

FROM THE DESK OF THE PRACTICE MANAGEMENT COMMITTEE

Diagnostic Coding Update for 2012: Interstitial Lung Diseases (ILD)

BY DR. ROBERT DEMARCO, FCCP, CHAIR; DONNA KNAPP BYBEE, MA, FACMPE, VICE-CHAIR; AND DIANE KRIER-MORROW, MBA, MPH, CCS-P, ACCP CODING AND REIMBURSEMENT CONSULTANT

Interstitial Lung Disease (ILD) is a broad term that covers over 100 individual disorders. These specific disorders are grouped together due to the similarities of their physiologic features, their clinical presentation, and their radiographic images. The tissue abnormalities that characterize most ILDs are in the interstitium and, eventually, affect a patient's ability to breathe. The patient's lungs also have more difficulty transferring oxygen to their blood streams. In most cases, the causes of ILDs are idiopathic (unknown). The disorders that are categorized as ILDs vary in diagnosis, treatment, and causality.

The ACCP Practice Management Committee, working with the American Thoracic Society Clinical Practice Committee, had requested several new 4th and 5th digit ICD-9-CM codes for several ILDs in order to increase specificity. These new ICD-9-CM codes in the Tabular List are listed in the Table. ILD codes are included in *Chapter 8: Diseases of Respiratory System (460-519)* of the ICD-9-CM book.

There are approximately 50 new ICD-9-CM codes all together that are of interest to pulmonary, critical care and sleep medicine, 15 of which are ILD codes. Of those ILD codes, 10 are new adult ILD codes ranging from 516.3 through 516.5 (some are four-digit codes and some are five digits). Two of these new four-digit adult ILD codes are for rare disorders. One is lymphangiomyomatosis

(LAM), a fatal lung disease that affects women in childbearing years. The other is Pulmonary Langerhan's Cell Histiocytosis (PLCH), a smoking-related disease. The other eight adult ILDs are different types of idiopathic interstitial pneumonia. Dr. Frank McCormack, who presented the case for the new ILD codes to the National Center for Health Statistics Coordination and Maintenance Committee, said that "specific ILD codes will facilitate proper reimbursement, as well as clinical, epidemiology, and comparative effectiveness research." There are five new five-digit ILD codes for children that fall under 516.6 *Interstitial lung disease of childhood*.

Please ensure that you utilize these new codes starting on October 1, 2011, or your reimbursements will be denied. Also, be sure that your practice encounter forms, templates, and software are updated with these new codes. Official ICD-9-CM annual code revisions are referred to as addenda, and the first volume of the addenda index is available on the National Center for Health Statistics (NCHS) Web site at www.cdc.gov/nchs/data/icd9/ICD-9-CMINDEXAD DENDAFy12.pdf. The tabular list of diseases addenda (Volume II) can be viewed at www.cdc.gov/nchs/data/icd9/ICD-9-CM%20TABULAR ADDENDAFy12.pdf. When you check the source addenda, check both the Diagnoses Index and the Tabular List for selection of the appropriate codes to report. For example, in the new 54 codes of interest, the Index lists multiple pulmonary nodules. However, the code (793.19) referred to does not list multiple pulmonary nodules. These new ILD codes will also be transitioned to ICD-10-CM on October 1, 2013. ■

