Addressing the Nuances of Pulmonary Coding

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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 an Emeritus 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 Associate Medical Director of the Respiratory Care Department at Emory University Hospital, the Associate 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, is Vice President of the Physicians Foundation and is active in a number of state and national medical organizations.

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

OBJECTIVES:

1. Participants will learn the CPT changes for 2019 and the new Conversion Factor.
2. Participants will learn the new documentation guidelines from CMS for 2019.
3. Participants will learn about possible new CPT changes in 2021.
4. Participants will learn about CMS's Competitive Bidding process and how it affects liquid O2 use by patients.

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ADDRESSING THE NUANCES OF PULMONARY CODING

NAMDRC Annual Meeting
March 15, 2019

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DISCLAIMER

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AGENDA

- CPT changes for 2019.
- Documentation changes for 2019.
- E/M changes for 2021.
- Multiple procedures payment reduction-- MPPR
- DME competitive bidding
- Outpatient liquid O2 therapy

CPT CHANGES FOR 2019

- **No significant changes** in CPT codes for Pulmonary/Critical Care/ Sleep MDs in 2019.
- Conversion Factor is $36.04 for 2019 ($35.99 in 2018).
- Changes to E/M **will be coming** in 2021.
- Documentation changes **began** in 2019.
- CMS is attempting to **lighten the documentation burden** for all physicians.

DOCUMENTATION CHANGES FOR 2019

- **Eliminates** need to document medical necessity of home visit in lieu of office visit
- For established outpatient visits, if relevant information already in chart, **no** need to re-record defined list of elements, but MD **must review** required information, **update it** as needed and **document it** in the record.

DOCUMENTATION CHANGES FOR 2019

- For new and established patients, MDs need only to **review**, **verify** and **document** CC and history entered by ancillary staff.
- For information entered into the record by residents and other members of the medical team, teaching MDs need only **verify** and **document** the information in the chart.

E/M CHANGES FOR 2021

- For 2019 & 2020, MDs should use either 1995 or 1997 guidelines (**unchanged**) for outpatient new or return visits.
- On Nov. 1, 2018, CMS released new policy changes for MDs **to begin in 2021**.
- There will be 3 documentation levels: level 1, **new level 2** combining old levels 2-4 and level 5 will be retained.

E/M CHANGES FOR 2021

- CMS will apply the **minimum documentation** standard of a **level 2 visit**.
- MDM, time, 1995 or 1997 guidelines can be used to choose the appropriate E/M level.
- If **time** is used, medical necessity of the visit **must** be documented and **face-to-face time must be documented in the chart.**

E/M CHANGES FOR 2021

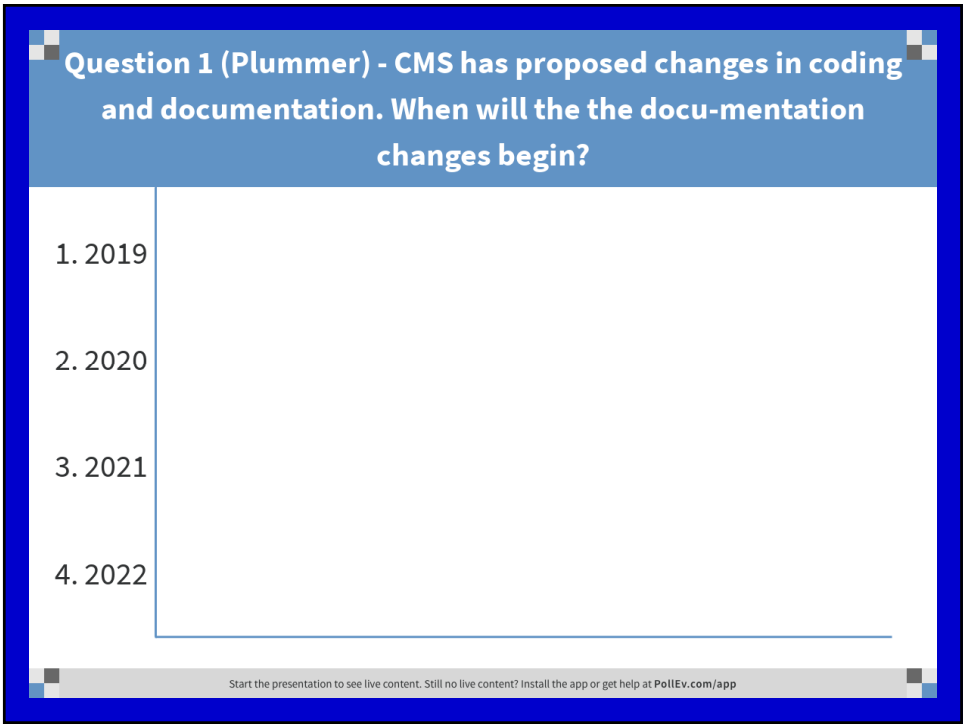
- CMS chose the **reimbursement level** to be **between level 2 and level 3 codes**.
- This level of reimbursement would have **cost** pulmonary/critical care/sleep MDs **tens of millions of dollars!**
- Other MDs likewise affected, particularly those seeing **level 4 & 5 patients**.
- **Strong opposition** stopped this—for now
- Reimbursement issues are **still** on the table.

