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# Coding & Billing Quarterly



## Editor's Letter

Welcome to the October issue of the ATS Coding and Billing Quarterly. This issue covers several timely topics including CMS proposed rules for the 2020 calendar year. The first article summarizes the key policy changes CMS is considering that will impact pulmonary, critical care and sleep providers.

A recent wave of OIG and carrier audits of critical care providers that are impacting some ATS members is the focus of one article. The article provides background on why the audits are happening now, process steps that happen in a typical audit and what you should do if you and your institution are subject to a critical care payment audit.

This issue also covers new and revised ICD-10-CM codes for 2020 and information on appropriate documentation for supplemental oxygen.

As always, I welcome your coding and billing questions or suggestions of future topics you would like to read about in CBQ.

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Alan L. Plummer MD

Editor

ATS Coding and Billing Quarterly

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### IN THIS ISSUE

Medicare Proposed Hospital Outpatient  
Prospective Payment Rule— P2

Medicare Physician Fee Schedule Proposed  
Rule— P2

Principal Care Management (PCM)  
Services— P5

Medicare Proposed Rules: E/M Services— P7

Critical Care Audits: Recently at Your Practice,  
Or...Just Coming Around the Corner?— P9

Medicare Critical Care Billing— P9

## Medicare Proposed Hospital Outpatient Prospective Payment Rule

### Respiratory Therapy Services/Pulmonary Rehabilitation

CMS is proposing to move respiratory therapy codes **G0237**, **G0238** and **G0239** from ambulatory payment classification (APC) 5732 to 5731 which would reduce the reimbursement for these codes by 27 percent. While CMS is proposing this change, the ATS has reviewed the cost reporting data and there does not appear to be a change in reported costs that would necessitate the CMS proposed change. In our comment letter to CMS, the ATS will oppose the APC change and urge CMS to review its own cost data for these services more closely.

CMS is proposing to keep the pulmonary rehabilitation code **G0424** in the same APC likely resulting in no change in the reimbursement rate for the service.

### Endobronchial Site of Service Designation

CMS is proposing to categorize endobronchial valve placement services as an office-based procedure and adjust the Medicare payment for bronchial valves at the lower office-based payment rate. The CMS proposal is flawed on many levels. The vast majority of valve placements are conducted in the hospital setting, either inpatient or outpatient. Further the literature supporting the use of endobronchial valves clearly indicates that the service should be conducted in a hospital setting; In fact, the FDA approval for many valves explicitly limits valve placement and revision to hospital settings. The ATS will express our strong concerns with the proposal and urge CMS to retain both the site of service and payment level only for the hospital setting.

### Maximum Breathing Capacity/Maximal Voluntary Ventilation Test

CMS is proposing to move the maximal breathing capacity test (CPT **94200**) from APC 5734 to APC 5733. If finalized, this will result in reduced reimbursement for the test. Unfortunately, the reported cost data for maximal breathing test show a decline in mean costs, dropping from \$67.24 in 2017 to \$46.31 in 2018, indicating CMS may be justified in moving the test to a different APC.

### Tobacco Cessation Services

The CMS proposed rule is a mixed bag for tobacco cessation services. CMS is proposing 14 percent decrease payment for behavioral therapy (CPT **99406**). The decrease was not caused by changing inputs for the specific code, but to payment adjustments made to family of behavioral therapy codes. However, is proposing to increase the reimbursement for lung cancer screening test (**G0297**) by 30 percent and increase reimbursement for the shared decision-making visit (**G0296**) by 6 percent.

## Medicare Physician Fee Schedule Proposed Rule

### Breathing Capacity (CPT **94200**)

The AMA RUC committee has recommended a lower physician work value for the code than was recommended by both ATS and CHEST. The ATS believes the AMA RUC inappropriately selected a lower value which was not supported by RUC survey data and, if finalized, will result in rank order anomalies in the RBRVS system.

### Sleep Code Phase In

Providers will continue to see payment reductions in a variety of home sleep codes (**95800**, **95801**, **95806**) due to the CMS decision in previous years to reduce practice expense costs across the family of sleep codes. The cuts proposed for 2020 are part of CMS continued phase in of the practice expense cuts.

