

# PULMONOLOGY CODING ALERT

The practical adviser for ethically optimizing coding reimbursement and efficiency in pulmonology practices

2008, Vol. 9, No. 6 (Pages 41-48)

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## Check for 2 Crucial Details to Land the Correct Thoracentesis Code

### ▶ **Clue: A catheter tells you therapeutic instead of diagnostic**

Patients who develop pleural effusions often require a thoracentesis to diagnose or treat the condition. If you fail to identify the procedure and equipment, you could end up selecting 32421, rather than 32422 — a difference of about \$38 per procedure.

Look for these clues to submit your thoracentesis claims correctly.

## Syringe Use Is a Factor in 32421 Claims

For some patients with a pleural effusion, the pulmonologist will need to obtain a small sample of pleural fluid for analysis. “The physician may be able to determine the cause of the pleural effusion after lab analysis of the fluid,” says **Carol Pohlig, BSN, RN, CPC, ACS**, senior coding and education specialist at the University of Pennsylvania department of medicine in Philadelphia.

When the pulmonologist performs a thoracentesis by withdrawing fluid through a needle connected to a syringe to diagnose the patient’s condition, you’ll report the service with 32421 (*Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent*), says **Pierre Edde, MD**, head of the pulmonology/critical care/sleep division at Pennsylvania’s Uniontown Hospital.

“The physician performs the procedure to obtain a sample of fluid to make the diagnosis,” Edde says. The physician will send the patient’s sample to the laboratory, which will determine whether the fluid is transudative (usually due to increased hydrostatic pressure from cardiac, liver or renal failure) or exudative (usually from pleural involvement from pneumonia, malignancy, connective tissue diseases, etc.).

**Example:** An established patient with shortness of breath reports to the office. The pulmonologist obtains pertinent historical information and performs an exam, including auscultation of the lungs, which sound muffled. He then taps on the patient’s chest and notes a dull “thud.” A chest x-ray confirms the presence of a pleural effusion.

Office notes substantiate a level-four E/M. Based on the evaluation, the pulmonologist decides to perform a diagnostic thoracentesis. After the patient is prepped, pleural fluid is withdrawn through a needle into a syringe and sent to the laboratory for analysis. The results indicate the presence of an exudative pleural effusion.

This is an example of diagnostic thoracentesis. On the claim, you should report the following:

- 32421 for the thoracentesis
- 511.9 (*Unspecified pleural effusion*) linked to 32421 to represent the pleural effusion
  - 99214 (*Office or other outpatient visit for the E/M of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision-making of moderate complexity*) for the E/M
    - modifier 25 (*Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service*) linked to 99214 to show that the E/M and thoracentesis are separate services
      - 786.05 (*Shortness of breath*) linked to 99214 to represent the patient's breathing difficulty.
      - 71020 (*Radiologic examination, chest, two views, frontal and lateral*) for the x-ray
      - 511.9 linked to 71020 to represent the effusion.

## Tube Placement Marks 32422 Service

When the pulmonologist performs a thoracentesis using a small catheter inserted over or through a needle for diagnostic or therapeutic purposes, you'll code the service with 32422 (*Thoracentesis with insertion of tube, includes water seal [e.g., for pneumothorax], when performed [separate procedure]*), Edde says.

According to Edde, the pulmonologist may perform a therapeutic thoracentesis to:

- relieve symptoms (such as shortness of breath or pain)
- reverse atelectasis/collapse (a condition the effusion can cause, which can result in pneumonia)
- improve oxygenation or pulmonary function/reserve (often caused by the atelectasis/collapse).

**Example:** A patient with a malignant effusion due to lung cancer requires a thoracentesis to help relieve dyspnea. During the procedure, the physician uses a thoracentesis kit containing a catheter over a needle to withdraw the maximum amount of pleural fluid.

In this instance, report 32422 for the thoracentesis. Link 511.9 (*Unspecified pleural effusion*) and 162.9 (*Malignant neoplasm of trachea, bronchus and lung; unspecified*) to 32422 to represent the patient's malignant effusion and cancer.

## Notes Can Light the Way Toward Proper Code

For patients who receive a thoracentesis, the medical record should describe clearly how the pulmonologist removed the fluid and which equipment he used. This information will help you choose the correct code.

### CONTACT INFORMATION

We would love to hear from you. Please send your comments, questions, tips, cases and suggestions for articles related to pulmonology coding, reimbursement or compliance to Chris Boucher at [chrisb@eliresearch.com](mailto:chrisb@eliresearch.com).