E/M CHANGES FOR 2021

- **New add-on codes** will be developed to describe additional resources for visits.
- New add-on codes **only reportable** for level 2-4 visits only.
- New add-on codes are **not restricted by MD specialty** and will **not** require new documentation requirements.
- New **"extended visit" add-on code** will be developed for level 2-4 visits for extra time spent with the patient.

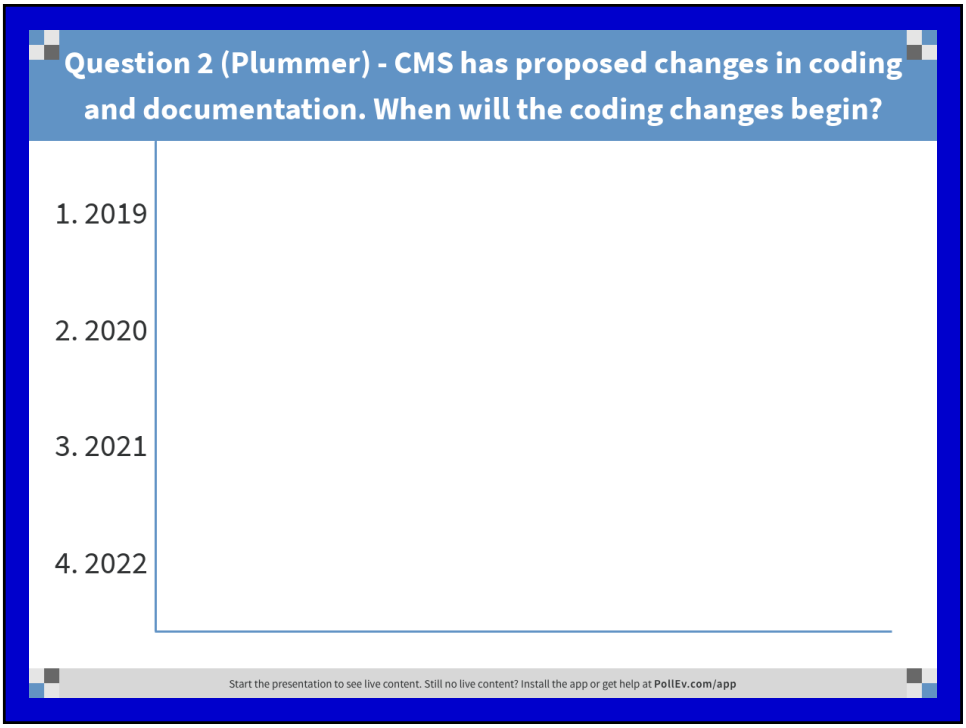
QUESTION ONE

- CMS has proposed changes in coding and documentation. When will the the docu-mentation changes begin?
  - 1. 2019
  - 2. 2020
  - 3. 2021
  - 4. 2022



QUESTION TWO

- CMS has proposed changes in coding and documentation. When will the coding changes begin?
  - 1. 2019
  - 2. 2020
  - 3. 2021
  - 4. 2022



