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In This Issue

Letter from the Editor

It's almost over! The SGR debacle will soon be behind us. I am writing this the morning after the Senate passed by a vote of 92-8 H.R. 2 – legislation to repeal and replace the Medicare Sustainable Growth Rate formula. While a few amendments were debated by the Senate, none were adopted and the House and Senate have now passed identical bills which President Obama has signed.

Enactment of a permanent SGR fix is a big relief and a big deal – in the near term and the long term. In the near term, enactment means physician and other Part B providers will avoid a 21% cut in reimbursements and will instead receive a 0.5% increase in payments for services provided April 1, 2015 or later. There will also be a 0.5% payment increase in years 2016-2019. In addition, CMS will start processing claims it has been holding since April 1.

As for long term implications, the bill accelerates the transition to Medicare payments based on quality reporting, speeds the adoption of voluntary alternative payment models and makes important changes to CMS quality incentive and payments systems (see SGR legislation article for more details).

While I am relieved that the SGR mess is finally over, I am frustrated that it took over 10 years to fix what should have been a simple problem. Congress repeatedly took the easy way out with temporary patches, making the problem worse every year. I hope our national leaders can show more wisdom in future.

Not allowing my frustration with the past cloud my vision for the future, fixing SGR is a win for patients and providers alike. Now on to the next challenge!

Sincerely,

Alan L. Plummer, MD
Editor

ICD-10 Webinars: Is Your Practice Ready?

The entire physician community should be gearing up for the looming ICD-10-CM transition deadline of October 1, 2015. At that time, CMS and its contractors will require all claims to use the ICD-10-CM format. To assist members in understanding the new coding system, ATS will hold a series of webinars in September on to use the new ICD-10-CM coding systems. The webinars will cover pulmonary, critical, sleep and pediatric pulmonary codes. If you are interested in participating in the coding webinar, please send an email to **codingquestions@thoracic.org** and put "ICD-10 Webinar" in the subject line. We will share more information on the webinars in the near future.

LUNG CANCER SCREENING - PENDING CMS BILLING INSTRUCTIONS AND POTENTIAL DENIAL OF PAYMENT

The Centers for Medicare & Medicaid Services (CMS) issued a national coverage determination (NCD) for Medicare coverage of screening for lung cancer with low dose computed tomography (LDCT) if certain eligibility requirements are met, effective February 5, 2015. Detailed information regarding the eligibility requirements is available in the NCD on the CMS.gov website (Decision Memo for Screening for Lung Cancer with Low Dose Computed Tomography (LDCT) (CAG-00439N). While the coverage for the care to Medicare patients is available as of the effective date, the billing instructions have not yet been communicated to the Medicare Administrative Contractors (MAC). CMS on an open door call April 7, 2015, stated, "providers need to make their own decisions if they will offer these services and when." Providers have the option to hold claims or submit, however if the MACs do not have the billing instructions claims are likely to be denied. The ATS is concerned that Medicare has left many unanswered questions. Some questions that remain unanswered at this time are:

1.) When does CMS expect to issue billing instructions to the contractors?

2.) What code can be used to report the shared decision making visit?

3.) Will all Medicare patients be spared the cost-sharing expense for the visit or for the procedure?

Providers can submit their own questions directly to CMS at Hospital_ODF@cms.hhs.gov. The ATS will hold a Webinar for our members once the CMS billing instructions are released and we have additional information from CMS.

SGR REPEAL LAW – NEXT STEPS

The law enacted by Congress and signed by the President changes the current Medicare physician reimbursement system by:

- Permanently repealing the Medicare SGR
- Establishing an update of 0.5 percent for the remainder of 2015
- Establishing an annual update of 0.5 percent for years 2016-2019
- Allowing physicians who enroll in CMS approved Alternative Payment Models (APMs) to receive a bonuses of plus 5 percent for years 2019-2024
- For years 2026 and beyond, establishing an update of 0.75 percent for providers in APMs and an update of 0.25 percent for providers who remain in the traditional Medicare fee for service payment system
- For all years, participation in APMs is voluntary and the Medicare traditional fee for service system will continue
- Providing smaller practices technical support (funded at $20 million annually) to assist in APM participation
- Providing funding to develop physician quality measures (funded at $15 million for 2015-2019)

The law also makes some important changes to Medicare's existing quality reporting programs. Starting 2018, Medicare's three existing quality reporting programs, Physician Quality Reporting System (PQRS) electronic health record/meaningful use (MU) and Value-based payment modifier (VBM) are consolidated into one program called Merit-Based Incentive Payment System (MIPS). Physicians who score well under the new MIPS system will be eligible for 4 to 9 percent bonus payments. MIPS also improves upon current quality incentives programs in that it eliminates the requirement that there be winners who get bonuses, and losers, who get penalties (as currently required in the VBM system). MIPS also allows "sliding scale" bonus payments for providers that partially meet performance standards – eliminating the "all or nothing" aspect of both MU and PQRS systems.