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*Pulmonology Coding Alert* (ISSN 1529-6121) (USPS # 019-442) is published monthly by The Coding Institute, a subsidiary of Eli Research, 2222 Sedwick Road, Durham, NC 27713. © 2008 The Coding Institute. All rights reserved. Subscription price is \$347. Periodicals postage is paid at Durham, NC, 27705 and additional entry offices. POSTMASTER: Send address changes to *Pulmonology Coding Alert* PO Box 413006, Naples, FL 34101-3006.

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**In short:** If the pulmonologist uses a syringe and needle during the procedure, but does not insert a catheter, it is a 32421 service, Edde says. If the pulmonologist inserts a catheter in the pleural cavity, the encounter is a 32422 service.

**Code 32421 example:** The pulmonologist inserts a needle in the patient's pleural cavity and obtains a syringe full of fluid, which he sends to the laboratory for analysis.

**Code 32422 example:** The pulmonologist inserts a catheter over a needle into the pleural cavity, withdraws the needle, and drains the pleural fluid. The catheter remains in place until the procedure is over when the physician removes it.

**Reimbursement:** The average amount you'll receive for 32422 is \$204.15 (5.36 RVUs x 38.0870 Medicare conversion rate). The 32421 code averages about \$165.68 (4.35 RVUs x 38.0870).

## Look for Separately Reportable Services

In addition to a possible E/M service, be on the lookout for two other separately reportable services. According to Pohlig, you may be able to report these procedures separately when the physician performs them during thoracentesis:

- 71020 — *Radiologic examination, chest, two views, frontal and lateral*
- 76942 — *Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation.*

**Exception:** Only one provider can report a chest x-ray. Therefore, in most facility settings, the radiologist will provide the formal report of interpretation and code for the chest x-ray. This precludes the pulmonologist from billing for the service.

**Example:** The pulmonologist meets a patient at the hospital. He performs diagnostic thoracentesis using a catheter with ultrasound guidance. On the claim, report the following:

- 32422 for the thoracentesis
- 76942 for the ultrasound guidance
- modifier 26 (*Professional component*) appended to 76942 to show that you are billing only the code's professional portion. □

## Net 15 Percent More on Some E/Ms With Shared Visits

### ► *NPP, pulmonologist can team up for certain hospital services*

In the office setting, incident-to billing is a vital cog in the practice's reimbursement machine: Under incident-to rules, qualified nonphysician practitioners (NPPs) can treat certain patients and still bill the visit under the physician's National Provider Identifier (NPI).

The hospital setting, however, is a different story. "There is no incident-to billing in the hospital," says **Mary Falbo, CPC**, president of Millennium Healthcare Consulting Inc. in Lansdale, Pa. "But shared/split visit billing is an option."

Shared visit billing is not exactly incident-to, but it is a way to bill for services that are provided jointly by the pulmonologist and a qualified NPP. If the encounter meets shared visit guidelines, you'll be able to report the entire visit under the pulmonologist's NPI — thereby garnering you 15 percent more pay for the same service.

**How?** Pulmonologists receive 100 percent of the Medicare allowable when services are reported under their own NPI. If you report the same service under the NPPs NPI, the reimbursement is set at 85 percent of the Medicare allowable.

*(Continued on next page)*

## You Be the Coder

### Coding CPAP Initiation, Follow-Up Visits

**Question:** *Our practice treats many patients with sleep apnea. We give out take-home continuous positive airway pressure (CPAP) machines to some of them. Recently, an established patient with primary central sleep apnea reported to the pulmonologist. After a level-two E/M, the physician performed CPAP initiation and sent the patient home with the machine. A week later, the same patient reported to the office, and a nurse practitioner (NP) adjusted the pressure settings on the machine. Is this follow-up visit codeable?*

Wisconsin Subscriber

**Answer:** See page 46. □

## 'Face Time' Is a Must When Using Physician's NPI

Remember that the shared visit billing rules apply to Medicare and those commercial insurers that follow Medicare rules. You shouldn't report shared visits to private insurers before making sure they allow payment for shared visits.

