Coding&BillingQuarterly

American Thoracic Society

In this Issue

Editor's Letter

Welcome to the next edition of the ATS Coding and Billing Quarterly. As I write this, we are in the fourth week of the federal government shutdown with no immediate solution in sight. For most physicians, in a federal shutdown, the first question is how will this affect my patients and my practice? The first impact providers will notice is the claims hold. All claims for Medicare services provided October 1st or later will not be processed by CMS and will be instead held for processing until after the federal government shutdown is resolved. Providers can continue to submit and CMS will receive claims, but no processing or payment will occur until federal funding is restored. I encourage you to visit the CMS website or visit your Medicare Administrative Contractor (MAC) website for updates on claims submission and processing during the shutdown.

The biggest challenge for the Medicare program is that authority to expand broad beneficiary access to telehealth services has expired. As you may recall, prior to the COVID-19 pandemic, Medicare telehealth services were limited to patients in rural areas. During the pandemic, Congress gave CMS temporary authority to expand Medicare telehealth services to all beneficiaries. Since the pandemic, Congress has extended that temporary authority for telehealth services but has not made coverage of telehealth services permanent. The temporary extension of Medicare telehealth services expired on Sept. 30, except for patients being treated for mental health or substance use disorders. The CMS website has more information on telehealth services during the shutdown.

It is expected that when Congress and the Administration reach a funding agreement, extension of the Medicare telehealth coverage will be included. Congress traditionally will restore Medicare coverage for any services provided during a federal shutdown, so it is likely, but not guaranteed, that Medicare telehealth services provided during the shutdown will eventually be paid by CMS. The federal shutdown has immediate impact on community health centers that rely on federal funding. Federal funding for most community health centers and federally qualified health clinics has expired and will likely create significant challenges for both providers who work at and patients who rely on these clinics for care.

My hope is that by the time you read this edition of the ATS Coding and Billing Quarterly, the shutdown will be over and Congress and the Administration will have reached a bipartisan agreement to provide yearlong funding to all federal programs. Let's hope Congress and the Administration do their job so we can keep doing ours.

Speaking of doing our job, this fall our jobs just got a bit harder as the Administration is changing the public discussion around the safety and efficacy of vaccines. In this edition, we try to summarize the current information on vaccine coverage for RSV and COVID-19 and provide some practical information to help this fall.

As always, we encourage you to submit coding and billing questions to codingquestions@thoracic.org.

Sincerely,
Katina Nicolacakis, MD
Editor, ATS Coding & Billing Quarterly

ATS/CHEST Response to the CMS Proposed Rules

In September, the ATS/CHEST Joint Clinical Practice Committee submitted our responses to the Centers for Medicare and Medicaid Services (CMS) CY2026 proposed payment policies under the Physician Fee Schedule (MPFS) and other changes to Part B payment and coverage policies. Below are some of the most relevant items on which we commented, although not a complete list of our comments.

1. **CPT 99291:** We yet again express our disappointment that CMS has not resolved what they termed a "technical correction" for CY2024 that required providers to deliver 105 minutes of critical care time before being able to report **99292.** We continue to believe this is an error that contradicts over 20 years of interpretation of time for billing CPT **99291** or **99292.** We will continue our advocacy around this important issue that affects appropriate reimbursement for critical care services.

2. **Conversion Factor (CF):** While we understand that CMS is bound by budget neutrality, we continue to be concerned about declining conversion factors which, when considering inflationary trends, mean very significant declines in overall reimbursement over the past several years. Currently, Congress has passed a one-time 2.5 percent increase for the CF which brings the overall increase in CF to 3.84 percent for CY2026. We appreciate the one-year legislative relief that will address the CF in CY2026, but we continue to call on CMS to work with Congress for a more durable long-term legislative solution to ensure appropriate inflation-adjusted payments.

3. **Efficiency Adjustment:** This year's proposed rule includes a decrease of 2.5 percent in work relative value units (wRVUs) and physician intraservice time of most MPFS services as an "efficiency adjustment" under the assumption that physicians have gained efficiency in providing services, and as a vehicle to reduce waste in spending. This affects almost 9,000 services with only 393 services exempted, including E/M, care management, and some telehealth services. We feel this arbitrary adjustment undermines the validity of the relative values established for these codes using the resource-based relative value system (RBRVS). While we certainly recognize the RBRVS is not a perfect system, its process already includes decreasing the wRVUs for increases in efficiency. contributes to ongoing deficits in reimbursement, and essentially neutralizes the effects of the one-time increase in CF. We do not agree with this efficiency adjustment and we urge CMS not to proceed with this unprecedented adjustment.