### Care Management Codes

#### Transitional Care Management (TCM) Services

CMS proposes to revise the billing requirements for TCM by allowing TCM codes to be billed concurrently with any of the following codes in Table 1.

For 2020, CMS also proposes to increase the work relative value units (RVUs) for TCM code 99495 from 2.11 to 2.36 and to increase the work RVUs for TCM code 99496 from 3.05 to 3.10 based on RUC recommendations. CMS also proposes to accept the RUC's practice expense input recommendations for these codes.

## Chronic Care Management Services

CMS proposes to adopt two new G codes with new increments of clinical staff time instead of the existing single CPT code (99490). The first G code would describe the initial 20 minutes of clinical staff time, and the second G code would describe each additional 20 minutes thereafter. CMS intends these would be temporary G codes, to be used for Medicare physician fee schedule payment instead of CPT code 99490 until the CPT Editorial Panel can consider revisions to the current CPT code set.

Specifically, CMS proposes that the base code would be code GCCC1 (Chronic care management services, initial 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; and comprehensive care plan established, implemented, revised, or monitored. (Chronic care management services of less than 20 minutes duration, in a calendar month, are not reported separately)). CMS proposes a work RVU of 0.61 for code GCCC1.

CMS proposes an add-on code GCCC2 (Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)). (Use GCCC2 in conjunction with GCCC1). (Do not report GCCC1, GCCC2 in the same calendar

**Table 1: 14 HCPCS Codes that Currently Cannot be Billed Concurrently with TCM by the Same Practitioner and are Active Codes Payable by Medicare PFS**

Code Family	HCPCS Code	Descriptor
Prolonged Services without Direct Patient Contact	99358	Prolonged E/M service before and/or after direct patient care; first hour; non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service
	99359	Prolonged E/M service before and/or after direct patient care; each additional 30 minutes beyond the first hour of prolonged services
Home and Outpatient International Normalized Ratio (INR) Monitoring Services	93792	Patient/caregiver training for initiation of home INR monitoring
	93793	Anticoagulant management for a patient taking warfarin; includes review and interpretation of a new home, office, or lab INR test result, patient instructions, dosage adjustment and scheduling of additional test(s)
End Stage Renal Disease Services (patients who are 20+ years)	90960	ESRD related services monthly with 4 or more face-to-face visits per month; for patients 20 years and older
	90961	ESRD related services monthly with 2-3 face-to-face visits per month; for patients 20 years and older
	90962	ESRD related services with 1 face-to-face visit per month; for patients 20 years and older
	90966	ESRD related services for home dialysis per full month; for patients 20 years and older
	90970	ESRD related services for dialysis less than a full month of service; per day; for patient 20 years and older
Interpretation of Physiological Data	99091	Collection & interpretation of physiologic data, requiring a minimum of 30 minutes each 30 days
Complex Chronic Care Management Services	99487	Complex Chronic Care with 60 minutes of clinical staff time per calendar month
	99489	Complex Chronic Care; additional 30 minutes of clinical staff time per month
Care Plan Oversight Services	G0181	Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities within a calendar month; 30+ minutes
	G0182	Physician supervision of a patient receiving Medicare-covered hospice services (Pt not present) requiring complex and multidisciplinary care modalities; within a calendar month; 30+ minutes

month as **GCCC3, GCCC4, 99491**). CMS proposes a work RVU of 0.54 for code **GCCC2**.

CMS proposes an add-on code **GCCC2** (Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure). (Use **GCCC2** in conjunction with **GCCC1**). (Do not report **GCCC1, GCCC2** in the same calendar month as **GCCC3, GCCC4, 99491**)). CMS proposes a work RVU of 0.54 for code **GCCC2**.

CMS further proposes to adopt two new G codes that would be used for billing under the fee schedule instead of CPT codes **99487** and **99489**, and that would not include the service component of substantial care plan revision. CMS believes patients needing complex CCM implicitly need and receive substantial care plan revision, which makes the service component of substantial care plan revision potentially duplicative with the medical decision-making service component and, therefore, unnecessary as a means of distinguishing eligible patients.

