Coding Guidelines for Certain Respiratory Care Services – May 2020 *(updates in blue)*

Overview

As a service to our members, we developed coding guidance for 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 advisers who have experience and knowledge of codes and coverage policies, **we suggest you 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 for Medicare and other health insurance programs to pay claims for medically necessary services 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, maintained, and registered by the American Medical Association (AMA). The CPT code set is the national coding standard for physicians and other qualified health care professionals to report medical services and procedures for billing public or private health insurance programs.

- **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).

- 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, durable medical equipment (DME), etc.
- **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 and are paid under the Inpatient Prospective Payment System (IPPS) based upon DRGs. Codes for individual services provided by respiratory therapists during an inpatient hospital stay are not separately billed but are maintained in the facility's finance department.

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 services that aid the physician in the treatment of the patient. With a few exceptions, 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 IPPS 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 OPPS is assigned to an APC group. The payment rate and coinsurance amount calculated for an APC apply to all 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). The physician bills Medicare directly as appropriate, not the RT. To be covered, "incident to" services must be: 1) commonly furnished in a physician's office or clinic (not an institutional setting); 2) an integral part of the patient's treatment course; 3) commonly rendered without charge or included in the physician's bill; and, 4) furnished under the supervision of a physician or other qualified health care professional.

CPT Codes for Respiratory Care

Ventilation Management including CPAP/Noninvasive Ventilation (e.g. BiPAP)

Ventilators used in the Emergency Department (ED) cannot be coded for subsequent days. 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) 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. There is no specific CPT code for noninvasive ventilation in the hospital setting, also referred to as Bi-Level Positive Airway Pressure. In these instances, some facilities use 94660 (CPAP) and some use Ventilator Management codes 94002 and 94003. Check with your coding professionals for advice.

- **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

Exercise Testing and the 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.

- **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:

- **94621** – Cardiopulmonary exercise testing, including measurements of minute ventilation, CO_2 production, O_2 uptake, and electrocardiographic recording.

To report an exercise test to determine the presence of bronchospasm use 94617. Administration of the bronchodilator by inhalation cannot be coded separately; the medication used can be coded as a supply.

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

Inhaler Techniques

The following code is appropriate for demonstration and/or evaluation of inhaler techniques and includes demonstration of flow-operated inhaled devices such as Positive and Oscillating Expiratory Pressure (PEP/OPEP) devices. The code may only be used once per day. For example, it cannot be billed at the same time/same visit as 94640. The code should not be reported for patients who routinely self-administer (e.g. prior to their hospitalization).

- **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.

(94664 can be reported 1 time only per day of service)

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. When providing inhalation treatment for acute airway obstruction, Medicare will not pay for both 94640 and 94644 or 94645 if they are billed on the same day for the same patient. The coder must decide which of the two codes to submit.

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. 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)

- **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)

Manipulation of the Chest Wall

Manipulation of the chest wall is for mobilization of secretions and improvement in lung function. Use code 94667 or 94668 for "hands on" manipulation of the chest wall, per session. CPT code 94669 is used when a mechanical device is used to achieve high-frequency chest wall oscillation (HFCWC), such as a HFCWC device.

- **94667** – Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function, initial demonstration and /or evaluation

- **94668** – subsequent

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

Pulse Oximetry and Carbon Dioxide

CMS has encouraged facilities to accurately bill for medically necessary pulse oximetry. To be medically necessary, there must be a documented request in the medical record by a physician/practitioner. Parameters for each measurement should be included in the request. Testing is expected to be useful in the continued management of a patient's care, particularly in acute exacerbation or unstable conditions (e.g., acute bronchitis in a patient with COPD).

- **94760** – Noninvasive ear or pulse oximetry for oxygen saturation, single determination

- **94761** – multiple determinations (e.g., during exercise)

- **94762** – by continuous overnight monitoring (separate procedure)

- **94770** – Carbon dioxide, expired gas determination by infrared analyzer

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.

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)

Car Seat Testing

Code 94780 was modified in 2019 to replace the term "neonate" (i.e., 28 days of age or younger) with the phrase "for infants through 12 months of age."

- **94780** – Car seat/bed testing for airway integrity, for infants through 12 months of age, with continual clinical staff 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 94760 and 94761)

- **94781** – each additional 30 minutes

  (Use 94781 in conjunction with 94780)

Chronic Care and Complex Chronic Care Management Services/Non-Face-to-Face Services Provided by Clinical Staff

There are a few new codes (2020) that can be used for outpatient visits, face to face or non-face-to-face with the patient. These are Evaluation and Management CPT codes that are associated with services provided by physicians and other qualified healthcare professionals (NPs and PAs) that can bill Medicare directly. The descriptions and requirements are lengthy and are listed in *CPT® Professional 2020*, published by the AMA. The term "clinical staff" as used by the AMA refers to professionals who do not bill patients independently such as respiratory therapists and nurses.

Care management services are non-face-to-face management and support services provided by clinical staff, under direction of a physician or other qualified health care professional (NPs and PAs), to a patient residing at home, in assisted living facility or rest home. Services include establishing, revising, implementing, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver. The *CPT® Professional 2020* AMA publication describes these codes in detail and should be reviewed before using these codes.