The law requires CMS to establish and reimburse at least one code for monthly chronic care management. The law also includes a provision that prevents quality standards and measures from being used as standard practice or duty of care standards in malpractice cases.

ICD-10 FOR PEDIATRIC PULMONOLOGISTS

All providers will be required to switch from ICD-9 to ICD-10 on October 1st this year for purposes of coding for billing and documentation. For Pediatric Pulmonologists, this includes both codes used by all pulmonologists and those that are specific to pediatrics. Listed below are common ICD-9 codes and their cross walks to ICD-10. Please note that there is additional granularity in ICD-10 that requires more specificity in many cases, in comparison to ICD-9. In such cases, a single ICD-9 code may cross-walk to multiple ICD-10 codes.

Only for NEONATES	
ICD-9-CM	**ICD-10-CM**
277.01 Cystic fibrosis with meconium ileus	E84.11 Meconium ileus in Cystic Fibrosis
760.79 Other noxious influences affecting fetus or newborn via placenta or breast milk	P04.2 Newborn (suspected to be) affected by maternal use of tobacco
765.21 Less than 24 comp wks of gest	P07.21 Extreme immaturity of newborn, gestational age less than 23 completed weeks
	P07.22 Extreme immaturity of newborn, gestational age 23 completed weeks
765.22 24 wks completed gestation	P07.23 Extreme immaturity of newborn, gestational age 24 completed weeks
765.23 25-26 wks completed gestation	P07.24 Extreme immaturity of newborn, gestational age 25 completed weeks
	P07.25 Extreme immaturity of newborn, gestational age 26 completed weeks
765.24 27-28 wks completed gestation	P07.26 Extreme immaturity of newborn, gestational age 27 completed weeks
	P07.31 Preterm newborn, gestational age 28 completed weeks
765.25 29-30 wks completed gestation	P07.32 Preterm newborn, gestational age 29 completed weeks
	P07.33 Preterm newborn, gestational age 30 completed weeks
765.26 31-32 wks completed gestation	P07.34 Preterm newborn, gestational age 31 completed weeks
	P07.35 Preterm newborn, gestational age 32 completed weeks
765.27 33-34 wks completed gestation	P07.36 Preterm newborn, gestational age 33 completed weeks
	P07.37 Preterm newborn, gestational age 34 completed weeks
765.28 35-36 wks completed gestation	P07.38 Preterm newborn, gestational age 35 completed weeks
	P07.39 Preterm newborn, gestational age 36 completed weeks
770.81 Primary apnea of newborn	P28.3 Primary sleep apnea of newborn
770.84 Respiratory failure of newborn	P28.5 Respiratory failure of newborn
770.89 Other resp problems after birth	P28.89 Other specified respiratory conditions of newborn
770.9 Unspecified resp condition of newborn	P28.9 Respiratory condition of newborn, unspecified
There are also a series of codes that can be used only in pediatric populations. Of interest to Pediatric Pulmonologists are the following:	
783.42 Delayed milestones	R62.0 Delayed milestone in childhood
786.31 Acute idiopathic pulm hemorrhage in infants	R04.81 Acute idiopathic pulmonary hemorrhage in infants
783.41 Failure to thrive	R62.51 Failure to thrive (child)
799.82 Apparent life threatening event infant	R68.13 Apparent life threatening event in infant (ALTE)