Instead of CPT code **99487**, CMS proposes to adopt code **GCCC3** (Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored; moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month. (Complex chronic care management services of less than 60 minutes duration, in a calendar month, are not reported separately)). CMS proposes a work RVU of 1.00 for code **GCCC3**.

Instead of CPT code **99489**, CMS proposes to adopt code **GCCC4** (each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure). (Report **GCCC4** in conjunction with **GCCC3**). (Do not report **GCCC4** for care management services of

less than 30 minutes additional to the first 60 minutes of complex chronic care management services during a calendar month)). CMS proposes a work RVU of 0.50 for HCPCS code **GCCC4**.

Like **GCCC1** and **GCCC2**, CMS intends these would be temporary G codes to remain in place until the CPT Editorial Panel can consider revising the current code descriptors for complex CCM services.

Beyond the proposed G codes, CMS also proposes to modify its description of what a care plan typically includes. Specifically, CMS proposes to eliminate the phrase “community/social services ordered, how the services of agencies and specialists unconnected to the practice will be directed/coordinated, identify the individuals responsible for each intervention” and insert the phrase “interaction and coordination with outside resources and practitioners and providers,” such that the new description would read as follows:

The comprehensive care plan for all health issues typically includes, but is not limited to, the following elements:

- Problem list.
- Expected outcome and prognosis.
- Measurable treatment goals.
- Cognitive and functional assessment.
- Symptom management
- Planned interventions.
- Medical management.
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources and practitioners and providers.
- Requirements for periodic review.
- When applicable, revision of the care plan.

CMS notes that because these are “typical” care plan elements, they do not comprise a set of strict requirements that must be included in a care plan for purposes of billing for CCM services. CMS welcomes feedback on its proposal, including language that would best guide physicians as they decide what to include in their comprehensive care plan for CCM recipients.

## Principal Care Management (PCM) Services

Steve Peters, MD – CHEST AMA CPT Representative

CMS proposes separate coding and payment for PCM services, which describe care management services for one serious chronic condition. CMS expects most of these services would be billed by specialists who are focused on managing patients with a single complex chronic condition requiring substantial care management and that most instances, PCM services would be billed when a single condition is of such complexity that it could not be managed as effectively in the primary care setting. Per CMS, the primary care practitioner would still oversee the overall care for the patient while the practitioner billing for PCM services would provide care management services for the specific complex chronic condition. In fact, CMS notes many patients will have more than one complex chronic condition and that if a clinician is providing PCM services for one complex chronic condition, management of the patient's other conditions would continue to be managed by the primary care practitioner while the patient is receiving PCM services for a single complex condition. CMS acknowledges it's also possible the patient could receive PCM services from more than one clinician if the patient experiences an exacerbation of more than one complex chronic condition simultaneously.

The expected outcome of PCM is for the patient's condition to be stabilized by the treating clinician, so overall care management for the patient's condition can be returned to the patient's primary care practitioner. If the beneficiary only has one complex chronic condition that is overseen by the primary care practitioner, then the primary care practitioner would also be able to bill for PCM services. CMS proposes that PCM services include coordination of medical and/or psychosocial care related to the single complex chronic condition, provided by a physician or clinical staff under the direction of a physician or other qualified health care professional.

Specifically, for 2020, CMS proposes to make separate payment for PCM services via two new G codes:

- **GPPPI** (Comprehensive care management services for a single high-risk disease, e.g., Principal Care Management, at least 30 minutes of physician or

other qualified health care professional time per calendar month with the following elements: One complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities)

- **GPPP2** (Comprehensive care management for a single high-risk disease services, e.g. Principal Care Management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities).

For **GPPPI**, CMS proposes a work RVU of 1.28 and for code **GPPP2**, CMS proposes a work 0.61 RVUs and PE inputs for **99490**.

## Chronic Care Remote Physiologic Monitoring (RPM) Services

For 2020, CPT is dividing existing code **99457** into a base code and add-on code as follows:

- **99457** (Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; initial 20 minutes)
- **994X0** (Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the

patient/caregiver during the month; additional 20 minutes).

