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Editor’s Letter

Welcome to the spring issue of the Coding and Billing Quarterly Newsletter. Spring will forever remind us of the onset of the COVID-19 pandemic, now three years out. Thankfully we are at a new phase in which COVID-19 is no longer surging and we are learning to live with it. We are now tasked with unwinding from the Public Health Emergency (PHE), and we have included information to assist you and your practices as this unfolds.

The most substantial regulatory changes that we are wrestling with are the changes that CMS instituted this year for critical care services. CPT code **99292** is now reportable after the 104th (not 75th) minute, for “additional 30-min increments.” CMS called this a “technical correction” and not a change in policy. We categorically disagree. ATS and multiple other societies sent comments to CMS with our concerns about this change in the proposed rule.

Unfortunately, CMS did not change their opinion in the final rule, and in fact said that they are aware that this is different from the billing guidance published by CPT. To say we are disappointed would be a gross understatement as this is counter to how critical care services have been defined since 2005. The only bright side is that, according to 2021 Medicare claims data, approximately 90 percent of roughly 6.6 million claims are billed using **99291** alone with only 10 percent utilizing **99292**. ATS is partnering with other specialties that are frequent users of the critical care codes to modify or create new CPT codes for critical care services. We also hope this will allow us to survey our members to provide data that will support modified values for critical care services. This is a process and will take time. Please be assured that we are working hard on behalf of our membership. We will provide updates as they come in future editions of this newsletter.

For those of you who missed the Joint ATS/CHEST webinar on the final Medicare reimbursement policy for 2023, the webinar can be found on the ATS website [here](#). The webinar is about an hour long and includes presentations on:

- Amy Ahasic, MD - 2023 Conversion Factor, Critical Care Billing, Split/Shared E/M Billing
- Laure Frye, MD - Coding & Billing for Pulmonary Procedures
- Omar Hussain, DO - Telemedicine & Ending of Public Health Emergency

For this issue of ATS Coding and Billing Quarterly, we cover a number of topics of interest to pulmonary, critical care and sleep providers including implications of unwinding the COVID PHE, documentation tips for interventional pulmonary procedures, report on a private insurance coverage win for electromagnetic navigational bronchoscopy, and coding and billing Q & As submitted by ATS members. As always, I encourage you to send your coding and billing questions to: codingquestions@thoracic.org.

Katina Nicolacakis, MD
 Editor, ATS Coding & Billing Quarterly

ATS, CHEST and AABIP United to Advocate for Navigational Bronchoscopy (NB) Coverage

Gary Ewart, MHS

The ATS, CHEST and the American Association of Bronchology and Interventional Pulmonology recently met with private health insurance company Elevance (formerly Anthem) to discuss their coverage policy for navigational bronchoscopy (NB). For years, Elevance considered navigational bronchoscopy “experimental” and did not provide routine coverage for NB.

For years, Medicare has covered NB for appropriate patients, but private insurers have been much slower in adopting NB coverage policies.

The ATS, in collaboration with colleagues at CHEST and AABIP, held meetings with Elevance coverage staff to discuss the limits of the coverage policy, reviewed recent studies documenting the safety and efficacy of NB and patient selection criteria for appropriate NB use. We followed up our meeting with written comments. As a result of joint society advocacy, Elevance has updated their policy to cover NB. Specifically, the updated Elevance policy states;

Navigational bronchoscopy is considered medically necessary for the following indications (A or B):

- In individuals for whom nonsurgical biopsy is indicated when both transthoracic needle biopsy and conventional bronchoscopy are considered inadequate to accomplish the diagnostic or interventional objective; or
- For the pre-treatment placement of fiducial markers within lung tumor(s).

Not Medically Necessary:

- Navigational bronchoscopy is considered not medically necessary for all other indications.

Joint ATS/CHEST Clinical Practice Committee member Raj Desai, MD, noted, “While it might not work every time, it does show that good data, combined with a united voice from the provider community can lead to improvements in private health insurance coverage.”

ATS Member Omar Hussain DO Elected to AMA RUC Committee

Gary Ewart, MHS

Omar Hussain, DO, co-chair of the Joint ATS/CHEST Clinical Practice Committee was recently elected to serve on the AMA/ Specialty Society Relative Value Scale Update Committee (better known as AMA RUC). The AMA RUC Committee plays a pivotal role in recommending physician work and practice expense values for the entire family of CPT codes used by the physician community to bill for professional services.

