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Internal Medicine Coding Alert

Coding for Diagnosis and Care of the Emphysema Patient

When a patient presents with symptoms of emphysema, many procedures are commonly performed by an internist. Physicians and coders are challenged in determining which E/M codes to use for initial and follow-up visits, which coding best fits for pulmonary function and other testing, which procedures are bundled, and how to report coordination of care with other providers.

Emphysema (492.0-492.8) is one form of chronic obstructive pulmonary disease (COPD), characterized by irreversible airflow obstruction. COPD is estimated to afflict about 10 percent of the population age 65 or older. When a patient presents with symptoms of the disease, the internist's suspicions are not enough the diagnosis must be confirmed through testing. "Before a diagnosis is established, the internists and their staff must code for the signs and symptoms," states **Catherine Brink,** principal of HealthCare Resource Management Inc., a practice management and consulting firm in Spring Lake, N.J. These might include shortness of breath (786.05), wheezing (786.07) and breathlessness (786.09).

Issues with Evaluation and Management

Walter J. O'Donohue, MD, FCCP, FACP, a representative of the AMA CPT Advisory Committee for the American College of Chest Physicians (ACCP) and CPT/RUC Committee chairman of the ACCP, says that a case could be made for coding the E/M visit as a level three or level four. "In the case of a patient suspected of having emphysema, which might be present in combination with some other form of COPD such as chronic bronchitis, it might be appropriate to use a level-four code (99204 or 99214), depending on whether you are seeing a new or established patient. These codes reflect a more comprehensive history and exam, as well as a moderate level of medical decision-making."

Michael Haynes, MD, internist and compliance director with University Medical Associates in Augusta, Ga., concurs: "I would think that this is a level-four visit, assuming that the history and physical met the requirements." Brink cautions that there is no hard and fast benchmark for coding E/M services. "The level of the exam is based on the level of care rendered; documentation to support the level of care should be provided with all claims," she says.

Coding and Billing for Tests and Interpretation

Internists can perform a variety of pulmonary function tests (PFTs) for emphysema. Codes for these tests are listed in the CPT series 94010-94799. Codes 94010 (spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement[s], with or without maximal voluntary ventilation) and 94060 (bronchospasm evaluation: spirometry as in 94010, before and after brochodilator) [aerosol or parenteral]) are two of the more commonly performed PFTs used to diagnose emphysema. Spirometry measures tidal volume, inspiratory reserve volume, expiratory reserve volume, residual volume, inspiratory capacity and vital capacity. A bronchospasm evaluation differs from spirometry in that the patient is tested before and after the administration of a bronchodilator.

According to Haynes, the internist should also order a chest x-ray (71020, radiologic examination, chest, two views, frontal and lateral) and diffusing capacity test (i.e., 94720, carbon monoxide diffusing capacity, [e.g., single breath, steady state]) if the spirometry results indicated abnormality. A lung volume test (e.g., 94260, thoracic gas volume; or 94350, determination of maldistribution of inspired gas: multiple breath nitrogen washout curve including alveolar nitrogen or helium equilibration time) is another option, but Medicare bundles lung volume tests with the spirometry. An exception is 94200 (maximum breathing capacity, maximal voluntary ventilation), which may be reimbursed if clearly documented as necessary in addition to spirometry.

O'Donohue says that he might conduct a pulmonary stress test (94620, pulmonary stress testing; simple [e.g., prolonged exercise test for bronchospasm with pre- and post-spirometry]) to assist in diagnosis if the initial spirometry test results

are inconclusive. O'Donohue recommends appending modifier -59 (distinct procedural service) to 94620 to differentiate the stress test from the initial spirometry.

Interpreting Test Results

CPT states that the actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the evaluation and management services. Physician performance of a diagnostic test/studies for which specific CPT codes are available may be separately reported by adding modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the E/M code.

"The internist could bill for the interpretation of the PFTs and chest x-ray if no one else did. Most PFT labs have a pulmonologist read the PFTs, and radiology offices have a radiologist read the x-ray," Haynes observes. If the internist interpreted the results, modifier -26 (professional component) would be appended to the procedure code to indicate the test was performed with equipment that was owned by someone other than the internist.

Treatment of the Patient

Once emphysema is the confirmed diagnosis, both Haynes and O'Donohue prescribe bronchodilators, which contain measured doses of medication that the patient can self-administer. Haynes prescribes a trial of Combivent or Serevent as the first treatment option with modification depending on clinical response. Follow-up visits would also be contingent upon how well the patient is responding to treatment. After treatment has begun, O'Donohue sees his patients within 30 days and repeats the spirometry (using code 94010). "While most carriers state that they will only cover spirometric testing once every six months, we have not had a problem getting paid for the repeat procedure," O'Donohue says. Haynes adds that if the patient is doing well, his practice bills the follow-up visit with a level-three E/M code (99213). However, if the patient was not responding and a new treatment was prescribed, a higher-level E/M code may be more appropriate.

Regarding the internist's coordination of care with a specialist, Haynes states that it depends on your continued role in the patient's problem. "If the pulmonologist, for example, is assuming the entire spectrum of care with regard to the emphysema, then you would not charge anything," he says. "If, on the other hand, you provide emergency care and ongoing care of this problem as part of your internal medicine service, then you should not only bill your services but copy your modifications to the pulmonologist. Expect that he or she will do the same for you so that you are both up-to-date on the treatment plan and medications."

Coding for the Care of a Severely Afflicted Patient

Oxygen administration combined with nebulizer treatment (and perhaps physical/respiratory therapy) is employed for patients with severe emphysema, whether in the patient's home or in a nursing home. Therapies like nasal positive pressure ventilation and noninvasive positive pressure respiratory assistance are reserved for extremely afflicted patients. "Almost all of these patients will already be on oxygen therapy and will have exhausted other medical treatments. Follow-up care by the internist for these patients is essential and would certainly be billed as delivered," notes Dr. Haynes.

CMS has instituted new codes that allow physicians to report certification and recertification services for home healthcare services, such as nursing visits, medication assessments and physical therapy:

1. G0180 physician certification services for Medicare-covered services provided by a participating home health agency (patient not present), including review of initial or subsequent reports of patient status, review of patient's responses to the Oasis assessment instrument, contact with the home health agency to ascertain the initial implementation plan of care, and documentation in the patient's office record, certification period

2. G0179 MD recertification, HHA patient.

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