Given the value of the base code (**99457**) at 0.61 work RVUs, CMS proposes a work RVU of 0.50 for the add-on code (**994X0**).

## Consent for Communication Technology-Based Services

CMS currently stipulates that verbal consent must be documented in the medical record for each service furnished (so the beneficiary is aware of any applicable cost sharing) whenever any of the following services are provided:

- **G2010** (Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment))
- **G2012** (Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion))
- **99446-99449** (Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional)
- **99451** (Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time)

- **99452** (Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes).

CMS seeks comment on whether a single advance beneficiary consent could be obtained for a number of communication technology-based services. During the consent process, the practitioner would make sure the beneficiary is aware that use of these services will result in a cost sharing obligation. CMS seeks comment on the appropriate interval of time or number of services for which consent could be obtained, after which a new consent would need to be obtained.

ATS generally agrees that the benefit of early G codes outweighs the burden of transitioning to their use in the intervening year(s) before a decision by the CPT Editorial Panel. However, we urge CMS to work with the CPT editorial panel at the earliest possibility and preferably during the CPT process, to reduce the need for G codes. The ATS also supports CMS's consideration of moving to a single advance beneficiary consent for communication technology-based services. Such a move would represent a move toward administrative simplification and burden reduction, which CMS is otherwise pursuing through its Patients Over Paperwork initiative. We think a consent that covers a specified period rather than a specified number of services would be easier for both physicians and their Medicare patients to understand and track. We believe an annual consent makes the most sense for Medicare beneficiaries and providers.

## Appropriate Use Criteria (AUC)

CMS was silent in the proposed CY 2020 rule regarding implementation of this new policy. The ATS is concerned the new policy will add a significant burden to the medical community. We are concerned that CMS intends to implement this policy 1/1/2020, but as of yet, has provided the physician community with limited information on how to comply with the policy. In our comments, the ATS will urge CMS to provide notice, education and implementation guidance in the final rule so that providers are prepared to supply the information to nuclear medicine providers that will be necessary

to comply with the sub regulatory information in CR 11268. We are working with qualified decision support mechanisms for the proper implementation of these criteria. However, CMS has developed HCPCS modifiers along with HCPCS CPT codes that will require referring physician provider education to implement properly. We are concerned that CMS has not done enough education to the referring physician community.

The ATS will address all the above issues in our comment letter to CMS on both the Hospital Outpatients Prospective Payment Rule and the Medicare Physician Fee Schedule.

## Medicare Proposed Rules: E/M Services

In late July, CMS released a Proposed Rule for calendar year 2020 that included changes to Evaluation & Management (E/M) coding documentation and reimbursement, to begin in 2021 (<https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-16041.pdf>). In the prior year, CMS described a plan to collapse E/M visit levels, with the stated intent of simplifying documentation and reducing clerical burden. Many specialty societies responded with concerns that higher levels of service and the care of complex patients would be devalued. The AMA CPT Panel revised E/M code descriptions in 2019, and the RUC established new values. The CMS proposal has largely adopted these recommendations.

The Proposed Rule includes the following for 2021:

- Separate payment for the office/outpatient E/M visit CPT codes, as revised by the CPT Editorial Panel and re-surveyed by the RUC, with minor changes. Background and descriptions by AMA are shown at: <https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management>
- Deletion of CPT code **99201** and adoption of the RUC-revised CPT descriptors for codes **99202-99215**, including prefatory language and interpretative guidance.
- Elimination of the use of history and/or physical exam to select among code levels. Instead of the history and physical elements determining the code, the visit would include a medically appropriate history and exam, when performed.

- **Choice of time or medical decision making to determine the level of office/outpatient E/M. Note: If time is selected, documentation of the time spent with the patient will be necessary, similar to critical care time documentation.**
- Payment for prolonged (extended) office/outpatient E/M visits using the revised CPT code for such services, including separate payment for new CPT code **99XXX** and deletion of HCPCS code **GPRO1**.