MULTIPLE PROCEDURES PAYMENT REDUCTION

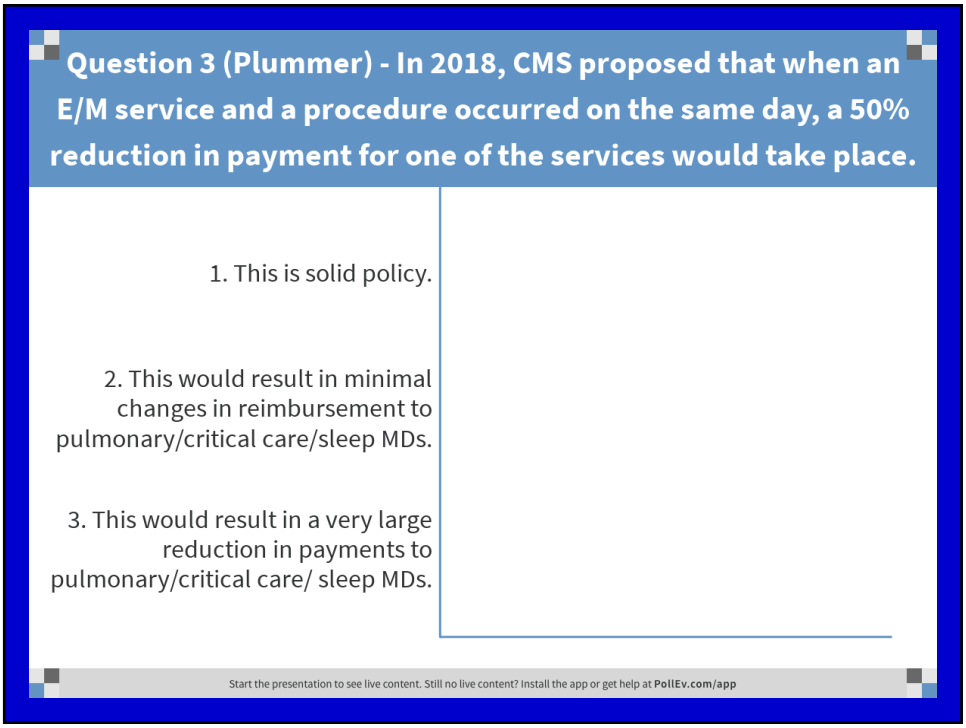
- For an E/M service and a procedure on the same day, CMS initially proposed **reducing payment** for the least expensive service by **50%!**
- MDs would have absorbed payment reductions or forced to have patients return on multiple days for services.
- Fortunately, universal opposition by MDs forced CMS **not** to adopt this policy.

MULTIPLE PROCEDURES PAYMENT REDUCTION

- CMS **may return** to this flawed policy in the near future!
- MPPR would be a **lose-lose proposition** for patients and MDs!
- This very issue caused a multi-state RICO lawsuit against payers in early 2000, resulting in settlements leading to the birth of the Physicians Foundation in 2003!

QUESTION THREE

- In 2018, CMS proposed that when an E/M service and a procedure occurred on the same day, a 50% reduction in payment for one of the services would take place.
  - 1. This is solid policy.
  - 2. This would result in minimal changes in reimbursement to pulmonary/critical care/sleep MDs.
  - 3. This would result in a very large reduction in payments to pulmonary/critical care/ sleep MDs.



MEDICARE DME COMPETITIVE BIDDINGPROGRAM

- DME competitive bidding program has been **"paused" for two years**.
- DME products can be provided by any **qualified** supplier who is willing to accept Medicare payment rate **("any willing provider")**.
- CMS will address some of current quality and access problems in the program.

OUTPATIENT O2 THERAPY

- CMS recognized problems in O2 market, but **failed to take meaningful action**.
- **Small increase** in payments for liquid O2.
  - $17.44 in **portable** liquid equipment
  - $20.87 in **portable** liquid O2 contents >4L/M
- **Reduction** in payments for other portable O2 systems.

