Internal Medicine Coding Alert

Correct Diagnosis Code Is Key to Consistent Reimbursement for Spirometry

"An increasing number of internists are performing spirometry (also referred to as pulmonary function tests or PFTs) as the equipment used for the tests has become less expensive and more portable. The increasing number of Medicare claims for PFTs, however, has caused local Medicare carriers to issue local medical reviews policies (LMRPs) that are very specific in detailing the medical coverage issues that must be met and covered diagnosis codes that must be reported in order to receive reimbursement for PFTs.

The two spirometry codes that are used most by internists are code 94010 (spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement[s], with or without maximal voluntary ventilation) and code 94060 (bronchospasm evaluation: spirometry as in 94010, before and after bronchodilator [aerosol or parenteral]).

Spirometry is the most basic ventilation test done in a pulmonary function study. It is used for preoperative testing, to evaluate lung disease or the effect of another systemic disease on the pulmonary function, and to assess the effectiveness of treatment. A spirometer is used to perform the following measurements: tidal volume, inspiratory reserve volume, expiratory reserve volume, residual volume, inspiratory capacity, and vital capacity.

Each measurement is usually taken three times and then an average result is calculated. However, only one unit of service can be billed for all of those measurements, says **Cynthia DeVries, RN, CPC,** coding and reimbursement specialist with Lee Physicians, a 140-physician practice with 27 internists in Ft. Myers, Fla.

A bronchospasm evaluation is spirometry performed before and after a bronchodilator a drug that relaxes the bronchial muscles has been administered to the patient. Code 94010 is considered bundled into 94060 by both Medicare and CPT and cannot be reported separately.

Whether a practice bills for the drugs used during the administration of a bronchospasm evaluation will often depend on the payer involved. DeVries practice does not bill separately for the broncholdilators. Because the CPT definition mentions the use of the drug, most of our payers interpret that to mean it is a standard component of the procedure, she explains. The Correct Coding Initiative doesnt include the J codes used to report drugs in its edits, so its hard to tell whether Medicare considers the drugs to be bundled with the procedure.

Code for Symptoms, Not Risk Factors

The key to getting consistent reimbursement for this service is to use an appropriate ICD-9 diagnosis code, according to DeVries. Most local Medicare carriers have a policy similar to the one of Nationwide Medicare, the Part B administrator for Ohio and West Virginia, which states, [R]egardless of the number of risk factors which a patient has, spirometry is not covered in the absence of symptoms.

You want to code for specific signs and symptoms, says DeVries. Dont code for a risk factor like family history of asthma (V17.5) or family history of other chronic respiratory conditions (V17.6).

Internists should check the medical policies of their local Medicare and private payers for a list of covered ICD-9 code because they can vary significantly from payer to payer. Nationwide Medicare, for example, instructs internists to use diagnosis code V72.82 (pre-operative respiratory examination) when a spirometry is performed as part of a preoperative test and to list the surgical condition as the second diagnosis. In New York, however, Empire Medicare Services has stated that it will not cover that same preoperative testing code for spirometry. Georgias Cahaba Government Benefits

Administrator specifically excludes the commonly used ICD-9 codes 491 (chronic bronchitis), 491.0 (simple chronic bronchitis) and 491.1 (mucopurulent chronic bronchitis) from its list of covered diagnoses.

Limits Placed on Bronchospasm Evaluations

In addition to covered and noncovered ICD-9 codes, the medical policies may also stipulate a number of coverage issues that must be met to prove the medical necessity of the PFT. Many local Medicare carriers have a policy similar to Floridas First Coast Service Options that limits the use of bronchospasm evaluations. Once it has been determined that a patient is sensitive to bronchodilators, the policy reads repeat bronchospasm evaluation is usually not medically necessary. The Florida carriers policy goes on to restrict the use of the bronchospasm evaluation after a patient has had normal results from a spirometry.

HGSA, the Part B administrator for Pennsylvania, also tries to limit the over use of code 94060 by requiring that claims for only pulmonary function studies be reported with code 94010.

The local carriers may also place restrictions on when a spirometry can be repeated. Nationwide Medicare states in its policy that [r]epeat spirometry performed for patients on bronchodilator therapy presenting without new symptomatology is considered routine screening and therefore not covered. The policy goes on to state, PFTs are covered for initial workup for a patient with a chronic cough. It is not expected that a repeat spirometry will be performed without additional symptomatology or failure to respond to a prescribed treatment.

Dont Confuse with Other CPT Codes

There are several other codes listed in the pulmonary section of CPT, which internists should be careful not to confuse with either spirometry or bronchospasm evaluation. While vital capacity is one of the tests measured by spirometry, code 94150 (vital capacity, total [separate procedure]) is considered bundled into codes 94010 and 94060 by the Correct Coding Initiative and cannot be reported in addition to those codes. Code 94014 (patient-initiated spirometric recording per 30-day period of time) and its component codes 94015 (patient-initiated spirometric recording per 30-day period of time, recording) and 94016 (patient-initiated spirometric recording per 30-day period of time, physician review and interpretation only) were intended by CPT to identify transtelephonic spirometry, but are not covered by most local Medicare carriers.

Both the spirometry and bronchospasm evaluation codes have a technical and a professional component. The technical component represents the value assigned to the ownership and maintenance of the spirometer and any other equipment used to perform the tests, and is indicated by the use of modifier -TC. The professional component represents the internists interpretation of the test results, and is indicated by the use of modifier -26. However, most internists will probably own (or partially own by being a partner in a practice) the spirometer and do the interpretation of the test results, according to DeVries. In that case, the global, unmodified code should be reported, even if a nurse or other non-physician employee administers the test, she says.

Office Visit Can Be Billed Separately

Finally, internists may be able to report an office visit in addition to the PFT. The CPT states, if a separate identifiable evaluation and management service is performed, the appropriate E/M service code should be reported in addition to 94010-94799.

The office visit, however, must be a full-service visit in order to be separately billable, DeVries emphasizes. The internist can count the results of the PFT as medical decision-making, but there also must be some history taken and a further assessment of the lungs done before the visit will qualify as a separately billable service, she explains. If the patient comes into the office just to take the test, then you should not be reporting an additional E/M service.

Some payers may require the use of modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) with the E/M service. Internists should contact their payers to get specific coding instructions."