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**OBJECTIVES:**

Participants should be better able to:

1. Understand changes in the description of services for extra-corporeal membrane oxygenation initiation and management;

2. Describe the sharing or splitting of critical care services by members of a group;

3. Understand the situations appropriate for the use of chronic care management codes for pulmonary patients.

**SATURDAY, MARCH 14, 2015 11:15 AM**
PRACTICE MANAGEMENT ISSUES 2015

Steve G. Peters, MD
NAMDRC Annual 2015

DISCLOSURE

Dr. Peters has declared no conflicts of interest related to the content of his presentation.
DISCLOSURE

• ACCP Advisor to the CPT Panel of the AMA
• ATS Clinical Practice Committee
• No financial conflicts of interest
• No off-label usages discussed

PRACTICE UPDATE

• Critical Care issues
• CPT update
  • ECMO
  • Chronic Care Management
• Pending issues
LEARNING OBJECTIVES

- Understand changes in the description of services for extracorporeal membrane oxygenation initiation and management
- Describe the sharing or splitting of critical care services by members of a group
- Understand the situations appropriate for the use of chronic care management codes for pulmonary patients

Q1: WHICH CRITICAL CARE SERVICE IS DESCRIBED CORRECTLY?

a) Physician provides 75 minutes at 8 am, NP in same group provides 30 minutes of service later, both billed under physician
b) NP provides 75 minutes in am, physician provides 30 minutes in afternoon, both billed under physician
c) Physician A provides one hour in the morning, physician B in same group provides one hour of service later; bill combined under physician A
d) Physician and NP in same group each bill separately for services on the same day
e) All of the above
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Q2: WHICH ONE OF THE FOLLOWING IS NOT BUNDLED INTO CRITICAL CARE SERVICES?

a) Gastric tube placement
b) Ventilator management
c) Adjustment of temporary pacing
d) Arterial puncture
e) Transesophageal echocardiogram
Q2: WHICH ONE OF THE FOLLOWING IS NOT BUNDLED INTO CRITICAL CARE SERVICES?

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TRANSESOPHAGEAL ECHOCARDIOGRAM

Trans-Gastric Short Axis
LV Filling & Function

Four Chamber
Biventricular Function

Superior Vena Cava
Fluid Responsiveness
TEE MONITORING

• 93318 Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis

TRANS-ESOPHAGEAL ECHOCARDIOGRAPHY (TEE) MONITORING IN ICU

• 93318
  • National Correct Coding Initiative directive that TEE bundled into critical care
  • SCCM, ATS, ACCP requested edit allowing placement and initial interpretation
  • 7/14 Approved and NCI edit modified such that 93318 allowed in addition to E&M or critical care, but “TEE monitoring” bundled into critical care services
EXTRA-CORPOREAL MEMBRANE OXYGENATION (ECMO) SERVICES

• For 2015 delete CPT codes 33960 (Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial day), 33961 (Prolonged extracorporeal circulation for cardiopulmonary insufficiency; each subsequent day), and 36822 (Insertion of cannula(s) for prolonged ECMO)

• Originally applied most commonly to premature neonates

• Recognition of current use for hypoxic respiratory or cardio-respiratory failure, wide age range

• Codes felt to be mis-valued

• Task force led to 25 new codes

EXTRA-CORPOREAL MEMBRANE OXYGENATION (ECMO) SERVICES

• Distinguish types of access: veno-venous, veno-arterial, peripheral or central, adult or child

• Distinguish initial placement of cannula(e) from repositioning, de-cannulation

• Distinguish initiation from daily management

• Distinguish management of adult versus pediatric (under age 6)

• Other physicians may still provide critical care or E&M services
EXTRA-CORPOREAL MEMBRANE OXYGENATION

VA-ECMO

- Femoral Artery
- Internal Jugular Vein
- Returning Oxygenated Blood
- De-oxygenated Blood

VV-ECMO

VENO-VENOUS ECMO
V-A ECMO: RA-> PUMP-> AORTA
NEW ECMO CPT CODES (ADULT)

• 33946 Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; initiation, veno-venous

• 33947 initiation, veno-arterial

• 33948 daily management, each day, veno-venous

• 33949 daily management, each day, veno-arterial

NEW ECMO CPT CODES (ADULT)

• 33952 Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older

• 33954 insertion of peripheral (arterial and/or venous) cannula(e), open

• 33956 insertion of central cannula(e) by sternotomy or thoracotomy

• 33958 reposition peripheral (arterial and/or venous) cannula(e), percutaneous
NEW ECMO CPT CODES (ADULT)