The AMA RUC Committee is an expert panel convened by AMA that is charged with ensuring the appropriate relativity of the entire CPT coding system. The AMA RUC committee makes recommendations to CMS on the value of new and revised CPT codes. Further AMA RUC will periodically review existing CPT codes to capture changes in physician practices and ensure overall appropriate relativity of the entire CPT family of codes.

The value of each CPT code is based on three building blocks:

Physician work – this a measure of time, intensity, medical decision-making, and risk of the service physicians provide. While varying by procedure, physician work is typically about 50 percent of the value of a CPT code.

Practice expense – this captures the inputs that are required to provide a physician service including direct costs (such as sutures and gauze used in stitching up a wound) and indirect costs (such rent, utilities, support staff needed). While varying by procedure, practice expenses are typically 48 percent of the value of a CPT code.

Medical malpractice – this captures the malpractice insurance costs attributed to a CPT procedure. While varying by procedure and specialty, medical malpractice costs typically are one to two percent of a CPT code.

The AMA RUC Committee reviews physician work, practice expense and medical practice data collected by medical specialties and makes recommendations to CMS on how to incorporate these data in the CPT relative values that translate into physician reimbursement. Private payers also use the CPT system to reimburse physicians, making the work of the AMA RUC Committee a pivotal point of impact for both Medicare and private payer physician reimbursement.

“Having Omar serve on the committee is a win for the pulmonary, critical care and sleep community,” says ATS President Greg Downey, MD. “His presence on the AMA RUC will ensure our community has strong representation when AMA and CMS are making decisions that directly impact reimbursement for pulmonary, critical care and sleep physician services. I am grateful to Omar for the time and effort in representing our members on the AMA RUC Committee.”

“I am joining the AMA RUC Committee at an interesting time,” notes Dr. Hussain. “In the near future, the AMA RUC Committee will be making recommendations on key CPT issues that impact pulmonary, critical and sleep providers and the entire field of medicine, including CPT values for telemedicine services, potential changes to critical care codes and valuations of evaluation and management (E/M) family codes. I look forward to using my expertise as a pulmonary, critical care and sleep medicine provider to serve the best interests of the entire physician community in our shared goal of providing superior patient care.”

Vaccine Coding

Omar Hussain, DO

If you are a healthcare provider or organization that is interested in administering the COVID-19 vaccines, you may be eligible for reimbursement through several programs. Here are some steps you can take to get reimbursed¹:

1. Enroll as a COVID-19 Vaccination Provider: Vaccine is being made available for emergency use exclusively through the CDC COVID-19 Vaccination Program. Healthcare providers must enroll as providers in the Vaccination Program and comply with the provider requirements¹.
2. Register with your state’s immunization program: Many states require enrollment in an automated immunization registry exchange. Many states also have their own immunization programs that offer reimbursement for COVID-19 vaccine administration. Contact your state health department to find out more about the reimbursement process and how to register.
3. Consider roster billing: If you’re enrolled in Medicare under the institutional (e.g. hospital, hospital outpatient department) or non-institutional (e.g. physician, clinic/group practice) provider types, you do not need to take any action to administer and bill the COVID-19 vaccine.² You can submit individual claims or roster bill. In order to roster bill, you must administer the same type of vaccine per roster claim to five or more people on the same date³. [Find](#) your Medicare Administrative Contractor (MAC) website to learn more about roster billing.

4. Use appropriate billing codes: When submitting claims for COVID-19 vaccine administration, use the appropriate billing codes. For example, the American Medical Association has released CPT codes for COVID-19 vaccine administration. [This link](#) can guide you.
5. Keep detailed records: Keep detailed records of all vaccine administration, including the date of service, the vaccine product name and the vaccine manufacturer. This information will be necessary when submitting reimbursement claims.
6. Submit claims in a timely manner: Make sure to submit claims for reimbursement in a timely manner to avoid delays or denials. Check with the specific program you are submitting claims to for their specific submission deadlines.

Medicare payment for COVID-19 vaccine shot is approximately \$40.⁴ It is important to note that reimbursement rates may vary depending on the program and the type of vaccine administered. Before submitting claims make sure to check with the specific program for their reimbursement rates and guidelines. Providers cannot charge patients a fee for administering COVID-19 vaccines. Providers cannot bill the recipient for the balance not covered by recipient’s plan or program⁵

