



## CODING UPDATE 2016

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Alan L. Plummer, MD was born in Ogallala, Nebraska in 1940. He received his undergraduate degree from the University of Nebraska and earned his MD (1966) from Northwestern University. He spent his internship at Passavant Memorial Hospital at Northwestern, and his residency and Fellowship in Pulmonary Diseases and Critical Care at the Mayo Clinic.

Dr. Plummer moved to Emory in the fall of 1971 and is currently a Professor of Medicine at the Emory University School of Medicine. He has served as The Emory Clinic Section Chief for Pulmonary, Allergy and Critical Care and has served as the Director of the Emory University Division of Pulmonary, Allergy and Critical Care. He is the Medical Director of the Respiratory Care Department at Emory University Hospital, the Medical Director of the Pulmonary Function Laboratory of The Emory Clinic and is the Associate Medical Director of the Emory University Hospital Pulmonary Function Laboratory.

Dr. Plummer participated in all three phases of the HSIAO studies to develop the RBRVS payment system. He is the RUC Advisor for the ATS and has served as a RUC member and as an Alternate RUC committee member for the Pulmonary Community.

He was a Consulting Editor for the Pulmonary Coding Alert and is the Editor of the ATS Coding and Billing Quarterly. He also has served as President of NAMDRC, is active in NAMDRC affairs and is still active in a number of state and national medical organizations.

He greatly enjoys his fantastic, wonderful eleven grandchildren and looks forward to spending quality time with each one. He also enjoys golf, boating, exercise, yoga, reading, and traveling with his marvelous wife, Ginny

### OBJECTIVES:

Participants should be better able to:

1. The participants will receive an update on the future of CMS Meaningful Use program.
2. The participants will learn how to code and bill for the new CMS lung cancer screening program.
3. The participants will learn about the new clarifications in the Incident-to guidelines.

4. The participants will receive an update on the success of the new coding system, ICD-10-CM, which began 10/19/2015.
5. The participants will learn how to code for several of the new asthma ICD-10-CM codes.

SATURDAY, MARCH 5, 2016 10:30 AM

## Coding Update 2016

**NAMDRC Annual Meeting**

March 5, 2016

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Pulmonary, Allergy, Critical Care & Sleep Division

Emory University School of Medicine

**Dr. Plummer has declared no conflicts of interest related to the content of his presentation.**

## Disclaimer

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ATS RUC Advisor

Opinions rendered are my own.

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## Agenda

- Meaningful use
- Lung cancer screening w LDCT
- Incident-to services
- Update on ICD-10-CM
- Questions

## Meaningful Use

- On Monday, January 11, 2016, CMS Acting Administrator, Andy Slavitt, announced that meaningful use in 2016 will be replaced with a better policy.
- AMA has been pushing hard to have the meaningful use regulations modified or eliminated.
- AMA has had multiple meetings with CMS

## Meaningful Use

- CMS appears to be changing its culture.
- CMS will focus more on listening to physicians' needs and giving them the freedom they need to keep patients at the center of the practice of medicine.
- Keep your eyes open for further information.

## Question 1

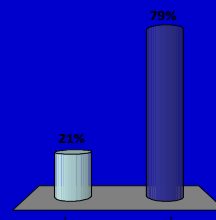
Which of the following is true about CMS's Meaningful Use program?

1. The Meaningful Use Program will continue until 2020.
2. There is a high likelihood that the program will be replaced in 2016.

## QUESTION 1

Which of the following is true about CMS's Meaningful Use program?

1. The Meaningful Use Program will continue until 2020.
- ✓ 2. There is a high likelihood that program will be replaced in 2016.



## Lung Cancer Screening with Low Dose CT Scans (LDCT)

- Lung cancer screening using low dose CT scans is a covered service in 2016.
- **G0296**: Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (service is for eligibility & shared decision making [SDM]).
- **G0297**: Low dose CT scan (LDCT) for lung cancer screening.

## Lung Cancer Screening with Low Dose CT Scans (LDCT)

- Reimbursement for SDM and LDCT has been modified for 2016.
- **G0296**: (SDM) \$69.65 in the hospital outpatient setting. \$28.64 in the office setting.
- **G0297**: (LDCT) \$112.49 in the hospital outpatient setting. \$254.93 in the office setting. Difference due to the practice expense in the office setting.

## Lung Cancer Screening with Low Dose CT Scans (LDCT)

- CMS Notice of Coverage Determination (NCD) states that LDCT & SDM are a covered Medicare service & what the conditions of coverage are. ([www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=274](http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=274)).
- Contains the official CMS policy.
- Does **not** limit which physician can perform the service.

