Respiratory Review
Respiratory News that Matters to You.
Winter 2013

Physician Update

CMS has made some adjustments in the reporting rules and reimbursement for particular codes that could potentially have an impact on the bottom line of Physicians' practices in 2013 and the years to follow.

"Some CPT and HCPC codes pertaining to Pulmonary Rehab, Sleep Studies and Oximetry have been nominated for review according to NAMDRC."

Some CPT and HCPC codes pertaining to Pulmonary Rehab, Sleep Studies and Oximetry have been nominated for review according to NAMDRC. These codes include 95800 (unattended sleep study), 94762 (continuous overnight pulse oximetry) and G0424 (clinical labor for pulmonary rehabilitation services).

CMS is allowing 480 minutes (8 hours) of equipment time for the pulse oximetry recording (CPT code 94762). They are also in the process of adjusting the supplies and equipment prices associated with this service.

Now that pulmonary rehabilitation is considered a "covered benefit," CMS has received multiple comments in regards to the value of the code associated with the services. CMS has proposed to modify the direct practice labor expense to include an additional 15 minutes of time for the Respiratory Therapist according to the 2013 final rule.

This will increase the time allotted for the Respiratory Therapist services to 30 minutes total (code L042B). Several of the comments CMS received suggested that the therapist time be extended to 60 minutes but CMS feels that since pulmonary rehab services can be furnished in "group settings," 30 minutes is ample time allotted for the therapist. CMS also made the decision to delete the time allocated for the CORF social worker/psychologist.

The Physician Quality Reporting System (PQRS) uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals. The reporting is mandated by federal legislation.

According to the Affordable Care Act, a financial penalty will be applied in 2015 to physicians who do not report data on the PQRS quality measures appropriately. The reporting period will be from January 1, 2013 through December 31, 2013 for the 2015 penalty. Payment adjustment for 2015 will be a 1.5% reduction and in 2016 it will be a 2% reduction in the Medicare compensation.

A provider can choose to participate in the PQRS as an individual provider or as a part of a group practice (GPRO-Group Practice Reporting Option).

CMS defines a "group practice" as a single Tax Identification Number with two or more eligible professionals who have reassigned their billing rights to the Group TIN. CMS is hoping that by expanding this definition to include smaller groups in the GPRO there will be greater participation in PQRS.

Group practices have until October 15th of the year in which the group practice wishes to participate in the GPRO to self nominate and select its reporting mechanism. If the group practice chooses to participate in PQRS as a "group," the individual providers in the practice cannot participate in PQRS individually. If a group practice changes its TIN, at that time the providers within that group have the option to participate in PQRS individually.

If you need some assistance with knowing what to do to get started with PQRS, you can refer to the following website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/How_To_Get_Started.html

References: www.cms.gov Washington Watchline, December 2012, Vol. 22, No. 12, Pgs 2,4,5 & 6

WHAT'S INSIDE

Medicare Makes Changes to Oxygen LCD

Insuring proper documentation for payment of oxygen for Medicare beneficiaries has never been more challenging than lately. Audit rates for both physicians and HMEs are high and denials likely higher. To that end, CMS has recently posted what they are referring to as "clarifications" to the Oxygen LCD. There is now some consistency across all four of the DME/MAC Regions. This was previously not the case; especially in the defining of "chronic stable state."

There have been two oxygen policy updates in the last quarter. The first was effective 10/1/2012. The second takes effect 1/1/2013.

The October update highlights include:

A new clarification under exercise testing stipulates these tests cannot be performed unattended (Exercise testing must be performed in-person by a physician or other medical professional qualified to conduct exercise oximetry testing. Unsupervised or remotely supervised home exercise testing does not qualify as a valid test for purposes of Medicare reimbursement of home oxygen and oxygen equipment).

Another statement was added to the Home Oximetry Section: (Home sleep oximetry is limited solely to stand-alone overnight pulse oximetry performed in the beneficiary's home… Overnight oximetry performed as part of home sleep testing or as part of any other home testing is not considered to be eligible under this provision to be used for qualification for reimbursement of home oxygen and oxygen equipment even if the testing was performed in compliance with the requirements of this section.)

The October update also included the Standard Documentation language that is being incorporated in all LCD updates. This refers to the need to have "use and need" of oxygen documented by the attending prescriber at least annually.

The January 2013 update includes the following highlights:

Oxygen tests can be performed while the beneficiary is on oxygen, but must still meet Group I or II criteria.

All oxygen testing must be performed in-person by a physician or other medical professional qualified to conduct oximetry testing. With the exception of overnight oximetry, unsupervised or remotely supervised home testing does not qualify as a valid test.

