



PRACTICE MANAGEMENT UPDATE 2019

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OBJECTIVES:

1. Understand recommendations for coding bronchial valves for emphysema.
2. Describe CMS changes regarding ECMO services.
3. Be aware of CPT development and practical implications of new telemedicine codes.
4. Identify hot topics in electronic health records, usability and “physician burnout”.

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Practice Management Update 2019

Coding, Documentation and Burnout

NAMDRC Annual Meeting

Steve G. Peters, MD

Disclosure

- No financial conflicts
- ACCP Advisor to AMA CPT Panel
- Joint ATS/CHEST Clinical Practice Committee
- ATS Coding & Billing Quarterly Advisory Board

Objectives

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Bronchial valves for emphysema

- 2018 FDA approval of bronchial valves for emphysema
- Areas of hyperinflation without collateral ventilation
- Assess by CT scan and/or endobronchial assessment of airflow when bronchus obstructed
- Common question regarding coding the procedure
- Recommendation to use existing codes

Bronchial valves for emphysema

Potentially appropriate codes

- **31634** with balloon occlusion, with assessment of air leak, with administration of occlusive substance (eg, fibrin glue), if performed
- **31647** Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe
- **+31651** Bronchoscopy...with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe
- **31648** Bronchoscopy...with removal of bronchial valve(s), initial lobe
- **+31649** Bronchoscopy...with removal of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure)

Question

Which one of the following is true regarding bronchial valves for emphysema?

- a) Balloon occlusion must be performed before each valve is placed
- b) If valves are placed in two lobes, the correct codes are 31647, +31651
- c) An airflow device to detect collateral ventilation is coded separately
- d) For removal of multiple valves, report multiple copies of code 31648

Question 1 (Peters) - Which one of the following is true regarding bronchial valves for emphysema?

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CMS ECMO changes

- 10/2018 CMS announced changes to reimbursement for ECMO
- Previously all under MS-DRG 003
- Determined that peripheral access (rather than central access via sternotomy) should be under lesser medical DRGs and ICD-10 Procedural Coding System (PCS), by indication and type of access
 - Venous-arterial (VA), Venous-venous (VV)
- From registry data: 5500 cases of ECMO in US adults/yr. 58% cardiac, 42% are respiratory; peripheral access in 89%
- Approx. 10% of ECMO recipients under Medicare

CMS ECMO changes

www.else.org

Previous Codes and DRG

PCS code	Description	DRG	Base \$
5A15223	ECMO	003	101,892

New Codes and DRG

PCS code	Description	DRG	Base \$
5A1522F	Central ECMO	003	101,892
5A1522G	Peripheral VA ECMO		
	Heart failure and shock	291	7,492
	Cardiac arrest	296	8,551
	VA ECMO plus pVAD	215	71,759
5A1522H	Peripheral VV ECMO		
	Vent support 96 hrs	207	31,165
	Sepsis with Vent support	870	35,057
	VV ECMO plus pVAD	215	71,759

pVAD is peripheral ventricular assist device (Impella)

Question

Which of the following is correct regarding ECMO support?

- The majority of cases require sternotomy for central access
- For adults with respiratory failure, survival to discharge is < 30%
- Peripheral VA ECMO cannot be used for cardiogenic shock
- DRG 003 can only be applied to central VA ECMO

Question 2 (Peters) - Which of the following is correct regarding ECMO support?

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Telemedicine coding updates

Communication with patient

- **99444** Online evaluation and management service provided by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient or guardian, not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network

Telemedicine coding updates

Communicating with other professionals

- **99446** Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review
- **99447** 11-20 minutes of medical consultative discussion and review
- **99448** 21-30 minutes of medical consultative discussion and review
- **99449** 31 minutes or more of medical consultative discussion and review

Telemedicine coding updates, 2019

- **99451** Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time
- **99452** Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes

CMS Recognition

	RVU
• 99446	• 0.35
• 99447	• 0.70
• 99448	• 1.05
• 99449	• 1.40
• 99451	• 0.70
• 99452	• 0.70

Chronic care remote physiologic monitoring

- **99453** Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment
- **99454** device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days
- **99457** Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month

Question

Which is correct regarding telemedicine coding?

- a) Patient consent is not required to bill 99446 for inter-professional consultation
- b) Verbal recommendations via phone call are adequate for 99446
- c) Time to review history, labs and radiographic images is included in 99446-99449
- d) If the consulting physician makes contact with the referring physician on consecutive days, a separate code is submitted for each day

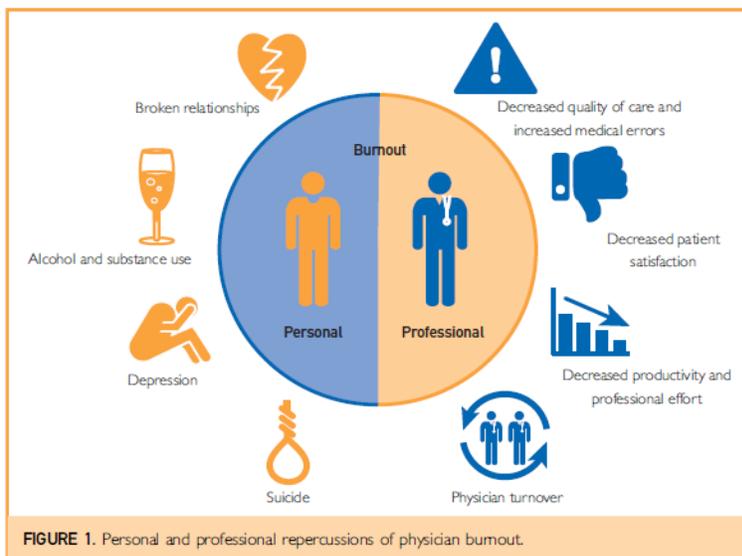
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Burnout

Shanafelt TD, Noseworthy JH. Mayo Clin Proc. 2017;92(1):129-146



Significant Changes with Electronic Records

- Chart review
- InBasket management
 - Volume, complexity, relentless
- Patient portal- expectation of access
- New content and workflows
 - Role of support staff, team based care, protocols, regulatory requirements of M.D.
- Electronic order entry
- Documentation (multiple options)
 - Self entry, templates, voice recognition tools, dictation/transcription
- Problem List management, coding
 - ICD-10, Hierarchical Condition Categories (HCC),

Satisfaction and technology

- Productivity, flexibility
- Mobility
- Efficiency
- Assistance with clerical tasks
- Increased use of automated decision support, Artificial Intelligence
- Team based care, patient engagement, telemedicine
- Alternative payment models, bundled care
(less documentation, less payment ?)

Burnout strategies

- Workload, job demands
- Clerical, regulatory burden
- Meaningful work, culture, values, fairness
- Respect
- Control and flexibility
- Work-life integration
- Social support, community

- What is the opposite of burnout?

Business decisions for support

- Support staff, number and types
 - NP, PA, coders, scribes?
- Dictation/transcription
- Workstation availability, hand held devices
- Physical space
- Flexibility of scheduling

Question

Which of the following is true regarding physician “burnout”

- a) Survey data over the past 5 years shows greater than 25% increase in signs of burnout
- b) Symptoms of burnout are reported by greater than 80% of physicians
- c) The use of scribes has been shown to reduce burnout by 50%
- d) Regulatory, documentation and coding requirements are not a significant contributor to burnout

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