Coding Guidelines for Certain Respiratory Care Services – January 1, 2024

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 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.

Critical Assess Hospitals (CAH)

CAHs are not included in Medicare's Hospital Inpatient or Hospital Outpatient Prospective Payment System. Medicare pays CAHs for most inpatient and outpatient services at 101% of the reasonable cost of the service. Medicare also pays CAH services according to Part A and Part B deductible and coinsurance amounts but does not limit the 20% CAH Part B outpatient copayment amount by the Part A inpatient deductible amount.

CPT Codes for Respiratory Care (Listed in Alphabetical Order)

Airway Management

- 31500 Intubation, endotracheal, emergency procedure
- 31502 Tracheotomy tube change prior to establishment of fistula tract

Arterial Puncture

- 36600 Arterial puncture, withdrawal of blood for diagnosis
- 36620 Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure)

Car Seat Testing

- **4780** – 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 Management (CCM) and Complex Chronic Care Management Services (CCCM)/Non-Face-to-Face Services Provided by Clinical Staff

Care management services are non-face-to-face management and support services which can 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 an assisted living facility or rest home. The term "clinical staff" as used by the AMA refers to professionals who do not bill Medicare independently such as respiratory therapists and nurses. Services include establishing, revising, implementing, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver. Clinical staff services can be provided under general supervision. General supervision means the service is performed under the overall direction and control of the physician or other qualified health professional, but their physical presence is not required.

- **99490** – 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 patient,
  - chronic conditions place the patient at significant risk of death, acute exacerbation, or functional decline,
  - comprehensive care plan established, implemented, revised, or monitored;

  - first 20 minutes **of clinical staff time** directed by a physician or other qualified health care professional, per calendar month.

- **99439** – each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. (List separately in addition to primary procedure.)

  (Use 99439 in conjunction with 99490)

  (Do not report 99439 more than twice per calendar month)

❖ **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

❖ first 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)

(Do not report 99489 for care management services of less than 30 minutes)

CPAP

❖ **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; with electrocardiographic recordings.

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. *(Note: A copy of the pulmonary NCCI edits listed in Chapter 11 of the NCCI Manual for 2022 are provided at the end of this document for your convenience. Red font denotes changes from the 2021 edits.)* 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.

*See attached letter from CMS, January 8, 2018. Remember that NCCI edits do not apply to inpatient services.

- **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)

- **94642** - Aerosol inhalation of pentamidine for pneumocystis carinii pneumonia treatment or prophylaxis

- **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)

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)

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. (Can be billed once per day.)

- **94668** – subsequent

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

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 Measurement Test and or Incentive Spirometry

There are no codes to identify these services.

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

Principal Care Management (PCM) Services

Medicare pays for Principal Care Management (PCM) Services related to a patient's care for a single high-risk disease or complex chronic condition. According to CMS, it is anticipated in most cases that PCM services will be billed when a single condition is of such complexity that it cannot be managed as effectively in the primary care setting and instead requires management by another, more specialized, practitioner, (e.g., pulmonologist). Initiation of PCM will likely be triggered by an exacerbation of the patient's complex chronic condition or recent hospitalization such that disease-specific care management is warranted. PCM services are care management care services and can be provided under general supervision, which means the physician/other qualified healthcare professional provides overall direction and control, but their physical presence is not required. The term "clinical staff" as used by the AMA refers to professionals who do not bill Medicare independently such as respiratory therapists and nurses.

- **99426** – Principal care management services, for a single high-risk disease, with the following required elements:
  - one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death,

- the condition requires development, monitoring, or revision of disease-specific care plan,
- the condition requires frequent adjustments in the medication regimen and/or the management of the condition is usually complex due to comorbidities,
- ongoing communication and care coordination between relevant practitioners furnishing care;

- first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month.

❖ **99427** – 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)

(Use 99427 in conjunction with 99426)
(PCM services of less than 30 minutes of duration in a calendar month are not reported separately)
(Do not report 99427 more than twice per calendar month)

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.

- **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)

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

- **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)

Pulmonary Rehabilitation

Medicare covers pulmonary rehabilitation (PR) programs (i.e., 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. For one pulmonary rehabilitation session, the duration of treatment must be at least 31 minutes. To report two sessions on the same day, the duration of treatment must be at least 91 minutes. Effective January 1, 2022, pulmonary rehabilitation is covered for beneficiaries who have had confirmed or suspected COVID–19 and experience persistent symptoms of COVID-19 that include respiratory dysfunction for at least 4 weeks. The 4-week timeframe may begin with symptom onset.