*Prolonged services can be coded in 15-minute increments. The long descriptor for CPT code 99XXX is Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes. The table below shows how E/M could be reported by time:*

**Table 2: Total Proposed Practitioner Times for Office/Outpatients E/M Visits When Time Is Used to Select Visit Level**

Established Patient Office/Outpatient E/M Visit (Total Practitioner Time, When Time is Used to Select Code Level)	CPT Code
40-54 minutes	99215
55-69 minutes	99215x1 and 99XXXx1
70-84 minutes	99215x1 and 99XXXx2
85 or more minutes	99215x1 and 99XXXx3 or more for each additional 15 minutes
New Patient Office/Outpatient E/M Visit (Total Practitioner Time, When Time is Used to Select Code Level)	CPT Code
60-74 minutes	99205
75-89 minutes	99205x1 and 99XXXx1
90-104 minutes	99205x1 and 99XXXx2
105 minutes or more minutes	99205x1 and 99XXXx3 or more for each additional 15 minutes

CMS is proposing to accept the RUC re-valuation of the E/M codes with minor modifications. The tables below show a comparison of current and proposed time components and values. CMS is seeking input regarding the discrepancies (in component and total times) that

could have implications for other codes that include similar work.

The net effect of these changes may be some decrease in documentation burden, with recognition (and

**Table 3: RUC-Recommended Pre-, Intra- Post-Service Times, RUC-Recommended Total Times for CPT codes 99202-99215 and Actual Total Time**

HCPSCS	Pre-Service Time	Intra-Service Time	Intermediate Post-Service Time	Actual Total Time	RUC-recommended Total Time
99202	2	15	3	20	22
99203	5	25	5	35	40
99204	10	40	10	60	60
99205	14	59	15	88	85
99211		5	2	7	7
99212	2	11	3	16	18
99213	5	20	5	30	30
99214	7	30	10	47	49
99215	10	45	15	70	70

**Table 4: Side by Side Comparison of Work RVUs and Physician Time for the Office/Outpatient E/M Services Code Set, and the New Prolonged Services Code (Current Versus Revised)**

HCPSCS Code	Current Total Time (mins)	Current Work RVU	CY 2021 Total Time (mins)	CY 2021 Work RVU	RUC rec Total Time (mins)	RUC rec Work RVU
99201	17	0.48	17	0.48	N/A	N/A
99202	22	0.93	22	1.76	22	0.93
99203	29	1.42	29	1.76	40	1.6
99204	45	2.43	45	1.76	60	2.6
99205	67	3.17	67	3.17	67	3.17
99211	7	0.18	7	0.18	7	0.18
99212	16	0.48	16	1.18	30	1.3
99213	23	0.97	23	1.18	49	1.92
99214	40	1.5	40	1.18	49	1.92
99215	N/A	N/A	N/A	N/A	15	0.61

redistribution) by CMS of primary care and those who see highly complex patients requiring prolonged services.