4. **Telehealth Services:** We support CMS's proposal to permanently remove frequency limitations for telehealth services including subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations. We also support CMS's proposal to permanently adopt a definition of direct supervision that allows real-time audio and visual interactive telecommunications (excluding audio-only) with the supervising qualified health care professional for services for which this is relevant.

5. **G2211 Add-on Code Utilization Correction:** We noted the significant overestimate of **G2211** utilization by the previous administration which contributed significantly to the reduction in the 2024 CF due to budget neutrality constraints. Thus, the creation of the **G2211** add-on code paradoxically contributed to decreased reimbursement for the specialties that it was intended to help. We urge CMS to correct these inflated utilization assumptions for **G2211** for CY2026 which could result in a $1B positive adjustment toward the CY2026 CF.

Advocacy continues to be a major part of the mission of the Joint ATS/CHEST Clinical Practice Committee. We continue to advocate on behalf of our members and their patients. We await the publication of the Final Rule which is expected in early November. Once the rule is out, the ATS and CHEST will hold a joint webinar to share key information from the final rules with members. Look for more information about the joint webinar in the near future.

National Coverage Determination (NCD) and Local Coverage Determination (LCD) – Explained

Robert DeMarco, MD

The myriad rules and regulations that govern the care of Medicare beneficiaries can be a major source of frustration for patient care providers. This frustration may be mitigated with a better understanding of the guidelines Medicare has in place to determine coverage.

The highest priority used in evaluation of any request is the National Coverage Determination (NCD). An NCD is a decision made by the Centers for Medicare & Medicaid Services (CMS) that determines whether a specific medical item or service is considered "reasonable and necessary" for Medicare coverage on a nationwide basis, outlining the criteria and limitations under which it will be paid for by Medicare across the country. At times, the NCD will state that coverage is reasonable and necessary, but the rules for coverage will be left to the local Medicare contractors. There are a number of these that cover the 50 states and U.S. territories. The rules developed by these contractors are called Local Coverage Determinations (LCDs).

An LCD is a decision made by a Medicare Administrative Contractor (MAC)* within a specific geographic area, determining whether a particular medical service or item is considered "reasonable and necessary" and therefore covered by Medicare within that jurisdiction; essentially, it outlines the criteria for when a service will be covered locally, based on the MAC's interpretation of Medicare guidelines, and is only applicable to patients within their region.

Rules and regulations outlined in NCDs and LCDs are not negotiable and must be followed unless it has been specifically stated that additional coverage will be granted based on the clinical aspects of the beneficiary's case, making it reasonable and necessary for that beneficiary. In these circumstances, the insurer may assess and determine coverage on an individual basis. There are also times that the NCD or LCD explicitly states that coverage may only be allowed for specific reasons, and all else will be denied as not reasonable and necessary. The insurer must follow Medicare prescribed conditions without ability to make its own determination.

There are many instances where Medicare is silent on a topic or has been vague in their coverage guidelines. In these cases, the insurer will decide the need for coverage. In January of 2024, Medicare mandated that all Medicare Advantage Providers have policies in place that will clearly outline how coverage will be decided. Thus, if Medicare has been silent or vague, coverage guidelines are available and listed on the insurer's website.

In summary, when requesting prior authorization, the NCD will first be reviewed. If this provides clear guidance, then no further review is needed. If the NCD is not specific, the LCD will be reviewed. Only if the LCD is insufficient will the insurer's coverage policy be used.

Should a provider request a service not covered by an NCD, LCD or insurer coverage policy, peer-reviewed medical literature, evidence-based clinical guidelines, or clinical decision support tools (e.g. UpToDate or MCG Care)may be used.

EXAMPLE: A provider orders a high frequency chest wall oscillation vest for a patient with a productive cough. The patient has severe chronic bronchitis with recurrent episodes of mucus plugging. The provider submits the request with appropriate documentation. The insurer would find that there is no NCD for this device. They would find that there is one LCD that covers this device for all regions of the U.S. The LCD is called High Frequency Chest Wall Oscillation Devices (L33785), and it clearly states the device is covered for cystic fibrosis, bronchiectasis and neuromuscular disease (ALS, muscular dystrophy etc.). They also define bronchiectasis as requiring a productive cough for six months and at least two exacerbations in a year requiring the need for antibiotics. More importantly, the LCD clearly says the following: "Chronic bronchitis and chronic obstructive pulmonary disease (COPD) in the absence of a confirmed diagnosis of bronchiectasis do not meet this criterion." Based on the LCD, the provider will get a denial for coverage. A peer-to-peer discussion would not be able to change this denial because the LCD explicitly says the device will not be covered for chronic bronchitis.

