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monthly memo
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Physicians Committed to Quality

An important announcement from Richard B.Toll, M.D., MVMA President

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Coding Tips – Pulmonary Function Testing – Spirometry and Peak Flow

Recent claim data reports show increases in the frequency of billing pulmonary function testing over the past three years. Please note that both spirometry and peak flow testing are key services in assessment of asthma and other pulmonary conditions. MVMA supports and encourages the appropriate use of these services in the treatment of these conditions.

This article offers coding clarification to insure that your office is billing the correct CPT4 code for the service performed on your claims. Please follow CPT4 guidelines listed below as found under the pulmonology sections in CPT as guidance in selecting the correct code.

Peak Flow Meter Testing vs. Spirometry

Please note that peak flow meter testing is not a reportable service, but is considered part of the E&M examination, according to CPT4. Spirometry, both performed in the office, as well the professional reportable services for patient initiated spirometric recording, is reportable per CPT4.

Evaluation and Management (Q&A); What is the appropriate code assignment for performance of peak flow rate measurement?

AMA Comment: From a CPT coding perspective when performed, ***peak flow rate is an inherent part of the evaluation and management examination,*** *and* ***is not separately reported.***[i]

Coding Clinical Vignettes • CPT™ Assistant, January 1999

Pulmonary Function Testing

Codes 94010, 94014, 94015, 94016, 94060, 94070, 94620, 94621, 94761

- There have been a number of additions and revisions to the pulmonary section of CPT 1999.
- Three new codes have been created to report spirometric measurements taken by the patient at home (94014, 94015, and 94016).
- Two of the existing codes describing bronchospasm evaluation have been editorially revised (94060 and 94070).

CPT4 Codes Pulmonary Function

94010 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

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

94015 Patient initiated spirometric recording per 30 day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)

94016 Patient initiated spirometric recording per 30 day period of time; physician review and interpretation only

94060 Bronchospasm evaluation: spirometry as in 94010, before and after bronchodilator (aerosol or parenteral)

94070 Prolonged postexposure evaluation of bronchospasm with multiple spirometric determinations after antigen, cold air, methacholine or other chemical agent, with subsequent spirometrics

[i] CPT Assistant April 1999

Continued

Clinical Vignettes – Pulmonary Function Testing

Vignette for Code 94060

A 68-year-old woman has a history of chronic non-productive cough with wheezing. She has also noticed increasing dyspnea with mild exertion. Spirometry is done before and after the administration of a nebulized bronchodilator to demonstrate the presence and severity of airways obstruction and to evaluate the response to bronchodilator.

Vignette for Code 94010

A 65-year-old man is evaluated for increasing shortness of breath with exertion; he has a history of coronary heart disease and has also been a cigarette smoker for 50 years. A spirogram is obtained in order to determine whether the patient has significant pulmonary dysfunction and to further separate this into predominantly restrictive or obstructive disease.

Asthma Guidelines: Spirometry

Spirometry and Peak Flow Measurement at Office Visits

The Expert Panel recommends that spirometry tests be done at (1) at the initial assessment, (2) after treatment has stabilized symptoms and peak flow (to document a baseline of "normal" airway function), and (3) at least every 1 to 2 years when asthma is stable, more often when asthma is unstable, or at other times the clinician believes it is needed.

The following National Institutes of Health link lists the full guidelines for asthma.

http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm