Refine Your Medicine, Cardiothoracic Surgery Reporting With Key Code Expansions

Give up diagnostic thoracoscopy code 32602 in favor of newbies 32607-32609.

Remember to check for deleted codes when preparing to use your CPT® 2012 manual, not just new codes and revised descriptors. Next year’s set of procedure codes will include fresh additions for coding some common medicine/pulmonary procedures. Concurrently, you will be missing the resistance to airflow determination code, as well as a few other familiar pulmonary procedures.

Gauge Potential Opportunities With Brand New Medicine Codes

You and your pulmonologists should pay special attention to the following new codes under the medicine/pulmonary section of CPT® 2012 manual:

- 94726 — Plethysmography for determination of lung volumes and, when performed, airway resistance
- 94727 — Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes
- 94728 — Airway resistance by impulse oscillometry
- +94729 — Diffusing capacity (e.g., carbon monoxide, membrane) (List separately in addition to code for primary procedure)
- 94780 — Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report; 60 minutes
- +94781 — ...each additional full 30 minutes (List separately in addition to code for primary procedure).

Some of these codes were formulated in an effort to try to adapt to current practice and clarify previous confusion when reporting PFTs. One example is plethysmography. Previous options for reporting this service was 93720 (Plethysmography, total body; with interpretation and report) or 94360 (Determination of resistance to airflow, oscillatory or plethysmographic methods). Effective Jan. 1 a new code will now reflect the more accurate testing method.

CPT® will also give way to 18 debuting cardiothoracic surgery codes in 2012. These codes include:

- 32096 — Thoracotomy, with diagnostic biopsy(ies) of lung infiltrate(s) (e.g., wedge, incisional), unilateral
- 32097 — Thoracotomy, with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (e.g., wedge, incisional), unilateral
The codes are cardiothoracic surgery codes. It seems that they [CPT®] have expanded each of these series to include more detail, and more accurately capture the amount of effort associated with unilateral vs bilateral services as well as procedures involving multiple (ipsilateral) biopsies,” says Carol Pohlig, BSN, RN, CPC, ACS, senior coding and education specialist at the University of Pennsylvania Department of Medicine in Philadelphia.

Prepare For Cardiothoracic Surgery Code Changes

As a matter of fact, CPT® will delete some of the old endoscopy procedures on the lungs and pleura for 2012. These are:

- 32602 — Thoracoscopy, diagnostic (separate procedure); lungs and pleural space, with biopsy
- 32603 — Thoracoscopy, diagnostic (separate procedure); pericardial sac, without biopsy
» 32605 — Thoracoscopy, diagnostic (separate procedure); mediastinal space, without biopsy
» 32657 — Thoracoscopy, surgical; with wedge resection of lung, single or multiple
» 32660 — Thoracoscopy, surgical; with total pericardiacdiectomy.

Instead of 32602, you will use 32607-32609 to report diagnostic thoracoscopy of lungs and pleural space with biopsy. CPT® 32601 will replace 32603 and 32605 for diagnostic thoracoscopy without biopsy. Meanwhile, surgical thoracoscopy code 32657 will give way to new codes 32666-32668.

Extra: You will also bid goodbye to removal procedure code 32500 (Removal of lung, other than total pneumonectomy; wedge resection, single or multiple) beginning Jan. 1. As replacement, you will report three new thoracotomy codes 32505-32507 which will more accurately reflect the effort of resections now reporting multiple wedge resections with additional codes rather than using a single “catch-all” code to report both single and multiple wedge resections.

94726-94727 Takes The Place Of FRC Deleted Code

You should also be aware of deletions within the medicine/pulmonary section of your CPT® manual. For instance, where you would code 94240 (Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method) to measure functional residual capacity (FRC) in 2011, next year you will have to report 94726-94727.

Other deleted codes for 2012 will include:
» 94260 — Thoracic gas volume
» 94350 — Determination of maldistribution of inspired gas: multiple breath nitrogen washout curve including alveolar nitrogen or helium equilibration time
» 94360 — Determination of resistance to airflow, oscillatory or plethysmographic methods
» 94370 — Determination of airway closing volume, single breath tests
» 94720 — Carbon monoxide diffusing capacity (e.g., single breath, steady state)
» 94725 — Membrane diffusion capacity.

2012 E/M Revisions

Supplement Your 99218-99220 Descriptors With Added Time Guidelines

CPT® confirms RVUs for subsequent observation care codes 99224-99226.