## Critical Care Audits: Recently at Your Practice, Or...Just Coming Around the Corner?

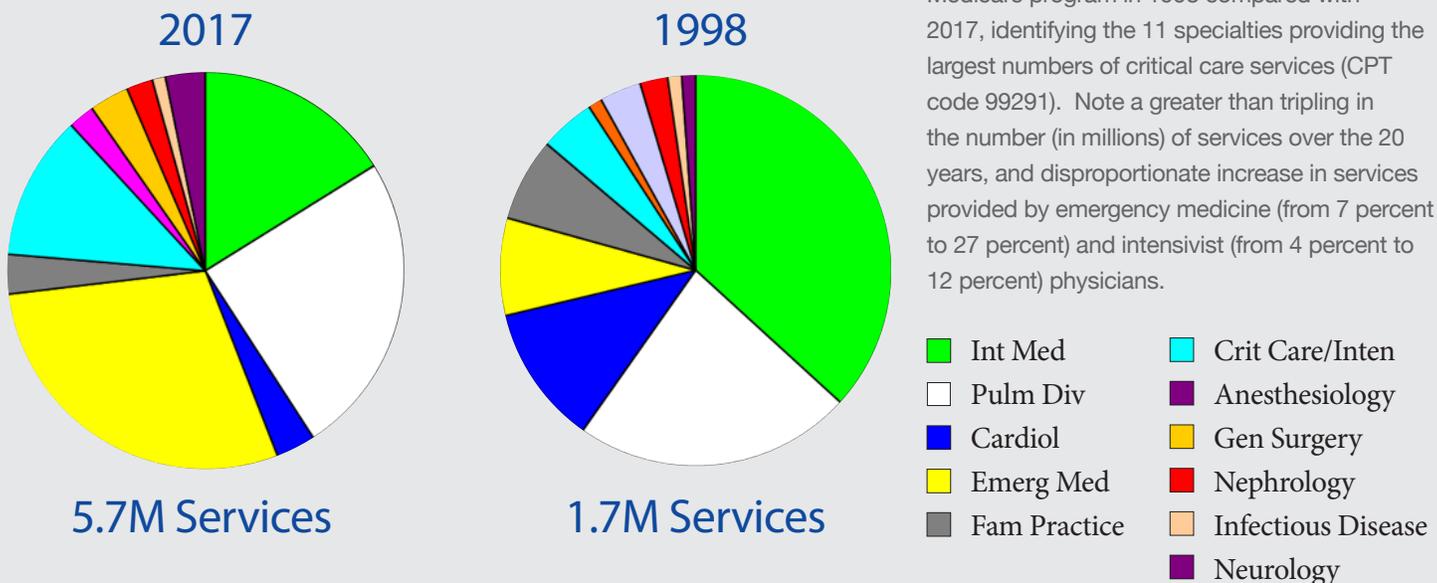
Scott Manaker, MD, PhD, and Denise A. Merlino, MBA, CNMT, CPC

Physicians, advanced practitioners and their practices all across the United States recently experienced a large increase in external reviews of their critical care billing practices, usually reported using Current Procedural Terminology (CPT) code **99291** (1). The majority of these reviews originated with local Medicare Administrative Contractors (MACs), under the Targeted Probe and Educate program (TPE) (2). In addition to Medicare, other payers (particularly Medicaid programs) may be reviewing claims for critical care services. Many large institutions were audited by the Office of the Inspector General (OIG) of the Department of Health and Human Services, performing the first large scale, national review of CPT code 99291 in 20 years (3, 4). CPT code **99291** has always been the most highly reimbursed evaluation and management service (1, 4). However, in retrospect over these two decades, the tripling in total volume and the disproportionate increase among specific specialties

(emergency medicine and intensivists) likely precipitated the recent focus on critical care services)(1, 4).

Some providers may receive letters from vendors, contracted to different payers, reporting relative performance (frequency and charges) compared to other providers in the region, for that payer. These performance letters are different from reviews of individual services provided, and provided for informational purposes. Unfortunately, receipt of such letters can have a chilling, even intimidating effect upon providers. Therefore, all purveyors of critical care professional services should familiarize themselves with the definitions and the documentation of critical care services (4, 5). Clinical notes must describe the critical illness or injury that requires the 1 to 1 care from an intensivist and must specifically document: (a) the specific diagnosis of the critical illness or injury; (b) the specific intervention(s) of the provider dedicated (1 to 1 care) to the specific critical care diagnosis(es); and (c) the time spent (either continuous, start to stop time; or aggregated total cumulative time during a 24 hour period)(4, 5). Additional important content in your notes should support medical necessity, including a description of the complex medical decision making, the patient assessment and considerations leading to an intervention, and descriptions of family discussions directly related to care decisions. Full CMS guidance can be

## Medicare Critical Care Billing



found in the manuals and as noted in Medicare Learning Network MLN Matters Article MM5993, [click here](#).

Additionally, a Medicare contractor critical care fact sheet can be accessed by [clicking here](#).

Audits can be pre-payment, after a claim is submitted but prior to processing for payment; or post-payment, following claim processing and reimbursement to the provider. TPE audits are generally pre-payment, while OIG audits are typically post-payment. Audits usually begin with a written request for the medical records, to support the claim submitted for critical care services. Usually 20-40 individual critical care services are requested for a TPE audit, while an OIG audit requests medical records for more than 100 services. Following individual review of the record for each service, if the aggregate denials exceed a threshold, progressive review can occur, with additional requests for more records. With TPE audits, the MAC must always offer the provider the opportunity for education (2). However, the education provided must be generic, and cannot specifically address any previously denied services, which remain subject to the Medicare appeals process (5).