- **94625** – Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)

- **94626** – with continuous oximetry monitoring (per session)
  (Do not report 94625, 94626 in conjunction with 94760, 94761)

If a patient does not meet the COPD criteria required to receive services provided under CMS' comprehensive pulmonary rehabilitation benefit noted above, their services can be covered as individual respiratory care or respiratory therapy services, not pulmonary rehabilitation. 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. CPT codes 94625 and 94626 should not be used in billing services for non-COPD patients. Unlike G0237 and G0238 in which individual services

are based on 15-minute intervals, G0239 represents a group situation where two or more patients are simultaneously receiving services. 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)

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)

Remote Physiologic Monitoring Services (Digitally Stored Data Services/Treatment Management Services)

Remote physiologic monitoring (RPM) services involve 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. CPT codes 99457 and 99458 are considered care management services which allow general supervision rather than direct supervision for "incident to" services furnished by clinical staff. General supervision means the service is performed under the overall direction and control of the physician or other qualified health professional although their physical presence is not required. Codes 99457 and 99458 may be reported during the same service period as CCCM,

CCM, TCM and PCM services. CPT Code 99453 is reported for each episode of care which is defined as beginning when the remote monitoring physiologic service is initiated and ends with attainment of targeted treatment goals.

- **99453** - Remote monitoring of physiologic parameters (e.g., weight, blood pressure, respiratory flow rate), initial set-up and patient education on use of equipment.

  (Do not report 99453 more than once per episode of care)
  (Do not report 99453 for monitoring of less than 16 days)

- **99454**- device(s) supply with daily recording/(s) transmission, each 30 days

  (Codes 99453 and 99454 are not reported if monitoring is less than 16 days)

- **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; first 20 minutes

  (Do not report 99457 for services of less than 20 minutes)
  (Do not report 99457 in conjunction with 93264, 99091)
  (Do not report 99457 in the same month as 99473, 99474)

- **99458** – each additional 20 minutes (List separately in addition to code for primary procedure)

  (Use 99458 in conjunction with 99457)
  (Do not report 99458 for services of less than an additional increment of 20 minutes)

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. (**NOTE**: In communications between AARC and CMS to clarify the role of respiratory therapists in furnishing smoking cessation counseling under Medicare's Part B "incident to" benefit category, CMS has remained steadfast that "*CMS can only cover tobacco cessation counseling for outpatient and hospitalized Medicare beneficiaries furnished by a qualified physician or other Medicare-recognized practitioners.*

Transitional Care Management (TCM) Services

TCM services are for a new or established patient who needs moderate or high complexity medical decision making during the transition from care in an inpatient hospital setting to the patient's community setting (e.g., home, domiciliary, rest home or assisted living). TCM begins on the date of discharge and continues for the next 29 days. The services are designed to prevent hospital readmissions within 30 days of hospital discharge. The TCM codes allow clinical staff to provide non-face-to-face services under the general supervision of the physician or NPP subject to applicable state law and scope of practice any time during the 30-day TCM service period. Services can include communicating with the patient or agencies and other community providers that the patient uses; educating the patient, family, guardian, or caregiver to support self-management, independent living, and activities of daily living; assessing and supporting treatment adherence including medication management; helping the patient and family access needed care and services; and identifying available community and health resources. CPT codes 99495 and 99496 can be provided via telehealth and under general physician supervision.

- **99495** – Transitional Care Management Services with the following required elements:
    - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
    - Medical decision making of at least moderate complexity during the service period
    - Face-to-face visit, within 14 calendar days of discharge

- **99496** – Face-to-face visit within 7 calendar days of discharge
  (Can be billed concurrently with 99487, 99489, 99490, 99439)

Ventilation Management including CPAP/Noninvasive Ventilation

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

(Do not report 94003 and 94002 used in the Emergency Department since this is not an inpatient or observation area as specified in the code description.)

- **94004** – nursing facility, per 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

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 is 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.

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Many of your questions relate to inpatient hospital services which are generally paid under a DR (Diagnosis Related Group) methodology. NCCI edits are not applied to these types of services.

CMS furt her wt th,t you may have about use ofwodilier 76 (, or service by hysic.'an or other qualified health care professional) dre 10) our local MAC (M cdi ini;.t rative Contractor).

CMS and we hope that this information is helpful.