**In a nutshell:** According to **Suzan Hvizdash, CPC, CPC-E/M, CPC-EDS**, physician educator for the University of Pittsburgh and past member of the American Academy of Professional Coders National Advisory Board, here's how the typical shared visit works:

- The NPP visits and examines a patient. The NPP documents her work establishing medical necessity.
- At a different time, the pulmonologist sees the patient and documents his work. This can be immediately after or even before the NPP's visit, but it "has to be on the same day," Hvizdash says.
- Then, you can add the documentation together to establish a billing level, Hvizdash said during *The Coding Institute* audioconference "9 Revenue-Boosting Billing Strategies for Incident-To Services."

**Benefit:** In many shared visits, the NPP conducts the preliminary interview and exam and then the pulmonologist sees the patient. This allows the pulmonologist to focus more on the medical problem and less on the other visit components.

To bill a shared visit under the physician's NPI, he must provide and document a face-to-face service for the patient. "Physicians must perform at least a portion of the E/M service that involves contact with the patient. General oversight, such as reviewing the medical record, is insufficient," according to the American College of Physicians Web site.

Ideally, you'll bill a shared visit under the pulmonologist's NPI, but you could also bill a shared visit under the NPP's NPI.

**When?** "There might be instances in which the MD's note may not include the face-to-face encounter that is required. Maybe he only writes that he 'looked at the CT scan and made recommendations,'" Hvizdash said.

Because the note Hvizdash described doesn't fully illustrate the pulmonologist's contact with the patient, you should bill this visit under the NPP's NPI. Shared billing is an option for only select hospital E/M services, including ED E/Ms (99281-99285); you cannot bill shared visits for consultations or critical care, Hvizdash said.

## Make Sure Physician Is Available

Under shared visit rules, the NPP can treat patients in the hospital in accordance with the scope of practice and hospital privileges granted.

Hvizdash offers this example: An advanced registered nurse practitioner (ARNP) makes rounds in the morning and visits a hospital inpatient with chronic obstructive bronchitis who has an episode of acute bronchitis (the patient was admitted the day before). The ARNP writes a detailed note of the patient's condition (including the history and exam elements gleaned during the visit) and the recommendations. The ARNP also notes in the patient file that the pulmonologist will be in later that day.

A few hours later, the pulmonologist and the ARNP visit the same patient together. The pulmonologist performs an exam, gathers history, reviews the data and makes recommendations. The pulmonologist details the findings in the chart, and links her note to the ARNP's note from earlier in the day. The compiled notes substantiate a level-two hospital care service.

"Combined, these two notes can now stand as evidence toward the billed level of service selected," Hvizdash said.

For this claim, you would report 99232 (*Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: an expanded problem-focused interval history; an expanded problem-focused examination; medical decision-making of moderate complexity*) for the shared visit.

Remember to append 491.22 (*Obstructive chronic bronchitis; with acute bronchitis*) to 99232 to represent the

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\* *Doc Says 4: How to Get Levels in Line*, on May 14 at 1 pm ET, presented by Jennifer Godreau, BA, CPC

\* *Bronchoscopies: Smart Diagnostic and Surgical Coding*, on June 3 at 11 am, by Becky Zellmer, CPC, CBCS, MBS

\* *Breathe Easy: Pulmonary Tests Coding Simplified*, on June 8, given by Denae M. Merrill, CPC-E/M

patient's chronic bronchitis complicated by an acute bronchitis episode.

**Benefit:** "The bill would go out under the physician's NPI, and the reimbursement would be at 100 percent of the fee schedule amount," Hvizdash said.

## Show Service Links in Documentation

Your documentation must support the level of E/M service you are coding for, or Medicare could deny your shared visit claim.

"Documentation should offer specific details [about both encounters] and physician input," says **Alan L. Plummer, MD**, professor of medicine, Division of Pulmonary, Allergy, and Critical Care at Emory University

### **Bronchoscopy Lingo Cheat Sheet** **LIVE Audioconference**

Pulmonology coding is full of nuances and special coding circumstances, particularly in the field of bronchoscopies. For example, was the procedure diagnostic, therapeutic or surgical in nature? And how can you tell from the op note? You probably also run into questions regarding modifiers, bundling and multiple procedures.

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School of Medicine in Atlanta. When submitting your shared service claims, be sure that you remember to:

- clearly identify both providers in the medical record
- link the pulmonologist's encounter note to the NPP's note
- include legible signatures from the pulmonologist and the NPP.

**Caution:** Your documentation must prove the pulmonologist provided at least one element of the encounter for you to bill a shared visit under the physician's NPI, Hvizdash said.