New ILD Diagnosis Codes From Tabular List

- 516 Other alveolar and parietoalveolar pneumonopathy
 - 516.3 Idiopathic interstitial pneumonia
 - 516.30 Idiopathic interstitial pneumonia, not otherwise specified (IIP) Idiopathic fibrosing alveolitis
 - 516.31 Idiopathic pulmonary fibrosis (IPF) Cryptogenic fibrosing alveolitis
 - 516.32 Idiopathic non-specific interstitial pneumonitis (NSIP) Excludes: non-specific interstitial pneumonia NOS, or due to known underlying cause (516.8)
 - 516.33 Acute interstitial pneumonitis (AIP) Hamman Rich syndrome Excludes: pneumocystis pneumonia (136.3)
 - 516.34 Respiratory bronchiolitis interstitial lung disease (RB-ILD)
 - 516.35 Idiopathic lymphoid interstitial pneumonia (LIP) Idiopathic lymphocytic interstitial pneumonitis Excludes: lymphoid interstitial pneumonia NOS, or due to known underlying cause (516.8) pneumocystis pneumonia (136.3)
 - 516.36 Cryptogenic organizing pneumonia (COP) Excludes: organizing pneumonia NOS, or due to known underlying cause (516.8)
 - 516.37 Desquamative interstitial pneumonia (DIP)
 - 516.4 Lymphangiomyomatosis (LAM) Lymphangiomyomatosis
 - 516.5 Adult pulmonary Langerhans cell histiocytosis (PLCH) Adult PLCH
 - 516.6 Interstitial lung diseases of childhood
 - 516.61 Neuroendocrine cell hyperplasia of infancy
 - 516.62 Pulmonary interstitial glycogenosis
 - 516.63 Surfactant mutations of the lung
 - 516.64 Alveolar capillary dysplasia with vein misalignment
 - 516.69 Other interstitial lung diseases of childhood
 - 516.8 Other specified alveolar and parietoalveolar pneumonopathies Interstitial pneumonia Lymphoid interstitial pneumonia due to known underlying cause Lymphoid interstitial pneumonia NOS Non-specific interstitial pneumonia due to known underlying cause Non-specific interstitial pneumonia NOS Organizing pneumonia due to known underlying cause Organizing pneumonia NOS

Code first, if applicable, underlying cause of pneumonopathy, if known
Use additional E code, if applicable, for drug-induced or toxic pneumonopathy
Excludes: cryptogenic organizing pneumonia (516.36) idiopathic lymphoid interstitial pneumonia (516.35) idiopathic non-specific interstitial pneumonitis (516.32)

ACCP Media Update

The ACCP and the journal *CHEST* have garnered an array of news coverage in the past several months.

CHEST

- ▶ The *Indiana Gazette* discussed a *CHEST* study that found people admitted to intensive care units on weekends are more likely to die than those entering during the week.
- ▶ The *New York Times* featured a 2009 *CHEST* study about musicians developing respiratory infections after not washing their instrument mouthpieces.
- ▶ The *Dayton Daily News* and

- the *Journal News in Cincinnati* quoted ACCP Sleep Medicine NetWorks Chair Dr. Kenneth Casey, FCCP, in an article discussing how shift work affects sleep habits.
- ▶ *Sleep Review* and *RD Magazine* discussed a May 2011 *CHEST* study about how heart rates in children with obstructive sleep apnea syndrome change after having adenotonsillectomies.
- ▶ More than 10 years after it first appeared in *CHEST*, the "Chicken Soup" study still has legs. The 2000 *CHEST* study, which examined chicken soup

- as a remedy for the common cold, was featured in a July article, "Can Chicken Soup Cure a Cold?", which was used by ABC 22-TV in New York, Montreal, and Vermont, and by KXVO-TV in Nebraska.
- ▶ Additional *CHEST* studies have appeared in *Science Magazine*, *US Pharmacist*, *Nurse-Week*, *Contemporary OB/Gyn*, *Managed Care*, *KevinMD.com*, and *Rehabilitation Management*.

Guidelines

- ▶ COPD – Joint guidelines developed by ACCP, the American College of Physicians,

American Thoracic Society, and the European Respiratory Society have appeared in a number of publications, including *MedPage Today* and the *St. Petersburg Times*.

COPD Alliance

- ▶ *Advance for Long-Term Care Management* featured the article "COPD Awareness: Get Residents Better Care, Diagnosis, and Treatment," which quoted JoEllen Wynne, MSN, FNP-BC, Vice Chair of the COPD Alliance, a collaboration between ACCP and four primary care medical associations. ■

PCCSU Lessons for September

- ▶ **Minimally Invasive Techniques for Diagnosing and Staging Lung Cancer.**

By Dr. Jonathan T. Puchalski



- ▶ **Noncystic Fibrosis Bronchiectasis.**

By Dr. Guang-Shing Cheng

Update on Pulmonary Function Coding for 2012

BY DR. EDWARD DIAMOND,
FCCP

The 2012 CPT® codes include significant revisions in the area of pulmonary function testing (codes 94010-94799) with multiple code deletions and multiple new codes. These changes will not take effect until January 1, 2012. The PFT codes commonly performed and billed together were consolidated into single

codes to eliminate payments for duplicative work.