Stationary Liquid Systems

Year	Charges	Claims	Medicare Patients
2010	$67,355,848	386,645	32,220
2011	$59,497,447	349,775	29,148
2012	$46,893,878	271,233	22,603
2013	$31,983,339	199,486	16,624
2014	$19,536,044	136,656	11,388
2015	$10,829,115	99,252	8,271
2016	$ 7,482,476	71,377	5,948

Portable Liquid Systems

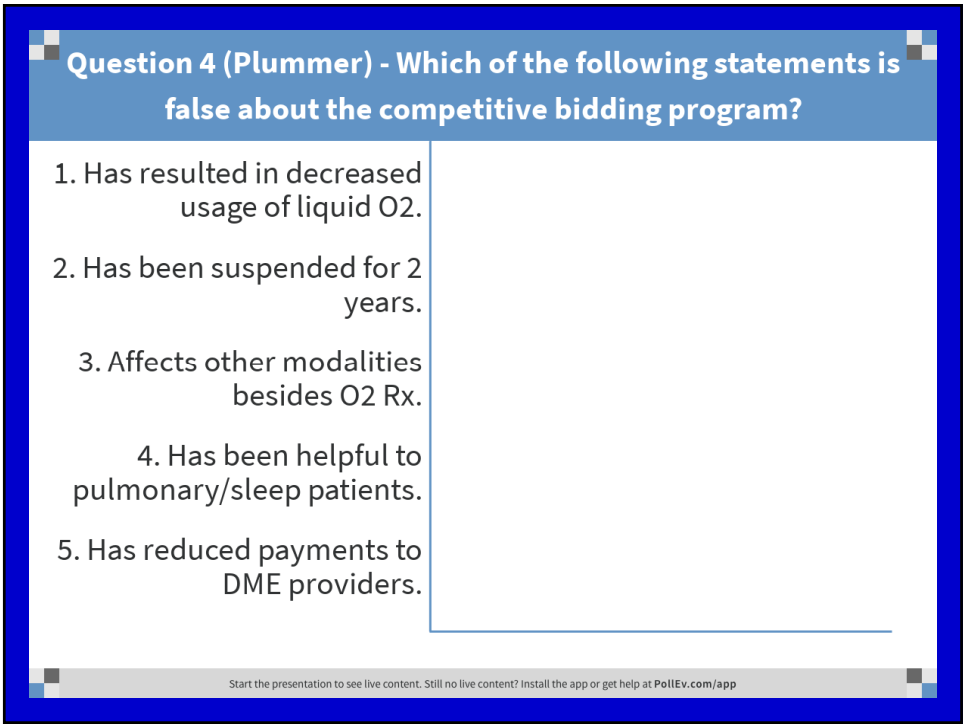
Year	Charges	Claims	Medicare Patients
2010	$14,127,684	491,253	40,938
2011	$12,439,576	442,027	36,836
2012	$9,728,130	337,668	28,139
2013	$6,814,689	250,125	20,844
2014	$4,368,905	173,161	14,430
2015	$2,455,215	128,727	10,727
2016	$2,020,306	97,690	8,141

OUTPATIENT O2 THERAPY

- The decreases (**>80%**) in the patients using liquid O2 from 2010 are truly **astounding!**
- CMS has recognized that there are problems in the O2 market, but **failed** to take meaningful action.
- New liquid O2 payments are **insufficient** to encourage DMEs to provide liquid O2.
- Doubt DME providers will have incentive to provide liquid O2 in the future!

QUESTION FOUR

- Which of the following statements is **false** about the competitive bidding program?
  - 1. Has resulted in decreased usage of liquid O2.
  - 2. Has been suspended for 2 years.
  - 3. Affects other modalities besides O2 Rx.
  - 4. Has been helpful to pulmonary/sleep patients.
  - 5. Has reduced payments to DME providers.



FUN CODING!

- A medical resident occupied with a cell phone turns to walk into a hospital bathroom and is struck by another resident leaving the bathroom which knocks him into the door frame striking his scalp. He is stunned, and bleeding, but is not knocked unconscious. He stems the bleeding with a handkerchief and rushes to the ED. How should the ED MD code this encounter?

FUN CODING!

- **99283** Level 3 ED visit.
- **S00.03XA** Contusion of scalp, initial encounter.
- **Z04.2** Encounter for examination & observation following work accident.
- **W51.XXXA** Accidental striking against or bumped into by another person, sequelae.
- **Z99.89** Dependence on enabling machines & devices, not elsewhere classified.
- **Y92.232** Hospital corridor as the place of occurrence of the external cause.

Questions?

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