- **33962** Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; reposition central (arterial and/or venous) cannula(e), open, 6 years and older
- **33964** reposition central cannula(e) by sternotomy or thoracotomy
- **33966** removal of peripheral (arterial and/or venous) cannula(e), percutaneous
- **33984** removal of peripheral (arterial and/or venous) cannula(e), open
- **33986** removal of central cannula(e) by sternotomy or thoracotomy

ECMO CPT RVU EXAMPLES 2015

- **33952** (insertion, percutaneous) 8.15
- **33954** (insertion, open) 9.11
- **33958** (reposition, peripheral, percutaneous) 3.51
- **33962** (reposition, central) 4.47
- **33966** (removal, peripheral, percutaneous) 4.5

Q3: A 27 YEAR-OLD WOMAN DEVELOPS ARDS FOLLOWING INFLUENZA. SHE REMAINS SEVERELY HYPOXEMIC ON CONVENTIONAL VENTILATION. BLOOD PRESSURE IS SATISFACTORY AND CARDIAC STATUS IS HYPERDYNAMIC. WHICH IS MOST APPROPRIATE?

a) Consider ECMO, and code for initiation and daily management
b) ECMO is not reported to be of benefit in ARDS in this setting
c) Consider sternotomy for veno-arterial ECMO
d) Plan veno-venous ECMO to support oxygenation
e) Plan peripheral veno-arterial ECMO to support oxygenation and cardiac output
CASE MANAGEMENT SERVICES (99363-99368)

• Anticoagulation management (99363-99364)
• Medical team conferences (99366-99368)
• Care Plan Oversight Services (99374-99380)

CARE MANAGEMENT SERVICES

• Management and support by clinical staff, under the direction of a physician or other qualified health care professional, to a patient residing at home or in a domiciliary, rest home, or assisted living facility.

• May include establishing, implementing, revising, or monitoring the care plan, coordinating other professionals and agencies, and educating the patient or caregiver about the condition, care plan, and prognosis.

• A comprehensive plan of care must be documented and shared with the patient and/or caregiver.

• Includes face-to-face and non-face-to-face time

• Does not include time if E&M also coded for a visit

• Once per calendar month, only one physician
CHRONIC CARE MANAGEMENT SERVICES

**99490** Chronic care management services, at least 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;
- comprehensive care plan established, implemented, revised, or monitored.

COMPLEX CHRONIC CARE

**99487** 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;
- establishment or substantial revision of a comprehensive care plan;
- moderate or high complexity medical decision making;
- 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.
COMPLEX CHRONIC CARE

- [+99489] 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)
  - <60 minutes not reported separately
  - 60-89 minutes 99487
  - 90-119 minutes 99487+99489
- These codes currently not recognized by CMS

CHRONIC CARE MANAGEMENT FOR PULMONARY

- Any physician treating two or more chronic conditions can use these codes
- Only one physician can code each month, so must manage all chronic conditions (e.g. COPD, CHF, diabetes)
- Since complex codes not recognized, could use 99490
- Patient must give consent, be aware, may have co-pay
- Separate E&M can be billed but cannot count those services or time toward chronic care
- No other care management services can overlap (e.g. anticoagulation, transitional care, on-line services)
Q4: WHICH ONE DESCRIBES AN ACCURATE CARE MANAGEMENT SERVICE?

a) Long term care of a COPD patient also managed by family physician
b) Chronic care management for three 15 minute phone calls in a one-month period following a consultation for asthma
c) Complex chronic care for a 72 year-old woman with COPD, CHF, renal failure and diabetes
d) Care management for coordinating inpatient hospital discharge and transition
e) 30 minutes of staff time in a calendar month, directed by physician, for a patient at home with severe asthma and steroid-induced diabetes
NEW CODES PENDING

• Deletion/expansion of add-on code for endobronchial ultrasound and addition of codes for EBUS sampling multiple lymph node stations
  • Under RUC review

• Review of moderate sedation codes, work group seeking codes for duration 15 minutes and separation of codes if sedation provided by a physician other than the proceduralist
  • Could have major impact on many codes for which moderate sedation is included

Q5: WHICH ONE OF THE FOLLOWING IS NOT AN APPROVED PROCEDURE FOR CODING?

a) Endoscopic placement of fiducial marker for localizing a lung tumor
b) Bronchial valves for large emphysematous bullae
c) Bronchial stent placement for stricture following lung transplant
d) Computer assisted navigation to a peripheral lung lesion
e) Endobronchial use of fibrin glue for broncho-pleural fistula
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