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OBJECTIVES:
Participants should be better able to:

1. Describe the current coding for the use of endobronchial ultrasound (EBUS) for the sampling of mediastinal lymph nodes.

2. Understand the use of EBUS as an “add-on” to other endoscopic procedures.

3. Describe the expectations for providing and documenting Chronic Care Management services.

4. Understand the requirements for Advance Care Planning.

SATURDAY, MARCH 5, 2016 11:15 AM
Dr. Peters has declared no conflicts of interest related to the content of his presentation.
Disclosure

- No financial conflict of interest
- Serve on NAMDRC Board of Directors
- Advisor to AMA CPT Coding Panel as ACCP representative

- CPT is a registered trademark of the American Medical Association

Practice Management Objectives

- Describe the current coding for the use of endobronchial ultrasound (EBUS) for the sampling of mediastinal lymph nodes
- Understand the use of EBUS as an “add-on” to other endoscopic procedures
- Describe the expectations for providing and documenting Chronic Care Management services
- Understand the requirements for Advance Care Planning
Node Stations

Convex-probe EBUS
Convex EBUS

- View is 30° forward oblique
- US and white light images can be seen simultaneously on the same screen
- White light image of the airway poorer than current standard video bronchoscope

Radial EBUS for Peripheral Lesions

- Radial ultrasound probe
- 1.7mm probe inserted through working channel flexible bronchoscope
Convex Probe vs Radial Probe

Convex Probe EBUS

Radial Probe EBUS

New codes mediastinal node sampling

- **31652** with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures

- **31653** with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), 3 or more mediastinal and/or hilar lymph node stations or structures
Question 1

Which one is true regarding EBUS sampling of mediastinal nodes?

a) Code 31653 may be used for a procedure requiring 3 passes to each of two node stations

b) 31652 should be used for a single EBUS guided biopsy of a peripheral lung mass

c) 31653 is reported once for EBUS biopsy of four different node stations

d) 31652 may be used twice for sampling bilateral mediastinal masses

QUESTION 1

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✓
d. 31652 may be used twice for sampling bilateral mediastinal masses
New EBUS add-on code
31620 deleted for 2016

+31654 with transendoscopic endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s) (List separately in addition to code for primary procedure[s])

(Use 31654 in conjunction with 31622, 31623, 31624, 31625, 31626, 31628, 31629, 31640, 31643, 31645, 31646) (For EBUS to access mediastinal or hilar lymph node station[s] or adjacent structure[s], see 31652, 31653)

Base codes transbronch lung Bx, needle aspiration

• 31628 with transbronchial lung biopsy(s), single lobe (31628 should be reported only once regardless of how many transbronchial lung biopsies are performed in a lobe) (To report transbronchial lung biopsies performed on additional lobe, use 31632)

• 31629 with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)
Question 2

Which one is true regarding EBUS add-on code +31654?

a) This code may be added to mediastinal node sampling 31652 if two different probes are used to assess the nodes

b) If EBUS is used to guide the needle biopsy of a mass in the right mainstem bronchus, use 31629 +31654

c) If four node stations are sampled, you may add 31654 to 31653

d) EBUS may not be coded with bronchial biopsy, single or multiple sites, 31625
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 Coordination


- 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.
(Chronic care management services of less than 20 minutes duration, in a calendar month, are not reported separately)
Complex Chronic Care Management

- **99487** Complex chronic care management services, with the following required elements:
  - 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 management services of less than 60 minutes are not reported separately)

- **+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)

Chronic care management for pulmonary

- Coding by any physician treating two or more chronic conditions
- Only one physician can code each month, so must manage all chronic conditions (e.g. COPD, CHF, diabetes)
- Since complex codes not recognized, use 99490
- Patient must give consent, 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)
Question 3

Which one accurately describes a chronic care management service, 99490?

a) Coordinating care of a COPD patient also managed by family physician
b) Three 15 minute phone calls in a one-month period following a consultation for asthma
c) Care management for coordinating inpatient hospital discharge and transition
d) 30 minutes of staff time in a calendar month, directed by physician, for a patient at home with severe asthma and steroid-induced diabetes
Advance care planning

- Direct discussion with physician or other qualified provider regarding wishes, options for future care, including end-of-life care and documentation, if performed
- Examples of these forms: health care proxy, durable power of attorney for health care, living will, medical orders for life-sustaining treatment
- Coverage initiated by CMS January 1, 2016
  - http://federalregister.gov/a/2015-28005
  - RVUs: 99497 2.4; 99498 2.09

Advance Care Planning

- 99497 Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

- + 99498 each additional 30 minutes (List separately in addition to code for primary procedure)
  - (Use 99498 in conjunction with 99497)
  - (Do not report 99497 and 99498 on the same date of service as 99291, 99292, 99468, 99469, 99471, 99472, 99475, 99476, 99477, 99478, 99479, 99480)
Question 4

Which one is true regarding advance care planning codes, 99497, +99498?

a) 99497 may be billed in addition to an E&M code for follow-up of COPD and long term oxygen

b) 99497 may be used for 40 minutes of family counseling after one hour of direct critical care time

c) +99498 cannot be added to 99497 for care planning discussion that takes 50 minutes

d) A living will must be on file in the record for the use of advance directive codes

QUESTION 4

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Bronchial Valves

- **31647** with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe

+ **31651** with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure[s])

Endobronchial valves (EBV) for emphysema


- 84 patients, 16 excluded because of collateral ventilation
- 34 pts each to EBV vs control
- EBV group showed greater improvements
  - FVC 340 ml, FEV1 140 ml
  - Six minute walk 74 meters
- More adverse events with EBV: pneumothorax (18%), valve replacement (12%), removal (15%), one death
- ?Use of existing codes for indication of emphysema
Lung volume reduction by endobronchial coils
Deslee G et al. JAMA 2016;315:175-84

- 100 patients, 1:1 randomization to usual care vs coils
- At six months, primary end point of >54 m improvement in six-minute walk
- 18 (36%) coil group, 9 (18%) controls
- At 12 mos FEV1 +0.08 L in coil group