References

1. <https://www.cdc.gov/vaccines/covid-19/provider-enrollment.html> (accessed March 20, 2023)
2. <https://www.cms.gov/medicare/covid-19/enrollment-administering-covid-19-vaccines> (accessed March 20, 2023)
3. <https://www.cms.gov/files/document/covid-19-vaccine-enrollment-scenario-1.pdf> (accessed March 20, 2023)
4. <https://www.cms.gov/medicare/covid-19/medicare-covid-19-vaccine-shot-payment> (accessed March 20, 2023)
5. <https://www.cdc.gov/vaccines/covid-19/vaccine-providers-faq.html> (accessed March 20, 2023)

Ending of the Public Health Emergency Creates Challenges for Patients and Providers

Gary Ewart, MHS

President Biden has set an end date for the COVID Public Health Emergency (PHE) effective May 11, 2023. Initially declared by President Trump and subsequently continued by President Biden, the declaration of the PHE allowed the federal government to use emergency powers to respond to the COVID pandemic including emergency spending, waiving of certain federal regulatory requirements, expanding coverage policies for Medicaid and the

Childrens Health Insurance Program and implementation of a wide range of public health measures. The end of the PHE will mean that much of the expanded Medicaid coverage, waiving of copays for COVID related services, waiving of certain Medicare regulations, and COVID telehealth policies will eventually come to an end, but not necessarily right on May 11, 2023.

Please note that CMS is expected to share additional guidance on PHE unwinding in the very near future. The ATS will share additional information as soon as it is available.

What We Know

CMS has published guidance on how ending the PHE will impact Medicare and Medicaid beneficiaries. Much of the information below comes from the CMS guidance.

Medicare Vaccines: Medicare beneficiaries will continue to get COVID vaccines without cost-sharing after the expiration of the PHE.

Medicare COVID Tests: Beneficiaries in the traditional Medicare program will continue to receive COVID PCR and antigen tests without cost sharing when the test is ordered by a healthcare professional. Beneficiaries in Medicare Advantage Plans may have cost-sharing for COVID tests after the PHE has expired, though plans may choose to waive co-pays at their discretion. In general, access to free at home COVID testing will end for all the public when the PHE expires.

Medicaid & Childrens Health Insurance Program

Vaccines & Testing: Under current law, Medicaid and CHIP beneficiaries will continue to have free access to COVID testing, vaccines and treatment through Sept. 30, 2024. Starting Oct. 1, 2024, Medicaid and CHIP patients will continue to have access to free COVID vaccines, but coverage for testing and treatment will vary by state policy. During the COVID pandemic, 18 states used Medicaid to expand coverage to uninsured people for COVID vaccines, tests and treatment. COVID coverage for these people will end on May 11, 2023.

Private Health Insurance

Vaccines: Most private insurance will continue to cover COVID vaccines and, if provided by an in-network provider, will be covered without copays.

Testing: When the PHE ends May 11, 2023, mandatory coverage for COVID tests will end. Private plans that do cover COVID tests may require copays.

Access to Telehealth Services Medicare and Telehealth

By an act of Congress, Medicare beneficiaries will continue to have broad access to telehealth services through Dec. 31, 2024. Services include:

- Medicare beneficiaries can access telehealth services in any geographic area in the United States, rather than only in rural areas.
- Medicare will continue to allow audio-only visits (such as a telephone) for Medicare beneficiaries unable to use audio/visual technology.

Beneficiaries in Medicare Advantage and Accountable Care Organizations should check with their plans for details about telehealth services.

Medicare and Virtual Supervision – During the COVID PHE, CMS allowed treatment programs that required “direct supervision” to meet the supervision requirement by having supervising clinicians virtually available. Prior to the COVID PHE, direct supervision had to be provided in person. Virtual direct supervision was helpful in allowing pulmonary rehabilitation programs to continue to operate during the COVID pandemic. CMS will continue to allow virtual direct supervision through Dec. 31, 2023.

Virtual Pulmonary Rehabilitation – As noted above, virtual physician office-based pulmonary rehabilitation programs are extended through Dec. 31, 2024, but the waiver that allows the direct supervision to be met virtually expires Dec. 31, 2023. The ATS and colleague organizations have reached out to CMS to urge them to use their discretionary authority to extend the virtual direct supervision waiver through Dec. 31, 2024. The waiver to allow hospital-based virtual pulmonary rehabilitation program expires Dec. 31, 2023. The vast majority of pulmonary rehabilitation programs are hospital-based, so ending hospital-based pulmonary rehabilitation programs at the end of 2023 may cause significant access problems.

What We Don't Know

There are some questions about unwinding of the PHE that CMS has not yet addressed. During the PHE, CMS waived the requirement for annual re-testing of several DME products including supplemental oxygen, CPAP and BiPAP machines and other respiratory assist devices. The end of the PHE means all the devices currently being used by Medicare beneficiaries will need to be immediately retested, potentially requiring thousands of office visits to conduct equipment retesting.