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ICD-9-CM	ICD-10-CM
V85.51 BMI, pediatric, less than 5th%	Z68.51 Body Mass Index (BMI) pediatric, less than 5th percentile for age
V85.52 BMI, pediatric ,5th% to less than 85th%	Z68.52 Body Mass Index (BMI) pediatric, 5th percentile to less than 85th percentile for age
V85.53 BMI, pediatric, 85th% to less than 95th%	Z68.53 Body Mass Index (BMI) pediatric, 85th percentile to less than 95th percentile for age
V85.54 BMI, pediatric , greater than or equal to 95th percentile for age	Z68.54 Body Mass Index (BMI) pediatric, greater than or equal to 95th percentile for age
V69.5 Behavioral insomnia of childhood	Z73.810 Behavioral insomnia of childhood, sleep-onset association type
	Z73.811 Behavioral insomnia of childhood, limit setting type
	Z73.812Behavioral insomnia of childhood, combined type
	Z73.819Behavioral insomnia of childhood, unspecified type
The following are common codes used by a pediatric pulmonologist, but not specific to pediatrics:	
V15.89 Other specified personal history presenting hazards to health	Z77.22 Exposure to environmental tobacco smoke
277.02 CF with pulm manifestations	E84.0 Cystic Fibrosis with pulmonary manifestations
493.90 Asthma, unspecified type	J45.2 Mild, intermittent asthma J45.20 uncomplicated J45.21 with acute exacerbation J45.22 with status asthmaticus
	J45.3 Mild, persistent asthma J45.30 uncomplicated J45.31 with acute exacerbation J45.32 with status asthmaticus
	J45.4 Moderate, persistent asthma J45.40 uncomplicated J45.41 with acute exacerbation J45.42 with status asthmaticus
	J45.5 Severe, persistent asthma J45.50 uncomplicated J45.51 with acute exacerbation J45.52 with status asthmaticus
518.89 Other diseases of the lung, not elsewhere classified	J98.4 Other disorders of the lung [includes restrictive lung disease]
518.81 Acute respiratory failure	J96.00 Acute Respiratory Failure, unspecified whether with hypoxia or hypercapnia
	J96.01 Acute respiratory failure with hypoxia
	J96.02 Acute respiratory failure with hypercapnia

ICD-9-CM	ICD-10-CM
	J96.90 Respiratory failure, unspecified with hypoxia or hypercapnia
	J96.91 Respiratory failure, unspecified with hypoxia
	J96.92 Respiratory failure, unspecified with hypercapnia
518.82 Other pulmonary insufficiency, NEC	J80 Acute respiratory distress syndrome (ARDS)
518.83 Chronic respiratory failure	J96.10 Chronic respiratory failure, unspecified with hypoxia or hypercapnia
	J96.11 Chronic respiratory failure with hypoxia
	J96.12 Chronic respiratory failure with hypercapnia
518.84 Acute and chronic resp failure	J96.20 Acute and chronic resp failure, unspecified with hypoxia or hypercapnia
	J96.21 Acute and chronic resp failure with hypoxia
	J96.22 Acute and chronic resp failure with hypercapnia
799.02 Hypoxemia	R09.02 Hypoxemia
	P27.0 Wilson-Mikity Syndrome
770.7 Chronic respiratory disease arising in the perinatal period	P27.1 Bronchopulmonary Dysplasia originating in the perinatal period
	P27.8 Other chronic respiratory diseases originating in the perinatal period
517.3 Acute chest syndrome	D57.01 Hgb-SS disease with acute chest syndrome D57.211 Sickle-cell/Hgb-C disease with acute chest syndrome

Q&A

Critical Care

Q. A pulmonologist and cardiologist, from our group, were both called to see an inpatient. Both of the providers saw the patient and both performed critical care. Can they both bill for their services?

A. The answer depends if they saw the patient at the same time period or not. If they performed the visit together at the same time period the answer is no. They cannot bill for the same minutes as only one physician can bill for critical care at a time. However, if the visits occurred at different times, the physicians in the same group practice who have different medical specialties may bill and be paid without regard to their membership in the same group. As long as the services are not duplicative, the critical care services may be reported by each regardless of their group practice relationship as long as they are for different periods of time.

Q. What happens if the critical care services occur over the midnight hour?

A. The CPT guidelines state that when time-dependent services are performed continuously over midnight, time should be accrued for and reported as occurring on the pre-midnight date. However, once the service is discontinued or is non-continuous, then the provider would begin a new time for the subsequent services on the post-midnight date.

Q. Does ATS recommend that we begin ordering the Lung Cancer Screening services for our patients?

A. At the time of the printing of this article, CMS has not yet posted billing instructions for Lung Cancer Screening to the contractors. The National Coverage Determination does have criteria available for providers to follow. We recommend that ATS members review the criteria carefully and if they believe a patient meets those criteria they may order the services. However, the patient should be notified in advance of the procedure that billing instructions and cost sharing has not yet been made available and providers can consider giving the patient an advance beneficiary notification informing the patient that without instructions there is a possibility of no payment by Medicare (education regarding ABNs see http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.pdf for details). We would also recommend you either hold claims until the instructions are published or contact your local Medicare contractor for advice in submitting claims.