Requirements for peer-to-peer discussions with Insurer Medical Directors are stressful and time-consuming. Having these discussions with a physician outside your specialty can be the most frustrating. When having these discussions, knowing Medicare guidelines will be to your advantage. If your request does not meet Medicare guidelines under an NCD or an LCD, they will not be able to overturn the denial. Only in those cases where coverage rules are vague may discussion be patient specific.

Medicare Administrative Contractors for Medicare Part A & B

- CGS Administrators
- First Coast Service Options
- National Government Service
- Noridian
- Novitas Solutions
- Palmetto
- Wisconsin Physician Services

Medicare Administrative Contractors for DME Services

- CGS Administrators
- Noridian

D-Day for Noninvasive Ventilation Treatment of Patients with Severe COPD and Hypercapnia

Peter Gay, MD, MS

June 9 is the Decision Day for the NCD (National Coverage Decision) publication date for:

Noninvasive Positive Pressure Ventilation (NIPPV) in the Home for the Treatment of Chronic Respiratory Failure consequent to COPD

https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&ncaid=315&doctype=all&timeframe=30&sortBy=updated&bc=21.

This is the culmination of five years of effort by the Technical Expert Panel (TEP) for the Optimal NIV Medicare Access Proposal (ONMAP) convened to address the Medicare reimbursement criteria for patients requiring coverage in all categories of noninvasive ventilation treatment in the home. Although the Medicare Coverage and Analysis Committee (MEDCAC) met in July 2020 to address just the needs for the COPD patient, the subsequent Technical Expert Panel organized by the ACCP and chaired by Dr. Peter Gay of Mayo Clinic and Dr. Robert Owens at the University of California San Diego convened 25 national non-invasive ventilation (NIV) experts, insisting that coverage be improved for all patients requiring NIV therapy so that the right device was delivered to the right patient at the right time. The recommendations were submitted by the TEP for NCD reconsideration in September of 2021, and it was an arduous process moving back and forth from the CMS central office and the Medicare Administrative Contractors (MACs) who publish the Local Coverage Determinations (LCDs) through which the claims are eventually processed. The recommendations of the five committees covering each category are outlined in the executive summary published in CHEST: https://doi.org/10.1016/j.chest.2021.05.074. While the results of the NCD are satisfying in that we were provided with essentially all of the requests made by the TEP in conjunction with multiple medical societies – including the AASM, ACCP, and ATS – there is still more to the process.

The NCD has been in effect since June 9 when CMS released the final decision memo and the implementation process eventually updated the LCD and Claims Processing Manuals. After discussion between the MACs and the TEP chairs in July and recent email communication in early October, we understand that the LCD will follow the NCD new access criteria for COPD patients. We have also strongly urged them to address the other disease categories for NIV equipment coverage that we have asked for in the previously submitted LCD reconsiderations. This has not been announced yet.

The benefits of the current NCD include the fact that the overnight oximetry criterion for qualification is gone. There are now ways to provide coverage for direct access to a bilevel device with a backup rate and even a home mechanical ventilator. This even includes a way to provide equipment to patients being dismissed from the hospital after an episode of acute hypercapnic respiratory failure. There is a further extension of the time allowed for patients to become accustomed to their NIV device, up to 6 months rather than the previous 61 to 90 days.

The downsides of the NCD include the requirement to see patients at six months for the initial continued coverage and then yearly for the duration that the patient uses NIV therapy. There is also a mandate to utilize a bilevel device with high intensity backup settings, including a minimum backup rate of 14 breaths per minute and an inspiratory pressure of 15 cm H2O. There are many other details that will require careful attention in the physician documentation. Education and communication to all caregivers will need to be crafted by the medical societies of QHPs that care for these patients. The precise documentation that will eventually be necessary for successful coverage results presents a new demand for caregivers of these patients.

Those of us dedicated to confronting regulatory and legislative barriers to the delivery of reasonable and necessary care for our patients have learned to "be careful what you ask for." Durable medical equipment (DME) providers may insist upon specific documentation to qualify a patient for requested equipment; however, we believe that we can figure this out and that this NCD is a win for the sleep and pulmonary physician as well as patients.

VACCINES: Fall 2025 Respiratory Virus Season and Vaccine Access Challenges

Katina Nicolacakis, MD

As pulmonary/critical care/sleep providers, we are acutely aware of how important it is for our patients to remain up to date with all available vaccines for respiratory pathogens including the influenza, COVID-19, RSV and pneumococcal vaccines. The fall of 2025 has brought unprecedented challenges in vaccine access, driven by shifting federal policies, insurance coverage uncertainties, and variability at the state level.

The ATS has responded to the evolving vaccine policy landscape by issuing public statements opposing the dismissal of previous CDC Advisory Council for Immunization members, opposing Secretary HHS Kennedy's inaccurate statements about the safety and efficacy of vaccines and sending comments to the CDC Advisory Council for Immunization Practices urging the panel to maintain broad access to essential vaccines like COVID-19, RSV, flu and pneumonia. The ATS will continue to advocate for broad patient access to safe and effective vaccines.