As in the past, if a separate identifiable Evaluation and Management (E/M) service is performed, the appropriate E/M code may be reported in addition to codes 94010-94799. For example, when spirometry (94010) is performed on the same day as an office visit for an established patient who meets documentation requirements for code

99214, both 94010 and 99214 would be reported. The appending of a 25 modifier to the E/M code is not necessary; however, many providers include it because it may be required by private payers. The five-digit numeric CPT code represents the global service that includes both the technical and professional (interpretation) components. A 26 modifier is added when reporting only the professional (interpretation)

service, and a TC modifier is added when reporting only the technical service. For example, code 94010 describes the global service provided by a physician who performs spirometry in a private office. The physician must bear all costs (clinical staff, medical supplies, equipment) associated with the testing. If a physician interprets a test performed in a hospital-based laboratory, the physician reports the professional component (94010-26), and the

Continued on following page



BRIEF SUMMARY

The following is a brief summary of the full prescribing information for TYVASO® (treprostinil) Inhalation Solution. Please review the full prescribing information prior to prescribing TYVASO.

INDICATIONS AND USAGE

TYVASO is a prostacyclin vasodilator indicated for the treatment of pulmonary arterial hypertension (PAH) (WHO Group 1) to improve exercise ability. Studies establishing effectiveness included predominately patients with NYHA Functional Class III symptoms and etiologies of idiopathic or heritable PAH (56%) or PAH associated with connective tissue diseases (33%). The effects diminish over the minimum recommended dosing interval of 4 hours; treatment timing can be adjusted for planned activities. While there are long-term data on use of treprostinil by other routes of administration, nearly all controlled clinical experience with inhaled treprostinil has been on a background of bosentan (an endothelin receptor antagonist) or sildenafil (a phosphodiesterase type 5 inhibitor). The controlled clinical experience was limited to 12 weeks in duration.

CONTRAINDICATIONS

None.

WARNINGS AND PRECAUTIONS

Patients with Pulmonary Disease or Pulmonary Infections—The safety and efficacy of TYVASO have not been established in patients with significant underlying lung disease (e.g., asthma or chronic obstructive pulmonary disease). Patients with acute pulmonary infections should be carefully monitored to detect any worsening of lung disease and loss of drug effect.

Risk of Symptomatic Hypotension—Treprostinil is a pulmonary and systemic vasodilator. In patients with low systemic arterial pressure, treatment with TYVASO may produce symptomatic hypotension.

Patients with Hepatic or Renal Insufficiency—Titrate slowly in patients with hepatic or renal insufficiency, because such patients will likely be exposed to greater systemic concentrations relative to patients with normal hepatic or renal function.

Risk of Bleeding—Since TYVASO inhibits platelet aggregation, there may be an increased risk of bleeding, particularly among patients receiving anticoagulant therapy.

Effect of Other Drugs on Treprostinil—Co-administration of a cytochrome P450 (CYP) 2C8 enzyme inhibitor (e.g., gemfibrozil) may increase exposure (both C_{max} and AUC) to treprostinil. Co-administration of a CYP2C8 enzyme inducer (e.g., rifampin) may decrease exposure to treprostinil. Increased exposure is likely to increase adverse events associated with treprostinil administration, whereas decreased exposure is likely to reduce clinical effectiveness.

ADVERSE REACTIONS

The following potential adverse reactions are described in Warnings and Precautions:

• Decrease in systemic blood pressure • Bleeding

Adverse Reactions Identified in Clinical Trials—Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice. In a 12-week placebo-controlled study (TRIUMPH I) of 235 patients with PAH (WHO Group 1 and nearly all NYHA Functional Class III), the most commonly reported adverse reactions to TYVASO included: cough and throat irritation; headache, gastrointestinal effects, muscle, jaw or bone pain, flushing and syncope. Table 1 lists the adverse reactions that occurred at a rate of at least 4% and were more frequent in patients treated with TYVASO than with placebo.

Table 1: Adverse Events in ≥4% of PAH Patients Receiving TYVASO and More Frequent* than Placebo

Adverse Event	Treatment n (%)	
	TYVASO n = 115	Placebo n = 120
Cough	62 (54)	35 (29)
Headache	47 (41)	27 (23)
Throat Irritation/ Pharyngolaryngeal Pain	29 (25)	17 (14)
Nausea	22 (19)	13 (11)
Flushing	17 (15)	1 (<1)
Syncope	7 (6)	1 (<1)

*More than 3% greater than placebo

The safety of TYVASO was also studied in a long-term, open-label extension study in which 206 patients were dosed for a mean duration of one year. The adverse events during this chronic dosing study were qualitatively similar to those observed in the 12-week placebo controlled trial. **Adverse Events Associated with Route of Administration**—Adverse events in the treated group during the double-blind and open-label phase reflecting irritation to the respiratory tract included: cough, throat irritation, pharyngeal pain, epistaxis, hemoptysis and wheezing. Serious adverse events during the open-label portion of the study included pneumonia in 8 subjects. There were three serious episodes of hemoptysis (one fatal) noted during the open-label experience.