## Lung Cancer Screening with Low Dose CT Scans (LDCT)

- Unfortunately, recent Medicare Learning Network Matter (MLNM) article stated that **only** primary care providers can provide SDM visits.
- ATS believes **strongly** that the MLNM article is **wrong** because nothing in the NCD indicates that only PCPs can provide SDM visits.



## Lung Cancer Screening with Low Dose CT Scans (LDCT)

- US Preventative Services Taskforce report on LDCT screening on which CMS based its NCD document states that patients will be referred for screening by non-PCPs.
- ATS has reached out to Medicare Adm. Contractors (MACs) who pay the claims and they will pay SDM visits from **all** physician providers provided proper coding and documentation is present.

## Lung Cancer Screening with Low Dose CT Scans (LDCT)

- ATS very sure that **all** physicians regardless of specialty will be able to order LDCT and provide SDM visits.
- ATS has asked CMS for clarification and correction of the MLNM article.
- CMS has responded to ATS inferring that **all** MDs who perform SDM visits and refer patients for LDCTs **will be paid**.
- MLN article **not** corrected or retracted.

## Lung Cancer Screening with Low Dose CT Scans (LDCT)

- ICD-10-CM coding issue.
- CMS will **deny** claims for **G0296** & **G0297** which do **not** contain **Z87.891** (Personal history of nicotine dependence).
- CMS intends also to include **F17.2\_** (Nicotine dependence) in the future.
- For current smokers, hold claims until **F17.2\_** has been added or they will be denied.

## Question 2

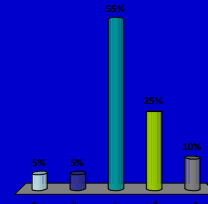
All of the following are true about using **G0296** when billing for a SCM visit about screening for lung cancer (LDCT) except:

- a. Patient must be present.
- b. Decision to screen is a shared decision.
- c. Patient may see several MDs about screening and each may bill **G0296**.
- d. Code **F17.2\_** must be on the bill.
- e. Code **Z87.891** also must be on the bill.

## QUESTION 2

All of the following are true about using **G0296** when billing for a SCM visit about screening for lung cancer (LDCT) except:

- a. A patient must be present.
- b. Decision to screen is a shared decision.
- c. Patient may see several MDs about screening and each may bill **G0296**
- ✓ d. Code **F17.2\_\_** must be on the bill.
- e. Code **Z87.891** also must be on the bill.



## Incident-to Services

- CMS has amended its Incident-to policy.
- Physician or other practitioner who bills for incident-to services **must be the same person** who directly supervised the personnel who provided the services.
- Direct supervision policy (physician must be present in the office suite) remains the same.

## Incident-to Services

- Does **not** mean supervising/billing MD has to be the one who initiated the original care plan upon which the incident-to service is based.
- **Example:** Dr. A treats Mr. Smith on Monday and requests follow-up in one week. At that time, Dr. A is on vacation and her partner Dr. B supervises the visit.

## Incident-to Services

- Dr. B must bill for the service under his provider number.
- Practices will need to decide which physician qualifies as the supervising physician.
- Medical record documentation should clearly name the supervising physician of an incident-to encounter.

## Incident-to Services

- Services and supplies provided incident-to Transitional Care Management (**99495**, **99496**) and Chronic Care Management (**99487**, **99489**) remain an **exception** to the direct supervision requirement.
- These can continue to be provided under general supervision (physician's presence in the office suite is **not** required).

## Incident-to Services

CMS also clarified that ancillary personnel are **prohibited** from providing incident-to services if they have been **excluded** from Medicare, Medicaid or any other federally funded health care programs by the Office of the Inspector General or have had their Medicare enrollment **revoked** for any reason.

### Question 3

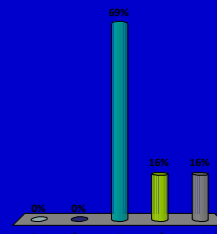
Which of the following statements about Incident-to encounters is true?

- a. PAs may not provide incident-to services.
- b. APNs may not provide incident-to services.
- c. Supervising MD must bill for the service.
- d. Supervising MD does not have to be in the office suite.
- e. Supervising MD must be in the room with the patient.

### QUESTION 3

Which of the following statements about Incident-to encounters is true?

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## Question 4

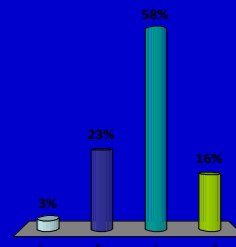
All of the following are true about Incident-to services except:

- a. Ancillary personnel must be in good standing with Medicare.
- b. Incident-to services with TCM only require general supervision.
- c. Incident-to services with CCM aren't allowed.
- d. Supervising MD has to bill for the Incident-to services.