Mark Those Extra Time Guidelines To Describe 99218-99220

Brace yourself for added time guidelines for the initial observation care codes 99218-99220 this Jan. 1, 2012. These add-ons will include the following text:
» 99218 — Physicians typically spend 30 minutes at the bedside and on the patient’s hospital floor or unit
» 99219 — Physicians typically spend 50 minutes at the bedside and on the patient’s hospital floor or unit
» 99220 — Physicians typically spend 70 minutes at the bedside and on the patient’s hospital floor or unit.

This will mirror the fact that these codes will feature typical times associated with them, just as subsequent observation care codes 99224-99226 already have since they were introduced. The CPT® committee’s reason for including these codes may not be entirely apparent until the AMA’s November CPT® Symposium, but the additional typical times could help you out when coding based on time.

There are only two musts for using time as a basis for selecting an E/M code, says Barbara J. Cobuzzi, MBA, CPC, CENTC, CPC-H, CPC-P, CPC-I, CHCC, president of CRN Healthcare Solutions, a consulting firm in Tinton Falls, NJ. “If counseling/coordination of care takes up more than 50 percent of the visit, and if the code has a typical time associated with it. So by these codes now having a time reference, it sounds like we may have a way to reference time used if counseling or coordination of care takes up greater than 50 percent of

(Continued on next page)
You Be the Coder

Medicare Covers PFT Technical Component — But With Limitations

**Question:**
My claim implies pulmonary function test without physician interpretation. Will Medicare still pay for the service?

**Wisconsin Subscriber**

**Answer:** See page 87.

CMS further clarified in an August transmittal that subsequent observation care codes, as initial observation care codes, are reserved for the observation attending/group of record. Consultants shouldn’t use them. If a pulmonologist were consulted during an observation case, he would report the appropriate outpatient/office code (99201-99215) with OH (Outpatient hospital) site of service. The pulmonologist would report the most appropriate new patient (99201-99205) or established (99212-99215) code, depending on whether or not the patient has been seen by the group within the last three years. Be sure your physician does not mistakenly report the observation care service codes if he is the consultant.

**Quick fact:** Typically, the emergency department (ED) physician or hospitalist would be the observation attending while the pulmonologist is reserved as the attending in intensivist (ICU) cases.

**New 2012 Modifier Doesn’t Guarantee Extra Pay**

It isn’t every year that CPT® adds new modifiers for your coding and billing needs, so when you see a new one gracing the pages of your 2012 manual, you might get excited — but don’t rejoice just yet.
Modifier 33 (Preventive service) went into effect on Jan. 1, 2011, but it didn’t make it into the 2011 CPT® book due to publishing deadlines, so the modifier will be making its first appearance in the 2012 manual. According to CPT®, the modifier should be appended “when the primary purpose of the service is the delivery of an evidence based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates.”

**Evaluation and Management**

**Q&A: Support Your E/M Skills With 3 Fresh Facts**

File that E/M claim regardless of inconclusive diagnosis — but make sure you document everything.

The level of evaluation and management (E/M) services provided during patient encounters for the pulmonology practice remains high. In fact, your physician’s income could largely depend on the RVUs attached to the E/M codes. However, ample questions continue to surface about how to properly report these services.

Put your E/M coding skills to the test by examining the following Q&A.

**Check Physicians’ Matching Tax ID Before Billing ‘New Patient’**

**Question 1:** My clinic consists of multiple-specialty groups of physicians, and lately we have had a case of rejection for new patient visit from Medicare when the patient is indeed a “new patient” for a practice. The pulmonologist performed 31720 (Catheter aspiration [separate procedure]; nasotracheal) on the patient. Before this encounter, a different physician from another practice saw this patient (for the same treatment). This is what Medicare cites as the reason for the rejection. The two practices are totally different entities and do not share the patient database or records. Could this have anything to do with physician specialty codes and how they are matched to provider numbers?

**Answer 1:** Multi-specialty groups may share the same tax ID, but are enrolled with payers under different two-digit specialty codes. If the first physician belongs to a different specialty, you should appeal the decision as the payer is trying to avoid an overlapping care issue (when two providers are primarily caring for the same issue). If the other group within your tax ID is also enrolled as pulmonology, then you will be viewed as the “same group,” even if you practice at different locations.