DRUG INTERACTIONS

Pharmacokinetic/pharmacodynamic interaction studies have not been conducted with inhaled treprostinil (TYVASO); however, some of such studies have been conducted with orally (treprostinil diethanolamine) and subcutaneously administered treprostinil (Remodulin®).

Pharmacodynamics—Antihypertensive Agents or Other Vasodilators—Concomitant administration of TYVASO with diuretics, antihypertensive agents or other vasodilators may increase the risk of symptomatic hypotension. **Anticoagulants**—Since treprostinil inhibits platelet aggregation, there may be an increased risk of bleeding, particularly among patients receiving anticoagulants.

Pharmacokinetics—Bosentan—In a human pharmacokinetic study conducted with bosentan (250 mg/day) and an oral formulation of treprostinil (treprostinil diethanolamine), no pharmacokinetic interactions between treprostinil and bosentan were observed.

Sildenafil—In a human pharmacokinetic study conducted with sildenafil (60 mg/day) and an oral formulation of treprostinil (treprostinil diethanolamine), no pharmacokinetic interactions between treprostinil and sildenafil were observed. **Effect of Cytochrome P450 Inhibitors and Inducers**—In vitro studies of human hepatic microsomes showed that treprostinil does not inhibit cytochrome P450 (CYP) isoenzymes CYP1A2, CYP2A6, CYP2C8, CYP2C9, CYP2C19, CYP2D6, CYP2E1 and CYP3A. Additionally, treprostinil does not induce cytochrome P450 isoenzymes CYP1A2, CYP2B6, CYP2C9, CYP2C19, and CYP3A. Human pharmacokinetic studies with an oral formulation of treprostinil (treprostinil diethanolamine) indicated that co-administration of the cytochrome P450 (CYP) 2C8 enzyme inhibitor gemfibrozil increases exposure (both C_{max} and AUC) to treprostinil. Co-administration of the CYP2C8 enzyme inducer rifampin decreases exposure to treprostinil. It is unclear if the safety and efficacy of treprostinil by the inhalation route are altered by inhibitors or inducers of CYP2C8. **Effect of Other Drugs on Treprostinil**—Drug interaction studies have been carried out with treprostinil (oral or subcutaneous) co-administered with acetaminophen (4 g/day), warfarin (25 mg/day), and fluconazole (200 mg/day), respectively in healthy volunteers. These studies did not show a clinically significant effect on the pharmacokinetics of treprostinil. Treprostinil does not affect the pharmacokinetics or

pharmacodynamics of warfarin. The pharmacokinetics of R- and S-warfarin and the INR in healthy subjects given a single 25 mg dose of warfarin were unaffected by continuous subcutaneous infusion of treprostinil at an infusion rate of 10 ng/kg/min.

USE IN SPECIFIC POPULATIONS

Pregnancy—Pregnancy Category B—There are no adequate and well controlled studies with TYVASO in pregnant women. Animal reproduction studies have not been conducted with treprostinil administered by the inhalation route. However, studies in pregnant rabbits using continuous subcutaneous (sc) infusions of treprostinil sodium at infusion rates higher than the recommended human sc infusion rate resulted in an increased incidence of fetal skeletal variations associated with maternal toxicity. Animal reproduction studies are not always predictive of human response; TYVASO should be used during pregnancy only if clearly needed.

Labor and Delivery—No treprostinil treatment-related effects on labor and delivery were seen in animal studies. The effect of treprostinil on labor and delivery in humans is unknown.

Nursing Mothers—It is not known whether treprostinil is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when treprostinil is administered to nursing women.

Pediatric Use—Safety and effectiveness in pediatric patients have not been established. Clinical studies of TYVASO did not include patients younger than 18 years to determine whether they respond differently from older patients.

