



Coding Guidelines for Certain Respiratory Care Services – **January 2018 (updates in red)**

Overview

From time to time the AACRC receives inquiries about respiratory-related coding and coverage issues through its Help Line or Coding Listserv. To assist our members, we have developed coding guidance for those respiratory care services we are asked about most frequently. This guidance is based on the Medicare program's coding and coverage policies since it is the largest payer of health care services and its policies are often used by private payers. Although this guidance is an informed opinion of respiratory therapists and advisors who are not coding specialists but have experience and knowledge of codes and coverage policies, **it is always best to verify the patient's eligibility and payer coding requirements before providing a service as benefits are subject to specific plan policies which can vary among both public and private payers. Regardless of the setting, respiratory therapists cannot bill any insurer directly for their services.**

Difference between CPT Codes and HCPCS Codes

Standardized coding is essential in order for Medicare and other health insurance programs to submit claims for payment in a consistent manner. The Healthcare Common Procedure Coding Set (HCPCS), which is divided into two principal subsystems, is established for this purpose.

- ❖ **HCPCS Level I** is comprised of CPT® (Current Procedural Technology) codes established and maintained by the American Medical Association (AMA). CPT is a registered trademark of the Association. The CPT code set is the national coding standard for physicians and other health care professionals to report medical services and procedures for billing public or private health insurance programs. However, Level I codes do not include separately billable codes used by suppliers other than physicians, such as durable medical equipment (DME) suppliers, to report medical items or services that they provide.
- ❖ **HCPCS Level II** is a standardized coding system used primarily to identify products, supplies and services for which there are no CPT codes assigned. For example, these include drugs, ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office.

Understanding the National Correct Coding Edit (NCCI) Edits

According to the Centers for Medicare & Medicaid Services (CMS), the National Correct Coding Initiative (NCCI) was developed to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of Part B claims. **The NCCI edits and policies are applicable to physician, ambulatory surgical center, and outpatient facility services.** The coding policies are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology (CPT) Manual*, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical

and surgical practice, and/or current coding practice. NCCI includes three types of edits: NCCI Procedure-to-Procedure (PTP) edits, Medically Unlikely Edits (MUE), and Add-on Code Edits.

- PTP edits prevent inappropriate payment of services that should not be reported together. NCCI PTP edits are utilized by Medicare claims processing contractors to adjudicate provider claims for physician services, outpatient hospital services, and outpatient therapy services (i.e., physical therapy, occupational therapy and speech pathology). **They are not applied to facility claims for inpatient hospital services.**
- Medically Unlikely Edits (MUEs) prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) under most circumstances reportable by the same
- Add-on code edits consist of a listing of HCPCS and CPT add-on codes with their respective primary codes. An add-on code is eligible for payment if and only if one of its primary codes is also eligible for payment.”

General Information about Medicare

There are four distinct parts to the Medicare program. The AARC’s coding guidance focuses on coverage and coding policies related to respiratory care services covered under Medicare Parts A and B which are discussed in greater detail below.

- ❖ **Part A** – Inpatient services such as acute care, hospice care, and skilled nursing facilities
- ❖ **Part B** – Outpatient services such as physician visits, clinics, free standing sleep labs, DME, etc. Patients must purchase Part B coverage.
- ❖ **Part C** – Medicare Advantage (i.e., managed care)
- ❖ **Part D** – Prescription drug coverage

Inpatient Hospital Reporting of Actual Services under Medicare Part A

Hospitals are paid under a prospective payment system in which items and services provided to hospital inpatients are categorized into a diagnosis-related group (DRG) regardless of the number of conditions treated or services provided. The payment rate for each DRG is based on the average resources used to treat Medicare patients in that DRG. Codes for individual services provided during an inpatient hospital stay are not separately billed but are maintained in the facility’s finance department. For respiratory care services, these codes are used often to measure volume of work or productivity.