While the vaccine situation will likely continue to evolve, we provide some guidance to support your patients in this season, focusing on COVID-19 and RSV.

COVID-19; Patients Under 65: A Landscape of Barriers and Confusion

For patients under 65, especially our patients with chronic pulmonary disease, access to the updated COVID-19 vaccines has become significantly restricted. The FDA now limits vaccine eligibility to individuals under 65 to those with at least one high-risk medical condition; chronic pulmonary diseases such as asthma, COPD, Cystic Fibrosis, ILD etc. do meet the criteria.

Key Challenges:

- Prescription Requirements: In many states, pharmacies require a prescription for patients under 65 to receive the vaccine. This has led to delays and confusion.
- Insurance Coverage Gaps: without the endorsement of the CDC for universal vaccination, some insurers are declining coverage for patients who do not meet the new criteria.
- State-by-State Variability: While some states (e.g., California, New York, Colorado) have issued executive orders or standing prescriptions to broaden access, others remain aligned with federal guidelines, leaving many patients in limbo.
- Public Health Messaging Conflicts: Professional Societies such as American Academy of Pediatrics and American College of Obstetrics and Gynecology continue to recommend vaccination for all individuals over six months, including pregnant women, but these recommendations conflict with federal policy, leading to further confusion.

Clinical Implications:

Patients under 65 years with chronic lung disease or other comorbidities may still qualify, but they often need to self-attest or obtain documentation or a prescription to obtain a vaccine. Patients should be encouraged to check with their local pharmacy and providers are encouraged to consider proactively offering prescriptions when appropriate.

Patients 65 and Older: Eligible but Not Always Accessible

Key Challenges:

- Pharmacy Confusion: Despite clear FDA approval for seniors, some pharmacies are still requiring prescriptions due to delayed CDC recommendations. This has led seniors being turned away or asked to verify eligibility.
- Supply Chain Delays: some regions report delays in vaccine shipments, particularly in rural areas.
- Misinformation and Hesitancy: Conflicting messages from federal agencies and political figures have sown doubt among older adults leading to increased vaccine hesitancy.
- Insurance Uncertainty: While Medicare is expected to cover the vaccine, some seniors report confusion over billing and coverage.

Clinical Implications:

Ensure that your older patients are aware of their eligibility and help them navigate local access issues. Partnerships with pharmacies and/or public health departments can streamline referrals and reduce barriers.

RSV Vaccination Recommendations and Barriers- Fall 2025

RSV (Respiratory Syncytial Virus) vaccination has become an essential tool in protecting vulnerable populations, including our patients with chronic lung disease. The RSV vaccine is a single dose, and no booster is currently required. The CDC now recommends the RSV vaccine for:

- All adults aged 75 and older (new age).
- High-risk adults aged 50-74 at increased risk of severe RSV disease including those with chronic lung disease and other chronic conditions.

Other Key Points and Potential Barriers:

- RSV vaccines are covered under Medicare Part D and may be obtained at retail pharmacies.
- Lack of vaccine stock: Many health care facilities do not stock RSV vaccines due to billing complexities with Medicare Part D.
- Insurance confusion: Patients and providers face uncertainty regarding coverage for patients under 65 years.
- Knowledge gaps: Both providers (including primary care) and patients may be unaware of RSV risks in adults or the availability of vaccines leading to missed opportunities for protection.

Conclusion:

This fall, our role as pulmonary, critical care and sleep providers extends beyond clinical care. Vaccine access is in constant evolution, and we must be navigators, advocates and educators to ensure our patients, especially those most vulnerable, receive the protection they need against COVID-19 and RSV. The landscape is complex, but with coordinated effort we can help bridge the gaps in access and ensure equitable care.

References:

https://www.cdc.gov/covid/hcp/vaccine-considerations/overview.html
https://www.cdc.gov/rsv/hcp/vaccine-clinical-guidance/adults.html

Q&A

Q: My practice would like to continue to provide E/M telehealth services to Medicare beneficiaries during the federal government shutdown. Is this advisable? Will my practice be reimbursed for these services after the shutdown is over?

A: Practices and Health systems across the country are struggling with this question. At the present time CMS is placing claims on hold for services affected by the expired waivers. We would recommend that all patients be notified that telehealth services may not be covered. Also, patients should have the option to change to an in-person visit. We are hopeful and expect that Congress will include retroactive reimbursement for these services in a future spending bill along with an extension of the waivers.
CMS and the MACs would issue guidance on how to resubmit claims which were on hold.