Geriatric Use—Clinical studies of TYVASO did not include sufficient numbers of patients aged 65 years and over to determine whether they respond differently from younger patients. In general, dose selection for an elderly patient should be cautious, reflecting the greater frequency of hepatic, renal, or cardiac dysfunction, and of concomitant diseases or other drug therapy.

Patients with Hepatic Insufficiency—Plasma clearance of treprostinil, delivered subcutaneously, was reduced up to 80% in subjects with mild-to-moderate hepatic insufficiency. Up-titrate slowly when treating patients with hepatic insufficiency because of the risk of an increase in systemic exposure which may lead to an increase in dose-dependent adverse effects. Treprostinil has not been studied in patients with severe hepatic insufficiency.

Patients with Renal Insufficiency—No studies have been performed in patients with renal insufficiency. Since treprostinil and its metabolites are excreted mainly through the urinary route, patients with renal insufficiency may have decreased clearance of the drug and its metabolites and consequently, dose-related adverse outcomes may be more frequent.

OVERDOSAGE

In general, symptoms of overdose with TYVASO include flushing, headache, hypotension, nausea, vomiting, and diarrhea. Provide general supportive care until the symptoms of overdose have resolved.

CPT Code Descriptors for Four New 2012 PFT Codes

94726 Plethysmography for determination of lung volumes and when performed, airway resistance (Do not report 94726 in conjunction with 94727, 94728)
94727 Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes (Do not report 94727 in conjunction with 94726)

94728 Airway resistance by impulse oscillometry (Do not report 94728 in conjunction with 94010, 94060, 94070, 94375, 94726)

+94729 Diffusing capacity (eg, carbon monoxide, membrane) (List separately in addition to code for primary procedure) (Report 94729 in conjunction with 94010, 94060, 94070, 94375, 94726-94728)

Note: Physician's Current Procedural Terminology (CPT®) codes, descriptions, and numeric modifiers are © 2010 by the American Medical Association. All rights reserved.

Deleted PFT Codes

Deleted 10 PFT Codes: 93720, 93721, 93722, 94240, 94260, 94350, 94360, 94370, 94720, 94725.

(93720-93722) Plethysmography codes have been deleted. To report, use 94726)

(94240) Residual Lung Capacity has been deleted. To report, see 94726, 94727)

(94260) Thoracic Gas Volume has been deleted. To report, see 94726, 94727)

(94350) Lung Nitrogen Washout Curve has been deleted. To report, see 94726, 94727)

(94360) Measure Airflow Resistance has been deleted. To report, see 94726, 94728)

(94370) Breathe Airway Closing Volume has been deleted. To report, see 94726, 94727)

(94720, 94725) Diffusing Capacity codes have been deleted. To report, see 94729)

Note: Physician's Current Procedural Terminology (CPT®) codes, descriptions, and numeric modifiers are © 2010 by the American Medical Association. All rights reserved.

Manufactured for: United Therapeutics Corporation
Research Triangle Park, NC 27709
Rx only February 2011
www.tyvaso.com

**United
Therapeutics**
CORPORATION

Continued from previous page

hospital reports the technical component (94010-TC). The 2012 revisions eliminate a current exception to this pattern. The new code 94726 for plethysmography replaces the deleted codes 93720, 93721, and 93722.

The tables identify the 2012 accepted pulmonary function testing codes and the deleted codes. The intent of the changes is to simplify some areas that were unclear and bundle codes to avoid double payment for two tests with common components of preservice and postservice times.

The 10 codes from 2011 being deleted for 2012 are the following: 93720, 93721, 93722, 94240, 94260, 94350, 94360, 94370, 94720, and 94725. Some of the significant changes include the replacement of 94360 (airway resistance) with 94728 (airway resistance by impulse oscillometry) that can be reported only separately. There will be no separate reimbursement for airway resistance measured by body plethysmography (94726). Code 94260 (thoracic gas volume) will be eliminated because the appropriate use of this code has been unclear, and it is included in 94726, 94727. Diffusing capacity (94729) replaces 94720, and 94725 is an add-on code to 94010, 94060, 94070, 94375, and 94726-94728. ■