Payment of Outpatient Hospital Services under Medicare Part B

Hospitals provide two distinct types of services to outpatients: services that are diagnostic in nature and other services that aid the physician in the treatment of the patient. With a few exceptions, all hospital outpatient departments are paid under an outpatient prospective payment system (OPPS), although there are some services that can be paid under a fee schedule. While inpatient services are paid under the DRG system as noted above, outpatient services are bundled into what are called Ambulatory Payment

Classification (APC) groups. Services within an APC are similar clinically and with respect to hospital resource use. Each HCPCS Code that can be paid separately under OPSS is assigned to an APC group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC.

Physician office or clinic-based services under Medicare Part B

In a physician office or clinic setting, respiratory therapy services are furnished “incident to” the care provided and ordered by a physician (or placed in an approved protocol). Other professions, such as RNs and LPNs also provide services under the “incident to” Medicare provision. The physician bills Medicare directly as appropriate, not the RT.

“Incident to” services are provided under the direct supervision of a physician and are of a type commonly furnished in a physician’s office or clinic (not an institutional setting); an integral part of the patient’s treatment course; and commonly rendered without charge (included in the physician’s bill). Medicare’s definition of “direct” supervision **does not mean that the physician must be present in the room** when the procedure is performed; however, **the physician must be present in the office suite and immediately available** to furnish assistance and direction throughout the performance of the procedure [emphasis added].

Smoking Cessation Codes

Retroactive to September 2015, CMS revised its national coverage decision to cover smoking and tobacco use cessation counseling for outpatient and hospitalized Medicare beneficiaries who use tobacco, regardless of whether they have signs or symptoms of tobacco-related disease. Previously, there were two separate policy decisions. As a result of this change, HCPCS Codes G0436 and G0437 previously used for asymptomatic patients have been deleted. Effective October 1, 2016, only codes 99406 and 99407 will be used to bill for smoking and tobacco use cessation counseling. Under current statutory and regulatory requirements, respiratory therapists can furnish smoking cessation counseling as “incident to” a physician’s service under Medicare Part B. Only the physician or other qualified healthcare professional recognized by Medicare can bill Medicare directly for the service.

Medicare covers two individual smoking cessation counseling attempts per year. Each attempt may include a maximum of 4 intermediate OR intensive sessions, with the total benefit covering up to 8 sessions in a 12-month period. Minimal counseling is already covered at each evaluation and management (E/M) visit (i.e., less than 3 minutes). If one of the services below is furnished on the same day as a scheduled office visit, Modifier 25 should be appended to the appropriate E/M code to indicate that the E/M service is a separately identifiable service from smoking cessation counseling, e.g., 99213-25 plus 99406.

- ❖ **99406** – Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes.
- ❖ **99407** – Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes
(Do not report 99407 in conjunction with 99406)

Inhaler Techniques

The following code is appropriate for Demonstration and/or evaluation of inhaler techniques and also includes demonstration of flow-operated inhaled devices such as flutter valves. The code may only be used once per day. This cannot be billed at the same time/ same visit as 94640. These can be billed on the same day, but must be a separate patient visit.

- ❖ **94664** – Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device can be used demonstrating (teaching) patients to use an aerosol generating device property.

Self-Management Education and Training Services (including Asthma)

Self-management education and training services are not separately billable codes under Medicare and are not paid by Medicare when submitted for any outpatient bill type (e.g., hospital outpatient, physician office). If the service is covered, payment for it would be bundled into the payment for other services for which the patient is being treated. This would be true in the inpatient setting as well where services are paid under the assigned DRG. However, certain private plans may not necessarily follow Medicare with respect to this issue and may cover these services. In any event, in order for these codes to be reported, the CPT coding guide sets out the following requirements.

- Prescribed by a physician or other qualified health care professional
 - Provided by a qualified, non-physician healthcare professional (i.e., nurse practitioner, physician assistant)
 - Must use a standardized curriculum
 - Qualifications of non-physician healthcare professionals and content of education/training programs are consistent with
 - Established guidelines or standards, **OR**
 - Recognized by a national professional society, **OR**
 - Other appropriate sources
- ❖ **98960** – Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (can include caregiver/family) each session 30 minutes: individual patient.
 - ❖ **98961** – 2 – 4 patients
 - ❖ **98962** – 5 – 8 patients

Office Spirometry

Physician office-based spirometry is covered if it meets the criteria stated in the code below, produces a tracing, and measures all the elements mentioned. If conducting spirometry on the same day as a scheduled office visit, Modifier 25 should be appended to

the appropriate E/M code to indicate that the E/M service is a separately identifiable service from spirometry, e.g., 99213-25 plus 94010.