**Example:** To support physician review, Plummer says, the physician could note, "I interviewed and examined the patient. I discussed the patient's data and findings with the NPP, and I agree with the NPP's findings, assessment and plans." □

### **CCI 14.1 Update:**

## **Time Is of the Essence on Inhalation Codes**

### **► New bundles also affect ECG/apnea recording encounters**

No fooling: The new Correct Coding Initiative (CCI) went in effect April 1, and it contains bundles for continuous inhalation treatment — as well as one for pediatric apnea monitoring and some new facility E/M edits. Read on to find out what the experts say about when you can break these bundles — and when you need to let them be.

### **Choose 94640 or 94644 — not Both**

Beware of one new bundle when coding inhalation treatments. You should not report an individual inhalation treatment, such as with a nebulizer, in addition to continuous inhalation treatment

CCI makes inhalation treatment code 94640 (*Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes [e.g., with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device]*) a component of the

*(Continued on next page)*

more extensive code 94644 (*Continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour*).

**Warning:** The edits do not allow you to override the bundle under any circumstances. Choose the correct code based on time following these guidelines:

- Use 94640 for intermittent inhalation treatment of less than 1 hour.
- Restrict 94644 only to procedures lasting at least 60 minutes, according to Medical Learning Inc.'s respiratory compliance experts.

## Code ECG Only When It's Unrelated to Monitoring

How many medicine codes should you report if your pulmonologist interprets results from an electrocardiogram (ECG) and pediatric home apnea monitoring recording?

### You Be the Coder

#### Coding CPAP Initiation, Follow-Up Visits

**Answer:** You can code the follow-up visit separately, but you cannot report an E/M service along with CPAP initiation. Check out this coding advice, which is split to reflect the separate encounters:

**Encounter 1:** On the claim, report the following:

- 94660 (*Continuous positive airway pressure ventilation [CPAP], initiation and management*) for the initiation
- 327.21 (*Primary central sleep apnea*) linked to 94660 to represent the patient's condition.

**Encounter 2:** On the claim, report the following:

- 94660 for the CPAP management
- 327.21 linked to 94660 to represent the patient's condition.

**Choose E/M or 94660:** The reimbursement for 94660 is higher than it is for a level-two office visit. For the initial encounter, you can code either 94660 or 99212 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem-focused history; a problem-focused examination; straightforward medical decision-making*) — but do not code both. □

The answer is one, CCI 14.1 says. Pediatric home apnea monitoring (94774-94777) also includes a related ECG (93000-93010).

Code 94774-94777 bundles also apply to telephonic transmission (93012-93014), ECG rhythm strips (93040-93042), pediatric pneumogram (94772), and sleep testing (95805).

The edits bring CMS in line with CPT. The AMA's *CPT Changes 2007: An Insider's View* states that "94774 includes attaching the monitor, downloading the data, reviewing and interpreting the data by a physician, and preparation of the report," says **Jill M. Young, CPC-ED, CPC-IM**, president of Young Medical Consulting LLC in East Lansing, Mich. "Any 'downloading of data' whether on-site or an electronic transmission would be included."

The edits have a 1 indicator, meaning if the physician orders the monitoring and the cardiovascular/pulmonary testing at different sessions, you can report the test code with modifier 59 (*Distinct procedural service*). □

### READER QUESTIONS

#### Use More Specific Quit-Smoking Codes

**Question:** *Sometimes we fret over the difficulty of getting paid for the numerous nonphysician counseling services our practice provides. I heard we'll have new smoking-cessation codes and won't have to report 99401-99404, 99411-99412, or 96150-96155. Is that true?*

Florida Subscriber

**Answer:** Yes. As of Jan. 1, you'll use 99406 (*Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes*) and 99407 (*... intensive, greater than 10 minutes*) when your pulmonologist provides smoking-cessation counseling.

**Notice:** The new codes are time-based. You'll use these two new codes rather than the generic counseling and/or risk factor reduction intervention codes (99401-99404, 99411-99412) for patients with no symptoms or established illness, or health and behavior assessment/intervention codes (96150-96155) for patients with disease-related problems.

Also, you should use the new codes rather than Medicare's G0375 (*Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up*

to 10 minutes) and G0376 (... intensive, greater than 10 minutes), which CPT converted into the new codes.

**Example:** A 21-year-old with worsening asthma visits the nurse for smoking-cessation assessment and returns in one month for intervention, beginning a cessation program. In 2008, if a payer doesn't cover 96150 (*Health and behavior assessment [e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires], each 15 minutes face-to-face with the patient; initial assessment*) and 96152 (*Health and behavior intervention, each 15 minutes, face-to-face; individual*) for this encounter, you could use a smoking-cessation counseling code based on time.