Update on Bronchoscopy Coding for 2012

BY DR. ALAN L. PLUMMER, FCCP

Over the past decade, many new codes have been created for pulmonary medicine. Most have been new codes for bronchoscopy procedures. For 2012, there are two new Category III CPT® codes for bronchial thermoplasty: 0276T should be used for bronchoscopy with bronchial thermoplasty of one lobe. 0277T should be used for bronchoscopy with bronchial thermoplasty of two lobes. They are Category III codes, so they have no physician work values and no specific reimbursement. They are to be used for tracking purposes, so data can be collected to assist pulmonary RUC advisors in applying for Category I status when the time is right. Achieving Category I status would necessitate the codes being surveyed by the RUC. At the RUC, the codes would be assigned physician work values plus practice and liability expense values then sent to the Centers for Medicare and Medicaid Services (CMS) for approval. Once the

codes have been approved by the CMS, they will be reimbursed by Medicare.

If Category III codes do not achieve Category I status within 5 years, those codes would sunset and would not be able to be used afterward. This again emphasizes the need to use these new bronchial thermoplasty codes, so Category I status for these codes can be achieved within the 5-year limit.

Currently, when bronchial thermoplasty is performed, the unlisted code 31899 (unlisted code for bronchial procedures) must be used on the claim form. A practice-determined charge should be added to the claim form, and a detailed description of the bronchial thermoplasty procedure should accompany the claim when it is

submitted. In 2012 and thereafter, when bronchial thermoplasty is performed, codes 0276T and 0277T should be reported.

A practice-derived fee for these codes can be submitted with the claim to request reimbursement. For example, one could submit a charge similar to your charge for 31641. In 2012, it will **not** be appropriate to use code 31899 (unlisted code for bronchial procedures) for bronchial thermoplasty.

For practice management issues or questions on coding, please contact Marla Brichta at (847) 498-8364 or mbrichta@chestnet.org. ■

DR. PLUMMER is the author of Chapter 9 of Coding for Chest Medicine 2011.

2012 CPT Category III Bronchial Thermoplasty Codes

0276T Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe

0277T Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes

Note: It is important to encourage physicians to report tracking codes that help us provide data for our request to transition to a CPT Category I code and having the code subsequently valued and paid.

AMERICAN COLLEGE OF CHEST PHYSICIANS

2011/2012 CME Live Activities



CHEST 2011

October 22-26, 2011
Honolulu, HI

Sleep Medicine 2012

January 26-29, 2012
Phoenix, AZ

ACCP Guidelines Methodology Course

March 15-16, 2012
Northbrook, IL

ACCP/AAP Pediatric Pulmonary Medicine Board Review 2012

August 17-20, 2012
Phoenix, AZ

ACCP Critical Care Medicine Board Review 2012

August 17-21, 2012
Phoenix, AZ

Lung Pathology 2012

August 21, 2012
Phoenix, AZ

Mechanical Ventilation 2012

August 21, 2012
Phoenix, AZ

ABIM Critical Care and Pulmonary Disease SEP Modules

August 21, 2012
Phoenix, AZ

ACCP Pulmonary Medicine Board Review 2012

August 22-26, 2012
Phoenix, AZ

CHEST 2012

October 20-25, 2012
Atlanta, GA

ACCP Simulation Program for Advanced Clinical Education

Fundamentals of Bronchoscopy

February 9-10, 2012
New Orleans, LA

Endobronchial Ultrasound

February 11-12, 2012
New Orleans, LA

Fundamentals of Mechanical Ventilation for Providers

February 23, 2012
Chicago, IL

Mechanical Ventilation: Advanced Critical Care Management

February 24-26, 2012
Chicago, IL

Fundamentals of Airway Management: Skills, Planning, and Teamwork

March 8, 2012
July 19, 2012
Northbrook, IL

Difficult Airway Management: A Critical Care Approach

March 9-11, 2012
July 20-22, 2012
Northbrook, IL

Improving Outcomes in Critical Care

April 13-15, 2012
Chicago, IL

Ultrasonography: Fundamentals in Critical Care

April 20-22, 2012
Philadelphia, PA

Focused Pleural and Vascular Ultrasound

May 3-4, 2012
September 20-21, 2012
Wheeling, IL

Critical Care Echocardiography

May 5-6, 2012
September 22-23, 2012
Wheeling, IL

Ultrasonography: Fundamentals in Critical Care

June 8-10, 2012
Denver, CO

Fundamentals of Bronchoscopy

August 2-3, 2012
Wheeling, IL

Endobronchial Ultrasound

August 4-5, 2012
Wheeling, IL