Sincerely,
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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

CHAPTER XI MEDICINE EVALUATION AND MANAGEMENT SERVICES CPT CODES 90000 - 99999 FOR NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES

J. Pulmonary Services

CPT coding for pulmonary function tests includes both comprehensive and component codes to accommodate variation among pulmonary function laboratories.

1. Alternate methods of reporting data obtained during a spirometry or other pulmonary function session shall not be reported separately. For example, the flow volume loop is an alternative method of calculating a standard spirometric parameter. CPT code 94375 is included in standard spirometry (rest and exercise) studies.

2. If a physician in attendance for pulmonary diagnostic testing or therapy obtains a limited history and performs a limited physical examination related to the pulmonary testing or therapy, separate reporting of an E&M service is not appropriate. If a significant, separately identifiable E&M service is performed unrelated to the performance of the pulmonary diagnostic testing or therapy, an E&M service may be reported with modifier 25.

3. If multiple spirometric determinations are necessary to complete the service described by a CPT code, only one unit of service shall be reported. For example, CPT code 94070 describes bronchospasm provocation with an administered agent and uses multiple spirometric determinations as in CPT code 94010. A single unit of service includes all the necessary spirometric determinations.

4. Cardiopulmonary exercise testing (CPT code 94621) is a comprehensive exercise test with a number of component tests separately defined in the "CPT Manual". It is inappropriate to separately report component services such as, but not limited to, venous access, ECG monitoring, spirometric parameters performed before, during and after exercise, oximetry, O2 consumption, CO2 production, and rebreathing cardiac output calculations when performed during the same patient encounter as a cardiopulmonary exercise test. It is also inappropriate to report a cardiac stress test, a pulmonary stress test (CPT code 94618), or a component of either of these stress tests when performed during the same patient encounter as a cardiopulmonary exercise test.

5. Pursuant to the "Federal Register" (Volume 58, Number 230, 12/2/1993, Pages 63640-63641), ventilation management CPT codes (94002-94004 and 94660-94662) are not separately reportable with E&M CPT codes. If an E&M code and a ventilation management code are reported, only the E&M code is payable.

6. The procedure described by CPT code 94644 (Continuous inhalation treatment with aerosol medication for acute airway obstruction, first hour) does not include any physician work RVUs. When performed in a facility, the procedure uses facility staff and supplies, and the physician does not have any practice expenses related to the procedure. Thus, a provider/supplier shall not report this code when the physician orders it in a facility. This code shall not be reported with CPT codes 99217-99239, 99281-99285, 99466-99467, 99291-99292, 99468- 99469, 99471-99472, 99478-99480, 99304-99318, and 99324-99337 unless the physician supervises the performance of the procedure at a separate patient encounter on the same date of service outside the facility where the physician does have practice expenses related to the procedure.

7. CPT code 94060 (Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration) describes a diagnostic test that is used to assess patient symptoms that might be related to reversible airway obstruction. It does not describe treatment of acute airway obstruction. CPT code 94060 includes the administration of a bronchodilator. It is a misuse of CPT code 94640 (Pressurized or non-pressurized inhalation treatment for acute airway obstruction... (IPPB) device) to report 94640 for the administration of the bronchodilator included in CPT code 94060. The bronchodilator medication may be reported separately.

8. CPT code 94640 (Pressurized or non-pressurized inhalation treatment for acute airway obstruction... (IPPB) device) describes either treatment of acute airway obstruction with inhaled medication or the use of an inhalation treatment to induce sputum for diagnostic purposes. 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 inhalation drugs are administered in a continuous treatment or a series of "back-to-back" continuous treatments exceeding one hour, CPT codes 94644 (Continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour) and 94645 (...; each additional hour) may be reported instead of CPT code 94640.

9. CPT code 94640 (Pressurized or non-pressurized inhalation treatment for acute airway obstruction... (IPPB) device) and CPT code 94664 (Demonstration and/or evaluation of patient utilization of an aerosol generator... (IPPB) device) generally should not be reported for the same patient encounter. The demonstration and/or evaluation described by CPT code 94664 is included in CPT code 94640 if it uses the same device (e.g., aerosol generator) that is used in the performance of CPT code 94640. If performed at separate patient encounters on the same date of service, the 2 services may be reported separately.

10. Practitioner ventilation management (e.g., CPT codes 94002-94005, 94660, 94662) and critical care (e.g., CPT codes 99291, 99292, 99466-99486) include respiratory flow volume loop (CPT code 94375), breathing response to carbon dioxide (CPT code 94400), and breathing response to hypoxia (CPT code 94450) testing if performed. (CPT code 94400 was deleted on January 1, 2021.)