Following sequential failure of three rounds of TPE audits, or alternatively following any OIG audit, additional sanctions may be levied (2, 5). Such sanctions can include complete pre-payment review of each and every claim submitted for CPT 99291. Providers can be subjected to extrapolation, where an error rate calculation is applied retrospectively over a universe of critical care services, typically for a three-year period of time, but potentially as long as five years, and then a repayment demand tendered to the provider (6). Any time a provider fails multiple audits or receives a repayment demand, the ATS member should consider obtaining formal legal advice (7). Such legal advice can be invaluable, since, although rarely occurring, failure of multiple audits can ultimately lead to civil and criminal penalties (2, 5-7).

In summary, experiencing an audit does not mean that you WILL receive a denial or refund request. Many audits have resulted in no such requests, when the documentation review reveals adequate notes that adequately document the medically necessary of critical care services. We encourage ATS members to supply the necessary documentation to support their services, as failure to respond to the audit and provide the documentation, may

result in denial or refunding of all the requested services. If you disagree with an auditor, challenge the findings through the appropriate appeals process. As noted earlier, at times legal representation can be helpful.

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## Documentation for Supplemental Oxygen: Not Just Hot Air

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The Centers for Medicare & Medicaid Services have Local Coverage Determination policies (LCDs) which govern qualification for oxygen and oxygen equipment for home use. While the general requirements around certification for medical necessity have not changed in regards to oxygen saturation or PaO<sub>2</sub> thresholds in patients with chronic lung disease, our membership has seen recent attention to the fifth item below from a representative LCD:

1. The treating physician has determined that the beneficiary has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, and
2. The beneficiary's blood gas study meets the criteria stated below, and
3. The qualifying blood gas study was performed by a physician or by a qualified provider or supplier of laboratory services, and
4. The qualifying blood gas study was obtained under the following conditions:

- If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than two days prior to the hospital discharge date, or
- If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the beneficiary is in a chronic stable state – i.e., not during a period of acute illness or an exacerbation of their underlying disease, and

5. Alternative treatment measures have been tried or considered and deemed clinically ineffective.

Of note, in this policy, the term “blood gas study” refers to either an oximetry test or an arterial blood gas test.

While there may be no true “alternative treatment” for hypoxemic patients, oxygen suppliers are increasingly requiring specific attention to this question. In the experience of our membership in various geographic regions, documentation of therapies to treat or optimize the underlying disease are helpful, including pharmacologic therapies (e.g. inhaled medications or antibiotics) as well as pulmonary rehabilitation or other non-pharmacologic therapies for COPD. Other disease states such as ILD and heart failure should also be optimally treated. The requirements for supplemental oxygen can be assessed at rest, with exertion, nocturnally, or at high altitude.

## ICD-10-CM Coding Changes for 2020

Alan L. Plummer, MD – ATS Representative AMA RUC Committee

The ICD-10 update committee meets twice yearly. New and revised ICD-10 codes for 2020 have just been released. These changes will go into effect on Oct. 1, 2019. There are only a few changes which will affect pulmonary, critical care and sleep physicians mainly involving adding RSV to several J code categories and two additions for subsegmental pulmonary emboli without cor pulmonale.

The following are the specific changes which will go into effect:

**No Change I26.9 Pulmonary embolism without acute cor pulmonale**

**Add I26.93 Single subsegmental pulmonary embolism without acute cor pulmonale**

**Add Subsegmental pulmonary embolism NOS**

**Add I26.94 Multiple subsegmental pulmonary emboli**

## without acute cor pulmonale

### **No Change J06.9 Acute upper respiratory infection, unspecified**

Add Use **Additional** code (B95-B97) to identify infectious agent, if known, such as:

Add respiratory syncytial virus (RSV) (B97.4)