**Potential payer problem:** Insurers that do not cover this service will expect the patient to pay for it. Many patients do not realize this until they receive a bill for services. So you should brush up on payer policy before providing a patient with 96150 service — and let the patient know if his insurance won't cover it.

---

## Type of Scope Drives Laryngoscopy Coding

**Question:** *I am looking at a claim that shows the pulmonologist performed a laryngoscopy. Notes indicate that the pulmonologist removed a foreign body during the procedure. How should I code this encounter? There are codes for "rigid" and "flexible" laryngoscopies, and I don't know which one to choose.*

Minnesota Subscriber

**Answer:** Basically, you should report 31525 (*Laryngoscopy, direct, with or without tracheoscopy; diagnostic, except newborn*) when the pulmonologist uses a rigid scope for the procedure. If the pulmonologist uses a flexible scope, opt for 31575 (*Laryngoscopy, flexible fiberoptic; diagnostic*) instead.

Based on your pulmonologist's actions, she probably used a rigid scope for this particular laryngoscopy.

**Explanation:** The pulmonologist may use a rigid scope when it is necessary for the procedure (for example, removal of polyps or foreign bodies). She might also use the rigid scope when taking biopsies, performing laser surgery or checking the larynx for cancer.

When the rigid scope is not necessary, the pulmonologist will use a flexible scope because it allows better diagnostic views and tends to be easier on the

patient. Check the physician's notes for the encounter. The notes should make it pretty clear which type of laryngoscopy to code for. If the notes are not sufficient help, ask the pulmonologist.

---

## Exceed Inherent E/M for Separate Code

**Question:** *A nurse practitioner (NP) sees a 65-year-old established patient for a pneumonia vaccination. Before administering the vaccine, she takes a brief history, checks the patient's vital signs and rules out any contraindications for the vaccine. Can I report an E/M in addition to the vaccination codes?*

South Carolina Subscriber

**Answer:** Probably not. From your description of the NP's actions, she did not do much beyond providing the E/M service built into most CPT codes. For that reason, you should just report the vaccination codes. On the claim, report the following:

- 90732 (*Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use*) for the pneumonia vaccine
- 90471 (*Immunization administration [includes percutaneous, intradermal, subcutaneous, or intramuscular injections]; one vaccine [single or combination vaccine/toxoid]*) for the vaccine administration.

**Note:** For Medicare patients, and payers that observe Medicare rules, report G0009 (*Administration of pneumococcal vaccine*) for the vaccine administration rather than 90471.

- V03.82 (*Other specified vaccinations against single bacterial diseases; Streptococcus pneumoniae [pneumococcus]*) linked to 90732 and 90471 (or G0009) to prove medical necessity for the service.

**Explanation:** All CPT codes have an inherent E/M service (a brief patient assessment required before undergoing any type of procedural service) built into them. The E/M the NP provides the patient during the vaccination must go beyond this inherent E/M in order to justify a separate E/M code.

If you can identify a problem that the nurse assesses and separately treats (at the direction of the

*(Continued on next page)*

physician), you might be able to report an E/M service along with the immunization codes.



## Freeze at 327.xx ICD-9 Section for Sleep Paralysis

**Question:** *A new patient reports to the pulmonologist. He says that shortly after waking up in the morning, it is extremely difficult for him to move his arms and legs. The patient says this has been happening “off and on” for about three weeks. He also reports mild hallucinations during these times of “paralysis.” The pulmonologist diagnoses sleep paralysis during a level-four E/M. I have pored over the sleep disorder ICD-9 code set (327.xx) and cannot find a diagnosis. Should I code the patient’s symptoms?*

North Carolina Subscriber

**Answer:** There is an ICD-9 code for sleep paralysis. The proper code for this patient’s condition is 327.43 (*Recurrent isolated sleep paralysis*).

On the claim, append 327.43 to 99204 (*Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; medical decision-making of moderate complexity*).

— *Answers to You Be the Coder and Reader Questions were answered/ reviewed by Alan L. Plummer, MD, professor of medicine, Division of Pulmonary, Allergy, and Critical Care at Emory University School of Medicine in Atlanta; and Carol Pohlig, BSN, RN, CPC, ACS, senior coding and education specialist at the University of Pennsylvania department of medicine in Philadelphia.* □

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