- **99490** – Chronic care management services, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month with the following required elements:

  - multiple (two or more) chronic conditions, expected to last at least 12 months, or until the death of the patient
  - chronic conditions place the patient at significant risk of death, acute exacerbation, or functional decline
  - comprehensive care plan established, implemented, revised, or monitored

- **99487** – Complex chronic care management services, with the following required elements:

  - multiple (two or more) chronic conditions, expected to last at least 12 months, or until the death of the patients
  - chronic conditions place the patient at significant risk of death, acute exacerbation, or functional decline
  - moderate or high complexity medical decision making
  - 60 minutes of clinical staff time as directed by a physician or other qualified health care professional , per calendar month

  (Complex chronic care management services of less than 60 minutes duration, in a calendar month, are not reported separately)

- **99489** – each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

Chronic Care Remote Physiologic Monitoring Services

In 2019, CMS began paying separately for chronic care remote physiologic monitoring (RPM) services involving the collection, analysis, and interpretation of digitally collected physiologic data (e.g., weight, blood pressure, pulse oximetry and respiratory flow rate), followed by the development of a treatment plan, and the managing of a patient under the treatment plan. Clinical staff (e.g., respiratory therapist) under the general supervision of a physician can provide 20 minutes of staff time that require monitoring treatment management services and interactive communication with the patient/caregiver. Billing is limited to once in a 30-day period. In 2020, CMS included an add-on code to allow an additional 20 minutes of clinical staff time which can be reported up to 2 times per patient, per month. The physician or other qualified health care professional bills Medicare directly for the services.

- 99457 – Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; initial 20 minutes

- 99458 – Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)

Smoking Cessation Counseling

CMS covers smoking cessation counseling for outpatient and hospitalized Medicare beneficiaries regardless of whether the individual has been diagnosed with a recognized tobacco-related disease or showed signs or symptoms of such a disease. When CMS or MedLearn report that respiratory therapists cannot furnish the service, they are referring to the fact that they do not have separate billing authority or a specific Medicare benefit category that recognizes respiratory therapy. However, when the national coverage determination was issued in 2005, it included §1861(s)(2)(A) of the Society Security Act among the Part B benefit categories in which smoking cessation could be covered. That category is "service furnished as an incident to a physician's professional service." Respiratory therapists can furnish smoking cessation counseling as clinical or auxiliary staff under this benefit in the physician's office or hospital outpatient setting. In such cases, the physician bills Medicare directly and the payment goes to the physician.

- **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)

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, stages II-IV. 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. To report G0424 for one pulmonary rehabilitation session, the duration of treatment must be at least 31 minutes. To report two sessions (two units of G0424) on the same day, the duration of treatment must be at least 91 minutes.

- **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), G0237 - 39. Medicare contractors have established local coverage determinations (LCD) for this subset of patients. In the absence of an LCD, contractors can pay claims on a case-by-case basis if the service is deemed medically necessary. G0424 should not be used in billing services for non-COPD patients.

G0239 represents group situations where two or more patients are simultaneously receiving services such as those described above for G0237 and G0238. G0239 is not a timed code and should be reported only once a day for each patient in the group.

- **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)

Pulmonary Diagnostic Testing

Codes 94010-94799 include laboratory procedure(s) and interpretation of test results.

- **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)

- **94011 –** Measurement of spirometric forced expiratory flow rates in an infant of child through 2 years of age

- **94012** – Measurement of spirometric forced expiratory flows before and after bronchodilator in an infant or child through 2 years of age

- **94013** – Measurement of lung volumes (i.e., functional residual capacity [FRC], forced vital capacity [FVC], and expiratory reserve volume [ERV]) in an infant or child through 2 years of age

- **94014** – Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and physician review and interpretation by a physician or other qualified health care professional (We already say this above)

- **94015** – recording (including hook-up, reinforced education, data transmission data capture, trend analysis, and periodic re-calibration

- **94016** - review and interpretation only by a physician or other qualified health care professional.

- **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)

- **94070** – Bronchospasm provocation evaluation, multiple spirometric determinations as in 94010, with administered agents (e.g., antigen[s], cold air, methacholine.
  (Report antigen(s) administration separately with 99070 or appropriate supply code)
  (Do not report in conjunction with 94640)

- **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)

- **94250** – Expired gas collection, quantitative, single procedure (separate procedure)
  (Do not report in conjunction with 94621)

- **94375** – Respiratory Flow Volume loop
  (Do not report 94375 with 94010, 94060, 94728)

- **94400** – Breathing response to CO2 (CO2 response curve)
  (Do not report in conjunction with 94040)

- **94450** – Breathing response to hypoxia (hypoxia response curve)

- **94452** – High altitude simulation test [HAST], with interpretation and report by a physician or other qualified health care professional.
  (For obtaining arterial blood gases, use 36600)

- **94453** – with supplemental oxygen titration

- **94680** – Oxygen uptake, expired gas analysis, rest and exercise, direct and, simple

- **94681** – including CO_2 output, percentage oxygen extracted

- **94690** – rest, indirect (separate procedure)
  (Do not report 94680, 94681, 94690 in conjunction with 94621)

- **94726** - Plethysmography for determination of lung volumes and when performed, airway resistance
  (Do not report 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 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)

- **94750** – Pulmonary compliance study (e.g. Plethysmography, volume and pressure measurements)

Miscellaneous Codes

- 31500 Intubation, endotracheal, emergency procedure

- 31502 Tracheotomy tube change prior to establishment of fistula tract

- 36600 Arterial puncture, withdrawal of blood for diagnosis

Modifiers

CPT modifiers (also referred to as Level I modifiers) are used to supplement information or adjust care descriptions to provide extra details concerning a procedure or service provided by an individual (MD, QHCP, RT). Code modifiers help further describe a procedure code without changing its definition.

- Modifier 59 is used to indicate that a procedure is distinct or independent from other procedures that are performed on the same day. Its use communicates to the MAC that these procedures are not usually reported together but are appropriate under the circumstances.
- Modifier 76 - Used to indicate a procedure or service was repeated by the same physician or other qualified health care professional after the original procedure or service when the procedure or service is performed on the same day.