### **No Change J12.1 Respiratory syncytial virus pneumonia**

Add RSV pneumonia

### **No Change J20 Acute bronchitis**

### **No Change J20.5 Acute bronchitis due to respiratory syncytial virus**

Add Acute bronchitis due to RSV

### **No Change J21 Acute bronchiolitis**

### **No Change J21.0 Acute bronchiolitis due to respiratory syncytial virus**

Add Acute bronchiolitis due to RSV

### **No Change J44 Other chronic obstructive pulmonary disease**

### **Revise from J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection**

### **Revise to J44.0 Chronic obstructive pulmonary disease with (acute) lower respiratory infection**

### **No Change Z11.1 Encounter for screening for respiratory tuberculosis**

Add Encounter for screening for active tuberculosis disease

### **Add Z11.7 Encounter for testing for latent tuberculosis infection**

Remember, these changes become effective Oct. 1, 2019 and must be used after that date. All other pulmonary/critical care/sleep ICD-10-CM codes remain unchanged.

## Changes in Medicare Local Coverage Determination Policy Process

Omar Hussain, DO – AMA RUC member, rotating internal medicine subspecialty seat

Based on the Federal 21 Century Cures Act, the local coverage determination (LCD) development process has been modified for all Medicare contractors. A local coverage determination (LCD) is a decision made by one

of several Medicare Administrative Contractors (MACs) on whether a particular service or item is reasonable and necessary, and therefore covered by Medicare in the MAC's jurisdiction. Medicare Administrative Contractors (MACs) are insurance carriers that administer the Medicare program in assigned jurisdictions. The revised process aims to be more open and more transparent. The frontload work in requesting an LCD will be more arduous. The modified process will be slower than before. It aims to allow time to collaborate with the other MAC's to collaborate in the decision-making process.

In addition to processing and paying claims, the MAC's scope of work includes establishing LCDs for certain services when there is no established national policy. While the Contractor Medical Director (CMD) makes all final determinations, s/he does receive input from a variety of sources including members of the Contractor Advisory Committees (CAC). Throughout the country, members of the American Thoracic Society and CHEST serve on CACs.

The LCD process may begin with informal meetings in which interested parties in the MAC's jurisdiction can informally discuss potential LCD requests. These meetings are for educational purposes only and are not pre-decisional negotiations. MACs publish how an interested party can contact them to set up an informal meeting on their contractor websites. These meetings are permitted but are not required and the process allows requestors to communicate via conference call or an in-person meeting before submitting a formal request. These meetings will assure that all relevant evidence needed for review for coverage is submitted with the request for a formal review.

Requirements for a new LCD request now include:

- The request clearly identifies the statutorily-defined Medicare benefit category to which the requestor believes the item or service falls under and provides a rationale justifying the assignment.
- The request shall identify the language that the requestor wants in an LCD.
- The request shall include a justification supported by peer-reviewed evidence. Full copies of published evidence to be considered shall be included and failure to include same invalidates the request.
- The request shall include information that addresses

the relevance, usefulness, clinical health outcomes, or the medical benefits of the item or service.

- The request shall include information that fully explains the design, purpose, and/or method, as appropriate, of using the item or service for which the request is made.

The MAC will review materials received within 60 calendar days and determine whether the request is complete or incomplete. If the request is incomplete, the contractor should respond, in writing, to the requestor explaining why the request was incomplete. A valid request response does not convey that a determination has been made whether or not the item or service will be covered or non-covered. The response to the requestor that the request is valid is simply an acknowledgement by the MAC of the receipt of a complete, valid request.

1. If the request is valid and a new LCD is developed, the MAC will follow a process that involves
2. Research of clinical guidelines, consensus statements, and consultation with the requestor or subject matter experts (if necessary);
3. Contractor Advisory Committee (CAC) meeting (if necessary);
4. Publication of a proposed LCD;
5. Open meeting to solicit comments from the public on the proposed LCD;
6. Opportunity for public comment in writing (minimum of 45 days following posting of proposed LCD);
7. Publication of a final LCD, including:
  - A response to public comments received;
  - Notice to public of new policy at least 45 days in advance of the effective date.

For further details describing the new LCD request process, visit the CMS website and contact the contractor advisory committee that administers your jurisdiction.

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c13.pdf>



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