Exercise testing requires 3 studies in the medical record: 1) at rest without oxygen; 2) during exercise without oxygen and 3) exercise with oxygen to demonstrate improvement. Oximetry after exercising while resting or "recovery" testing is not part of the three required tests and is not valid for determining eligibility. All 3 tests must be performed in the same session and unsupervised or remote testing does not qualify.

Overnight Sleep Oximietry can be performed in a facility or at home. All overnight oximetry studies require the beneficiary satisfy the requisite criteria for 5 minutes, but it does not have to be for 5 continuous minutes (with a minimum of 2 hours of recorded data).

When being tested for oxygen, in addition to being in a chronic stable state, the beneficiary must also have a severe lung disease, such as chronic obstructive pulmonary disease, diffuse interstitial lung disease, cystic fibrosis, bronchiectasis, widespread pulmonary neoplasm or hypoxia related symptoms or findings that might be expected to improve with oxygen therapy.

For beneficiaries with OSA, the OSA must be sufficiently treated such that the underlying severe lung disease is unmasked. This must be demonstrated before oxygen saturation results obtained during a polysomnography are considered qualifying for oxygen therapy.

Qualified data can only be obtained during a titration study (either split-night or stand-alone) that meets the following criteria:

- The study is conducted over a minimum of 2 hours;
- Where the AHI/RDI is reduced to less than or equal to 10 events per hour, or if the original AHI/RDI was already less than or equal to 10 events per hour the titration shows further reduction in AHI/RDI;
- Nocturnal oximetry for oxygen qualification purposes is only performed AFTER optimal PAP settings have been determined and the beneficiary is using the PAP at these settings, and
- SAT is less than or equal to 89% for 5 minutes (not necessary to be continuous).

By knowing these "clarifications" up front, the Physician office can enjoy some added efficiencies.

References:

This summary was provided by Andrea Stark of MiraVista, LLC. MiraVista offers reimbursement consulting and outsourced billing services to DME providers throughout the country.

Do You Know?

According to the Medicare LCD, what pulse oximetry tests must be performed with someone in attendance in order to qualify as a valid test?

Submit your answers to kriley@medgroup.com. All correct answerers will be submitted for a drawing for a $50 Amazon gift certificate!

Winner will be announced in the next issue of the Respiratory Review!

Last Issue's Winner

Candee Zicari LPN
Vero Beach, FL

Face-to-Face Expanded for DME

In November, The Centers for Medicare and Medicaid Services (CMS) published the 2013 Medicare Physician Fee Schedule Final Rule. Included among the many provisions and payment changes is the requirement that expands the list of DME items that require a face-to-face physician encounter and a written order prior to delivery. This new requirement becomes effective on July 1, 2013. This article highlights the major components of that requirement and provides examples to help physician practices incorporate these requirements into your patient appointment routine.

A face-to-face encounter is a needs assessment conducted by the treating medical professional for the medical condition that supports the need for the DME that is prescribed.
One face-to-face visit can support the need for multiple DME items so long as the encounter supports those multiple needs. This encounter must be documented in the patient's medical record. The medical record must include the evaluation of the patient, needs assessment, and medical condition/diagnoses that support the specific DME item. Examples can include patient history, physical examination, diagnostic tests, summary of findings, diagnoses, treatment plans or other information as appropriate relating to the ordered DME.

The face-to-face encounter may be conducted by a physician, physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS). Please note that when the face-to-face encounter is performed by a PA, NP or CNS, the overseeing physician must document the face-to-face encounter was performed by signing or cosigning the portion of the medical record that documents the face-to-face encounter. The physician can be compensated for this oversight with the new code G0454 that is also effective July 1, 2013.

The code is only billable when physicians do not bill an evaluation and management code for that same patient visit. If multiple written orders for covered items originate from a single face-to-face encounter, the physician can only receive the G-code payment once.

The face-to face visit must occur within the 6 month period prior to the ordering date of the DME. This is important because it provides a larger window of patient history to qualify for coverage. The face-to-face encounter cannot occur after the ordering date of the equipment. The requirement is effective for all affected DME ordered after July 1, 2013.

This new rule includes a written order requirement for all DME requiring the face-to-face. The physician's written order must include the following five components: patient's name, DME item being ordered, physician's NPI, date of order, and the signature of prescribing physician. Written order can include more information including diagnosis but must at minimum include the five components. This must be provided to DME provider before they can dispense the equipment to the patient. This is a significant change for those items that previously could be dispensed by a verbal order.

Not all DME equipment is affected by the new rule. CMS has shared a list of specific HCPCs that are included. This list includes items that currently require a detailed written order prior to delivery such as pressure reducing mattresses, wheelchair cushions, and seat lift mechanisms. The new rule has added items that cost more than $1,000 and also items that CMS believes are at risk for fraud and abuse. These new items include hospital beds, oxygen equipment, CPAP, manual wheelchairs/accessories, and nebulizers. For a complete list by HCPC, reference the following website: http://www.medtrade.com/news/manufacturer-provider/details?id=531.