- ❖ **94010** – Spirometry, including graphic tracing, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation
(Do not report 94010 with 94150, 94200, 94375, 94728)

Peak Flow Meter

A peak flow meter is covered as a supply when furnished in the physician office setting for home use by the patient.

- ❖ **HCPCS A4614** – Peak expiratory flow rate meter, hand held

Peak Flow Measurement Test and or Incentive Spirometry

There are no codes to identify these services at this time

Inhalation Treatment for Acute Airway Obstruction

CPT code 94640 describes treatment of acute airway obstruction with inhaled medication **and/or** the use of an inhalation treatment to induce sputum for diagnostic purposes.

Hospital inpatient services: If more than one inhalation treatment is performed on the same date of service, the code should be reported by appending modifier 76. If inhalation drugs are administered in a continuous treatment or a series of “back-to-back” treatments exceeding one hour, CPT codes 94644 and 94645 should be reported instead of CPT code 94640. Inpatient services are generally paid under a diagnosis-related prospective payment to the hospital and therefore are not billed separately to insurers or Medicare. However, hospitals will keep track of the number of procedures as an indication of productivity which can guide staffing requirements.

Hospital outpatient services, such as emergency departments: If inhalation treatments are administered in an outpatient setting, the use of CPT code 94640 is subject to NCCI edits which are described on pages 1 and 2 of these guidelines. This means CPT code 94640 shall only be reported once during an episode of care regardless of the number of separate inhalation treatments that are administered. [Note: This policy has been in effect since January 1, 2014.] If CPT code 94640 is used for treatment of acute airway obstruction, spirometry measurements before and/or after the treatment(s) shall not be reported separately. It is a misuse of CPT code 94060 to report it in addition to CPT code 94640. The inhaled medication may be reported separately. An episode of care begins when a patient arrives at a facility for treatment and terminates when the patient leaves the facility. If the episode of care lasts more than one calendar day, only one unit of service of CPT code 94640 shall be reported for the entire episode of care.

If a patient receives inhalation treatment during an episode of care and returns to the facility for a second episode of care that also includes inhalation treatment on the same date of service, the inhalation treatment during the second episode of care may be reported with modifier 76 appended to CPT code 94640.

If you have questions about the use of CPT code 94640 or use of modifier 76 (repeat procedure or service by the same physician or other qualified health care professional), we strongly recommend you check with the coding and billing representatives at your facility. If further clarification is necessary, the facility should check with the Medicare contractor that pays its claims.

- ❖ **94640** – Pressurized or non-pressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device.

(For more than 1 inhalation treatment performed on the same date append modifier 76)

(Do not report 94640 in conjunction with 94060, 94070 or 94400)

- ❖ **94644** – Continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour
(For services of less than 1 hour, use 94640)
- ❖ **94645** – each additional hour (List separately in addition to code for primary procedure)
(Use 94645 in conjunction with 94644)

Note: Since 94640 cannot be reported on the same day as 94644 or 94645, the coder must decide which of the codes to report. Generally, it would be the code that has the greatest volume/quantity.

Ventilation Management including CPAP

There is no CPT code for ventilators used in the Emergency Department (ED). This includes instances where a patient expires in the ED or is transferred to another facility. However, if the patient in the ED is admitted as a hospital inpatient in the same facility, 94002 may be reported for the ventilator. Ventilation management CPT codes (94002-94004 and 94660-94662) are not separately reportable with evaluation and management (E&M) CPT codes. If an E&M code and a ventilation management code are reported, only the E&M code is payable.