**Consider Family Consultation Billable Under Certain Conditions**

**Question 2:** My pulmonologist met with an elderly patient’s family in the office to discuss treatment options and the patient’s plan of care. The meeting took place without the presence of the patient. Can I still bill for an E/M service based on the time spent with the family? What about if a patient was present but cannot participate due to cognitive issues?

**Answer 2:** Most payers will only pay for an office visit if the patient is present.

CPT® requires that the physician must meet face-to-face with the patient to report an established patient E/M visit (99211-99215). The only exception is if the physician must contact another individual (such as a spouse, parent, child, or other family member) to “secure background information to assist in diagnosis and treatment planning,” according to the Medicare National Coverage Determinations Manual, Chapter 1, Part 1, Section 70.1 (available at www.cms.hhs.gov/manuals/downloads/ncd103c1_Part1.pdf).

The manual further states, “In certain types of medical conditions, including when a patient is withdrawn and uncommunicative due to a mental disorder or comatose, the physician may contact relatives and close associates to secure background information to assist in diagnosis and treatment planning. When a physician contacts his patient’s relatives or associates for this purpose, expenses of such interviews are properly chargeable as physician’s services to the patient on whose behalf the information was secured. If the beneficiary is not an inpatient of a hospital, Part B reimbursement for such an interview is subject to the special limitation on payments for physicians’ services in connection with mental, psychoneurotic, and personality disorders.”

A physician may also have contacts with a patient’s family and associates for purposes other than securing background information, says Carol Pohlig, BSN, RN, (Continued on next page)
CPC, ACS, senior coding and education specialist at the University of Pennsylvania Department of Medicine in Philadelphia. In some cases, the physician will provide counseling to members of the household. Family counseling services are covered only where the primary purpose of such counseling is the treatment of the patient’s condition.

For example, two situations where family counseling services would be appropriate are as follows: (1) where there is a need to observe the patient’s interaction with family members; and/or (2) where there is a need to assess the capability of and assist the family members in aiding in the management of the patient. “Counseling principally concerned with the effects of the patient’s condition on the individual being interviewed would not be reimbursable as part of the physician’s personal services to the patient. While to a limited degree, the counseling described in the second situation may be used to modify the behavior of the family members, such services nevertheless are covered because they relate primarily to the management of the patient’s problems and not to the treatment of the family member’s problems,” explains Pohlig.

**Key:** Be sure to query your payer before submitting a claim for patient services when the patient is not present. Also, be sure your documentation precisely reflects the circumstances and discussion.

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**Reader Questions**

**Oxygen Therapy: Designate Supply Code Instead Of 94799**

**Question:**
*I’m billing oxygen therapy provided during an office visit for a Medicare patient. What CPT® should I use? What are the limitations set by Medicare on oxygen therapy coverage?*

Indiana Subscriber

**Answer:**
No CPT® code represents the administration of oxygen therapy. Don’t report 94799 (*Unlisted pulmonary service or procedure*), because you must bill oxygen in measurable units (i.e., per liter, per hour). You would include this in your E/M service. Should the patient require home oxygen, the physician must certify the need for this, after meeting certain requirements (available in Chapter 20 of the Medicare Claims Processing Manual, http://www.cms.gov/manuals/downloads/clm104c20.pdf).

**Coverage:** As long as you appropriately document the need for oxygen therapy, Medicare will likely cover this service. Make sure you submit a physician’s written order for the oxygen, stating the device and/or specific flow rate or concentration of oxygen preferred. The order must also include time limits, and indicate reasons for beginning and ending the therapy.

**Bill 31628 If Biopsies Occurs In The Same Lobe**

**Question:**
*Op note says: The pulmonologist introduced the scope through the right nostril and advanced to the vocal cords and into the trachea. The tracheal rings appeared normal. The physician, then, withdrew the scope to the upper lobe and lower lobe subsegments. No endobronchial lesions were noted. The scope was withdrawn and advanced to the right upper lobe and right middle and lower lobe subsegments. No endobronchial lesions noted. Then,*

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**Report E/M Encounter Despite ‘Likely’ Diagnosis**

**Question 3:** A new patient reported to our office complaining of wheezing and shortness of breath. The physician performed a level-four E/M, and then ordered spirometry with graphic record (we own the equipment, and the test was performed and interpreted in-house). Encounter notes describe “likely” emphysema, though the spirometry would not be expected to confirm it. How should I handle the diagnosis coding here? Should I wait for a definitive diagnosis before coding this claim?