Please note that this new rule does not include PMD (power mobility devices) because they already have their own specific face-to-face requirements of 45 days prior to delivery.

It is important that the face-to-face visit is aligned with the equipment being ordered. For example, if a patient visits Dr. Smith on June 1, 2013 for shortness of breath or other respiratory ailment and the medical records reflects this, then it is reasonable that this would support the order of a nebulizer assuming medical necessity coverage criteria are met. This encounter would not be sufficient for ordering DME such as a gel mattress pad or TENS device.

Many HMEs will be focused on updating their own policies and procedures in the first six months of 2013 to ensure that they are compliant with the new rule. This may include new order forms and other tools to make it easier for physician practices to comply with new requirement. DME suppliers must keep records of the written order and the face-to-face medical record supporting documentation provided by the physician. This documentation has to be available to CMS upon request for 7 years from the equipment date of service. Working together, physicians and DME providers can assure that patients continue to have access to the equipment and services that improve their quality of life and keep them at home where they want to be.

References: Cook, Emily J., Joan Polacheck, and Monica Wallace. "Overview of 2013 Final Rule on DME Written Order and Face-to-Face Encounter Requirements." JD Supra. 14 Nov. 2012. Web. <http://www.jdsupra.com/legalnews/overview-of-2013-final-rule-on-dme-writt-88450/>.

Baird, Jeffrey S. "Final Rule: DME Face-to-Face Requirement." Medtrade.com. 5 Nov. 2013. Web. <http://www.medtrade.com/news/manufacturer-provider/details?id=530>.

Cara, Bachenheimer. "National Industry Update: Crossroads for HME and Health Care in America." OAMES 32nd Annual Meeting & Exhibition. OAMES. Columbus, Ohio. 14 Nov. 2012. Lecture.

Payers Drive Diagnosing OSA to HST Model

In 2012, several commercial payers including Aetna, Humana and Wellpoint/Anthem began to require preauthorizations for in-lab (PSGT) also known as polysomnography.

Aetna's Clinical Policy Bulletin (#0004) states "sleep test for OSA should be performed through home sleep testing for clinically appropriate patients and may be more comfortable and reflective of the patients typical sleep patterns compared to a PSG." Other payers have also cited patient comfort and convenience as a factor for this policy change.

This is not news to many Sleep Physicians. Samuel T. Kuna, M.D., Chief of the Pulmonary, Critical Care and Sleep Section at the Philadelphia VA Medical Center, presented his research findings at the ATS 2010 International Conference. His findings demonstrated that those patients who performed sleep testing in their home showed similar improvements in daytime function as compared to patients who underwent overnight testing in a sleep center after three months of treatment with CPAP. Furthermore, patient adherence to CPAP over the first three months of treatment was similar in patients with OSA who received home versus in-lab testing.

Obstructive sleep apnea, a breathing disorder during sleep, is common, dangerous and relatively easy to treat, but expensive to diagnose. "These findings represent a possible turning point for both patients with sleep-disordered breathing and the clinicians who treat them," said Samuel T. Kuna. "One of the biggest and most insurmountable barriers to treatment is the need for overnight testing in a sleep laboratory. Our research suggests that this may no longer be a mandatory for diagnosis."

The researchers conducted a two-site study in which they randomized nearly 300 patients to undergo either standard in-laboratory sleep-testing or at-home testing.

"Proponents of in-laboratory testing argue that patients performing in-lab testing might have better outcomes than those performing home testing. For example, during in-lab testing, the patient spends a greater amount of time with a technologist who is able to educate the patient about OSA and CPAP and help the patient overcome any barriers to diagnosis and treatment that might arise during testing," said Dr. Kuna. "But our results did not find a difference between home versus in-lab testing in terms of clinical outcomes. The two management pathways appear to be equivalent in terms of patients' functional outcomes and ability to use CPAP treatment."

It is important that as Physicians look to adding HST to their practice offerings either via an IDTF or on their own, they ask for validation of performance. This can include clinical papers that validate the specificity and sensitivity for the HST device compared to the standard PSG.

References: "Clinical Policy Bulletin: Obstructive Sleep Apnea in Adults." Aetna.com. Aetna, 17 Oct. 2012. Web. <http://www.aetna.com/cpb/medical/data/1_99/0004.html>.

American Thoracic Society. (2010). At-Home Sleep Testing Equal to Overnight in a Sleep Lab in Treatment Results [Press release]. Retrieved from http://www.thoracic.org/media/press-releases/conference/articles/2010/sleep-testing-at-home.pdf.

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