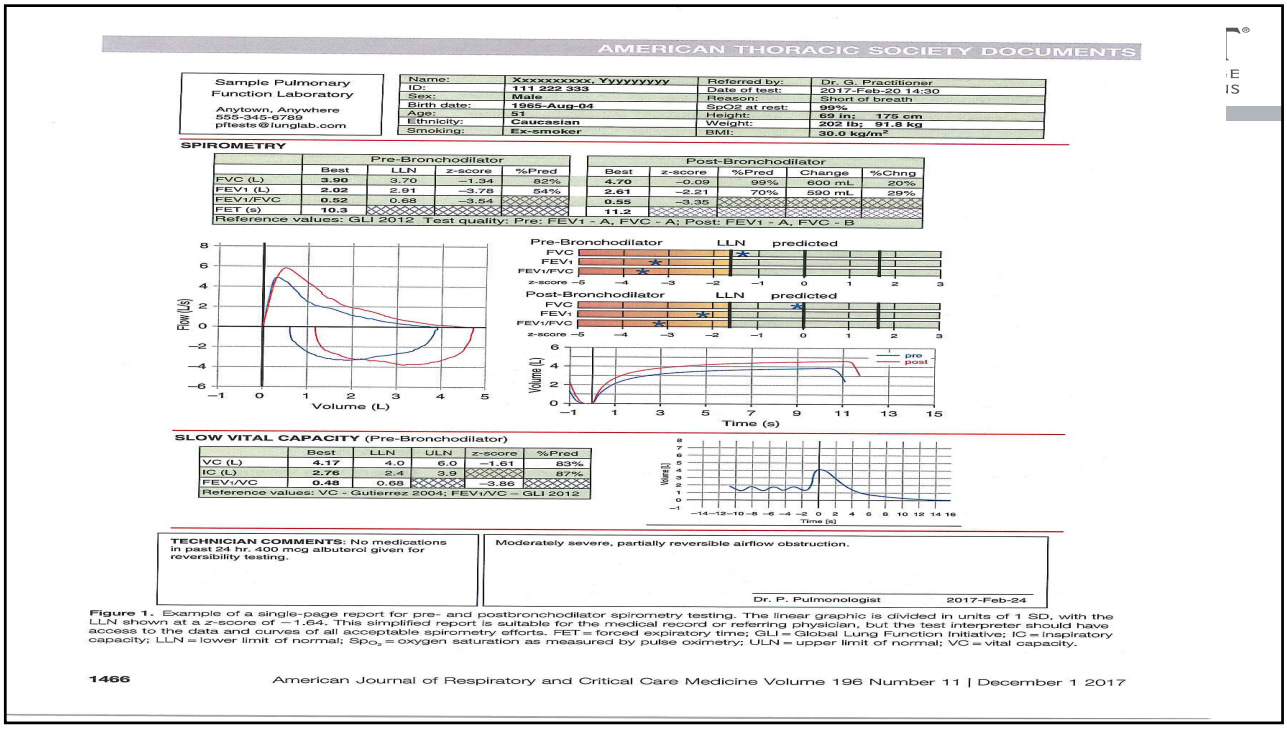
Am J Respir Crit Care Med Vol 196, Iss. 11, pp 1463-1472, Dec 1, 2017

Uniformity, single page

Grading system for test quality

Reports comparison of actual value with LLN and with % predicted

- LLN is lower limits of normal which is 1 standard deviation from the mean.
- Z score = 1.645
- Z score may also be reported



AMERICAN THORACIC SOCIETY DOCUMENTS

Sample Pulmonary Function Laboratory
Anytown, Anywhere
555-345-6789
pftests@lunglab.com

Name:	Xxxxxxxxx, Yyyyyyyyy	Referred by:	Dr. G. Practitioner
ID:	111 222 333	Date of test:	2017-Feb-20 14:30
Sex:	Male	Reason:	Short of breath
Birth date:	1965-Aug-04	SpO2 at rest:	99%
Age:	51	Height:	69 in; 175 cm
Ethnicity:	Caucasian	Weight:	202 lb; 91.8 kg
Smoking:	Ex-smoker	BMI:	30.0 kg/m²

SPIROMETRY

	Pre-Bronchodilator				Post-Bronchodilator				
	Best	LLN	z-score	%Pred	Best	z-score	%Pred	Change	%Chng
FVC (L)	3.90	3.70	−1.34	82%	4.70	−0.09	99%	600 mL	20%
FEV1 (L)	2.02	2.91	−3.78	54%	2.61	−2.21	70%	590 mL	29%
FEV1/FVC	0.52	0.68	−3.54		0.55	−3.35			
FET (s)	10.3				11.2				

Reference values: GLI 2012 Test quality: Pre: FEV1 - A, FVC - A; Post: FEV1 - A, FVC - B

SLOW VITAL CAPACITY (Pre-Bronchodilator)

	Best	LLN	ULN	z-score	%Pred
VC (L)	4.17	4.0	6.0	−1.61	83%
IC (L)	2.76	2.4	3.9		87%
FEV1/VC	0.48	0.68		−3.88	

Reference values: VC - Gutierrez 2004; FEV1/VC – GLI 2012

TECHNICIAN COMMENTS: No medications in past 24 hr. 400 mcg albuterol given for reversibility testing.

Moderately severe, partially reversible airflow obstruction.

Dr. P. Pulmonologist 2017-Feb-24

Figure 1. Example of a single-page report for pre- and postbronchodilator spirometry testing. The linear graphic is divided in units of 1 SD, with the LLN shown at a *z*-score of −1.64. This simplified report is suitable for the medical record or referring physician, but the test interpreter should have access to the data and curves of all acceptable spirometry efforts. FET = forced expiratory time; GLI = Global Lung Function Initiative; IC = inspiratory capacity; LLN = lower limit of normal; Sp_{O_2} = oxygen saturation as measured by pulse oximetry; ULN = upper limit of normal; VC = vital capacity.

1466 American Journal of Respiratory and Critical Care Medicine Volume 196 Number 11 | December 1 2017

Exhaled Nitric Oxide eNO: 95012

Valuable test for upper airway disease. Technology adopted by a number of know institutions, value-added service rather than financial driver. Reimbursement and coverage challenges continue, but improving.

Questions?