**Answer 3:** Just because the encounter resulted in an inconclusive diagnosis, doesn’t mean you cannot report — and be paid for — the physician’s services. Just make sure the documentation supports the patient’s presenting symptoms.

ICD-9-CM coding guidelines (Section I.B.6. and Section IV.E) state, “Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.”

**What this means:** If the doctor does not confirm emphysema, do not consider reporting any emphysema diagnoses. If the patient comes back for further testing that does reveal emphysema, then you can report an emphysema diagnosis. Instead, you’ll probably look to 786.05 (*Shortness of breath*) and 786.07 (*Wheezing*).
under fluoroscopic guidance, the scope was wedged in the right upper lobe and posterior subsegment, and the area corresponding to the lung nodule was noted on fluoroscopy, and transbronchial biopsy was performed four times under fluoroscopic guidance. Again, under fluoroscopic guidance, the physician performed cytology brushing twice, and bronchoalveolar lavage (BAL) on the same area (sent for path and cyto and culture and sensitivity). We billed 31623, 31624 and 31628, 31632x3 but the payer denied 31632x3. What did we do wrong? What do we report?

Illinois Subscriber

**You Be the Coder**

Medicare Covers PFT Technical Component — But With Limitations

*(Question on page 84)*

**Answer:**

Pulmonary function test (PFT) claims without interpretation is acceptable for Medicare — as long as you’re billing services with modifier TC (Technical component). However, be sure to accomplish physician interpretation (by a member of your group, or via arrangement with another physician group) within a reasonable amount of time (i.e., 48 to 72 hours) to ensure that clinical and quality of care guidelines are met.

**Tip:** Don’t forget that when component coding occurs for PFTs, the location of the testing plays a part in how you code these tests.

**Example:** A technologist in an outpatient hospital PFT lab performs respiratory flow volume test (94375, Respiratory flow volume loop). The lab should report 94375 appended by modifier TC to describe the technical component of the service. On the other hand, the physician who will provide the interpretation of the test should be sure to report the same code (94375) appended by modifier 26 (Professional component). The place of service for the interpretation should match the location in which the testing occurred (outpatient hospital), even if the physician typically practices in a private setting (such as the physician’s office) since the interpretation was provided for a test that was performed in a facility setting.

BAL with 31624 (…with bronchial alveolar lavage), while you could capture the transbronchial biopsy with 31628 (…with transbronchial lung biopsy[s], single lobe). Despite having biopsied four times, the physician should only report 31628 since all of the biopsies took place in the same lobe. Reserve code 31632 (…with transbronchial lung biopsy[s], each additional lobe [List separately in addition to code for primary procedure]) for transbronchial biopsies that occur in each lobe that is different from the primary lobe biopsied.

Submit Your Medicare Enrollment Revalidation Before March 2013

**Question:**

What does CMS’s policy on revalidation of provider enrollment information imply?

South Carolina Subscriber

**Answer:**

Under this policy, providers and suppliers who enrolled in Medicare before Mar. 25, 2011 must revalidate their enrollment information between now and Mar. 23, 2013. The Center for Medicare and Medicaid Services (CMS) specifically states that this must be done only after receiving notification from their Medicare administrative contractor (MAC) (see CMS SE1126 at http://www.cms.gov/MLNMattersArticles/downloads/SE1126.pdf.)

Wait for notices sent out by your MACs to begin your revalidation process.

Designate Place Of Service Codes With Appropriate NPI

**Question:**

What POS should we use when our physician does interpretations of sleep studies for various hospitals around our area? He is not actually at their location to do the interpretations — can be at our office, at home, another hospital, etc.

Hawaii Subscriber

**Answer:**

The location for the interpretation should match the location in which the testing was performed. The interpreting physician would report the same place of service in which the testing occurred (e.g., in an outpatient hospital setting, you should use the “22” code). The interpreting physician can report his/her service with modifier 26 under his corresponding NPI, and the facility would report the technical portion with modifier TC under their corresponding NPI.

Clinical and coding expertise for this issue are provided by Carol Pohlig, BSN, RN, CPC, ACS, senior coding and education specialist at the University of Pennsylvania Department of Medicine in Philadelphia.
We would love to hear from you. Please send your comments, questions, tips, cases, and suggestions for articles related to Pulmonology coding and reimbursement to the Editor indicated below.

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