- ❖ **94002** – Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing, hospital inpatient/observation, initial day
- ❖ **94003** – hospital inpatient/observation, each subsequent day
- ❖ **94004** – nursing facility, each day

(Do not report 94002-94004 in conjunction with Evaluation and Management services 99201-99499)

- ❖ **94660** – Continuous positive airway pressure ventilation (CPAP), initiation and management
- ❖ **94662** – Continuous negative pressure ventilation (CNP), initiation and management

Pulmonary Rehabilitation

Medicare covers pulmonary rehabilitation (PR) programs (i.e., those consisting of components set forth in law) for patients who have been diagnosed with moderate, severe, or very severe COPD as established by the GOLD guidelines. No more than two one-hour sessions may be billed in a single day and the services are only covered if provided in a physician's office or hospital outpatient department. Individual components of the comprehensive PR program can be provided by one or more members of the multi-disciplinary team, which includes RTs, but none of those services are separately billable under the PR benefit. The individual services furnished prior to the PR benefit are now bundled into a single HCPCS code as described below.

- ❖ **G0424** - Pulmonary rehabilitation, including aerobic exercise (includes monitoring), per session, per day

If a patient does not meet the COPD criteria above, their services can be covered as individual respiratory care services (not pulmonary rehabilitation). Medicare contractors have established local coverage determinations (LCD) for this subset of patients. In the absence of a LCD, contractors can pay claims on a case-by-case basis as long as the service is deemed medically necessary. G0424 should not be used in billing services for non-COPD patients.

- ❖ **G0237** – Therapeutic procedures to increase strength or endurance or respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring)
- ❖ **G0238** – Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes (includes monitoring)
- ❖ **G0239** – Therapeutic procedures to improve respiratory function or increase strength or endurance or respiratory muscles, two or more individuals (includes monitoring)

Six-Minute Walk Test

It is appropriate to use the six-minute walk test code to evaluate distance, dyspnea, oxyhemoglobin desaturation, and heart rate. Heart rate, blood pressure, oxygen saturation, and liter flow of supplemental oxygen are to be reported at rest, during exercise, and during recovery. Physician analysis of data and interpretation of the test are procedurally inclusive components of this code. **[Note: CPT code 94620 is no longer valid as of January 1, 2018. The new codes are described below.]**

- ❖ **94618** – Pulmonary stress testing; simple (e.g., 6-minute walk test), including measurement of heart rate, oximetry, and oxygen titration, when performed.

To report exercise testing use:

- ❖ **94617** – Exercise test for bronchospasm, including pre- and post-spirometry, electrocardiographic recording(s), and pulse oximetry.

Pulmonary Function Testing

A major revision of PFT codes occurred in 2012. Below are some of the codes and restrictions that resulted in that change.

- ❖ **94010** – Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation.
(Do not report 94010 with 94150, 94200, 94375, 94728)
- ❖ **94060** – Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration
(Do not report 94060 with 94150, 94200, 94375, 94640, 94728)
(Report bronchodilator supply separately with 99070 or appropriate supply code)
- ❖ **94150** - Vital Capacity, total (separate procedure)
(Do not report 94150 with 94010, 94060, 94728)
- ❖ **94200** – Maximum breathing capacity, maximal voluntary ventilation
(Do not report 94200 with 94010, 94060)
- ❖ **94375** – Respiratory Flow Volume loop
(Do not report 94375 with 94010, 94060, 94728)
- ❖ **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 (e.g., carbon monoxide, membrane) (List separately in addition to code for primary procedure)
(Report 94729 in conjunction with 94010, 94060, 94070, 94375, 94726-94728)

Mechanical Chest Wall Oscillation

Effective January 1, 2014, a new code was established to identify the application of and training for a device to accomplish mechanical high-frequency chest wall oscillation (HFCWC), such as a HFCWC Vest. The code is reported per session and identifies applying the device for use and/or training provided by the health care professional for independent patient use which resulted in two methods of accomplishing chest wall manipulation; manual (94667, 94668) or mechanical (94669).

- ❖ **94669** – Mechanical chest wall oscillation to facilitate lung function, per session

Miscellaneous Codes

- ❖ **94728** – Airway resistance by impulse oscillometry
(Do not report 94728 in conjunction with 94010, 94060, 94070, 94375, 94726)
- ❖ **94780** – Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report; 60 minutes
(Do not report 94780 for less than 60 minutes)
(Do not report 94780 in conjunction with 94010, 94060, 94070, 94375, 94726)
- ❖ **94781** – Each additional full 30 minutes (List separately in addition to code for primary procedure).