## QUESTION 4

All of the following are true about Incident-to services except:

- a. Ancillary personnel must be in good standing with Medicare.
- b. Incident-to services with TCM only require general supervision.
- ✓ c. Incident-to services with CCM aren't allowed.
- d. Supervising MD has to bill for the Incident-to services.



## ICD-10-CM Update

- ICD-10-CM mandated beginning Oct. 1, 2015.
- Conversion appears to have been made rather smoothly.
- Some MACs (Medicare Administrative Contractors) identified several LCDs which needed further refinements.
- Claims affected by these edits were suspended temporarily & then processed.

## ICD-10-CM Update

- Questions about the specific LCDs should be directed to the appropriate MAC.
- Claims appear to be processing normally.
- Those with EMRs appear to have had very few problems.
- Suspect those without EMRs have had some difficulties.



## ICD-9-CM Asthma Codes

- **493.00** Extrinsic asthma
- **493.01** Extrinsic asthma, status asthmaticus
- **493.02** Extrinsic asthma, acute bronchitis
- **493.10** Intrinsic asthma
- **493.11** Intrinsic asthma, status asthmaticus
- **493.12** Intrinsic asthma, acute bronchitis
- **493.20** Obstructive asthma, unspecified
- **493.90** Asthma, unspecified
- **493.91** Asthma, unspecified, status asthmaticus
- **493.92** Asthma, unspecified, acute bronchitis
- **493.81** Exercise-induced bronchospasm
- **493.82** Cough variant asthma

## ICD-10-CM Asthma Codes

- **J45.20** Mild intermittent asthma, uncomplicated
- **J45.21** Mild intermit. asthma, w acute exacerbation
- **J45.22** Mild intermit. asthma, status asthmaticus
- **J45.30** Mild persistent asthma
- **J45.31** Mild persistent asthma, w acute exacerbation
- **J45.32** Mild persistent asthma, status asthmaticus.
- **J45.40** Moderate persistent asthma
- **J45.41** Mod. persistent asthma, w acute exacerbation
- **J45.42** Mod. persistent asthma, status asthmaticus
- **J45.50** Severe persistent asthma
- **J45.51** Severe persistent asthma, w acute exacerbation
- **J45.52** Severe persistent asthma, status asthmaticus

## ICD-10-CM Asthma Codes

- **19** codes in ICD-10 vs **14** codes in ICD-9
- **No** direct cross-walks for **most** of asthma codes, since severity of asthma important for the ICD-10-CM asthma codes.
- **493.90** to **J45.90** Unspecified asthma.
- **493.91** to **J45.902** Unspec. Asthma w stat.
- **493.92** to **J45.901** Unspec. Asthma w AB.
- **493.81** to **J45.990** Ex. Induced asthma.
- **493.82** to **J45.991** Cough variant asthma.

## Chronic Obstructive Asthma Coding

A patient with long-standing asthma on ICS with LABA and albuterol is seen for an evaluation and is found to have moderate airflow limitation on PFTs. What ICD codes would you use?

ICD-9-CM: **493.20** (Obstructive asthma)

ICD-10-CM: **J44.9** (COPD, unspecified)

**J45.40** (Moderate, persistent asthma, uncomplicated)

## ICD-10-CM COPD Codes

- **J44.9** COPD, unspecified (includes asthma with COPD, chronic bronchitis w emphysema, chronic obstructive asthma).
- Code **also** asthma severity (use 2 codes).
- Use additional code to identify:
  - **Z87.891** Hx of tobacco use
  - **Z72.0** Tobacco use
  - **F17.-** Tobacco dependence

## Documentation for Asthma

- **Document history:** onset, triggers, wheezing frequency, use of SABA (nocturnal), exacerbations, other items to justify severity and acuity of asthma.
- **Treatment medications:** (ICS, LABA, LAMA, montelukast, theophylline, etc.
- **Document** results of PFTs and FENO.
- Use **5 or 6 character code** when possible.

## Question 5

A current patient who is a college student is seen urgently in the office. He was walking on campus with his pet parrot. He decided to dash into the library to look up a reference which he needed. During this research, the parrot began squawking. When he tried to silence the parrot, it bit him on the neck.

How would you code this level 3 visit?

## Answer to Question 5

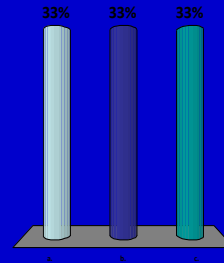
- **99213** for the office visit.
- **W61.12** for being bitten by a parrot.
- **Y92.241** for being injured at the library.

## Answer to Question 5

a. **99213** for the office visit.

b. **W61.12** for being bitten by a parrot.

c. **Y92.241** for being injured at the library.



## Agenda

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# Questions?

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