In collaboration with colleague respiratory organizations, the ATS sent a letter to CMS urging the agency to triage which Medicare beneficiaries receiving supplemental oxygen or other respiratory assist devices would need retesting.

What Happens Next?

ATS and colleague organizations will continue to urge CMS to use its administrative authority to address retesting issues and to harmonize virtual supervision for physician office-based pulmonary rehabilitation programs. CMS does not have the administrative authority to allow hospital-based pulmonary rehabilitation programs to continue to provide virtual pulmonary rehabilitation services. Only Congress has that authority. The pivot to telemedicine during the pandemic is forcing policymakers to rethink the role of telemedicine in the U.S. health system. Legislation has been introduced to widely expand Medicare coverage of telehealth services, including hospital-based pulmonary rehabilitation programs. The ATS will continue to advocate for pulmonary rehabilitation as Congress considers the larger issue of telemedicine nationally.

While the ending of the PHE is largely a federal issue, it impacts state policy, too. To facilitate medical care during COVID, many states waived state requirements that limited telehealth services to physician licensed in their state. This allowed providers to give care across state lines. Whether states return to the previous policy or continue to allow telemedicine services to be provided by out-of-state providers remains to be seen.

Bronchoscopy Question

Question: A bronchoscopy procedure with biopsy on the right lung and then EBUS done on the left lung with transbronchial aspirations in mediastinal and hilar lymph node stations as well as trachea and main stem. Is it possible to bill **31625** for bronchoscopy done on right lung with transbronchial aspirate on 4R, **31629** for aspirations done on paratracheal mass and **31653** for EBUS?

Answer: The enclosed description describes endobronchial ultrasound guided transbronchial needle aspiration at three locations. The code for this is **31653** (EBUS TBNA of three or more locations).

Additional information: If there were endobronchial biopsies (not in description) then **31625** would be used no matter how many sites.

If there were needle aspirations without ultrasound (also not in description), **31629** would be used for one node or lesion. Each additional needle site in other regional locations would get **31633**.

CPT Codes	Long descriptors
31652	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; 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	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; 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
31625	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites
31629	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)
31633	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), each additional lobe (List separately in addition to code for primary procedure)
31628	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe
31632	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), each additional lobe (List separately in addition to code for primary procedure)

For transbronchial biopsies, biopsies of lung or lesions that traverse the airway path to get to the lesion (not in description), **31628** for first lobe and **31632** for each additional lobe.

Additional Resources

- Desai NR et al. Advanced Diagnostic and Therapeutic Bronchoscopy: Technology and Reimbursement. *Chest*. 2021 Feb 11;S0012-3692(21)00267-1.
- Gildea, TR; Nicolacakis K. *Chest*. 2016;150(6):1387-1393

Critical Care Questions

Question: CMS has changed when we can bill for **99292** to more than 104 minutes. Do we follow this or the definition we have used for years, which is in the CPT book for **99292**?

Answer: **+99292** Critical Care each additional 30 minutes has been historically billed after 74 minutes of critical care. (See Editor's Letter). In 2023, CMS has now changed the definition for when a **99292** may be reported, and we must complete an additional 30 minutes, or meet at least 104 minutes before reporting the **99292**. Claims to Medicare must meet these requirements. We advise checking with your institution to see how they are handling non-Medicare payers. It is unclear if they will pay more than CMS, and many institutions have decided to submit all claims with the new CMS guidance.

Question: The coding/billing department at my employer is telling me and my pulmonary/critical care group that most of our ICU patients that we see do not qualify for critical care billing (i.e. **99291** and **99292**). They are telling us that once the patient is stabilized on the ventilator, drips (including vasopressors), and/or even on ECMO, then the patient no longer has a probability of imminent or life-threatening deterioration. Hence, the encounter should be billed as a **99233**. I am baffled by this reasoning and do not agree. What guidance can you provide me and my group regarding billing for critical care time?

Answer: This is a question that comes back periodically and may lead to confusion among coders and critical care providers alike. There are several things to remember when documenting critically ill patients whose status may not change day to day. Remember to document that there is evidence of threat or imminent deterioration and indication that continued critical care is required to prevent further deterioration. Even if the critical care services provided do not change day to day, your documentation should reflect that the patient persistently requires that level of support. Avoid using the word "stable" as this may be confusing to coders and opt for words like "consistently requiring" or "persistently" instead. Always remember to document your critical care time. ●

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