

Internal Medicine Coding Alert

Procedure Coding: Take These Tips to Perfect Your Pulmonary Testing Knowledge

Master the ins and outs of PFT coding with these four expert suggestions.

Confused by the complex procedures? Baffled by the bundling? Pulmonary function testing (PFT) coding is no walk in the park, even for the most experienced coders.

Why? From spirometry to impulse oscillometry, CPT® offers 50 codes in its Pulmonary Diagnostic Testing and Therapies section, making PFT documentation a real challenge.

So, read on for a practical guide to some of the common problems you might encounter when your internist administers these vital procedures.

Tip 1: Know the relationship between the codes

The main issue facing coders when coding 94010 (Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement[s], with or without maximal voluntary ventilation) is knowing whether the test is a component of other codes, or whether other codes are components of the test itself. As **Kent Moore**, senior strategist for physician payment at the American Academy of Family Physicians puts it, "to avoid problems, coders need to be familiar with the guidelines preceding this section and the relationships among commonly reported codes from this section."

Consequently, three codes cannot be reported with 94010 because, as 94010's descriptor notes, the three procedures are already integral to the spirometry procedure itself. The codes in question are:

- 94150 - Vital capacity, total (separate procedure),
- 94200 - Maximum breathing capacity, maximal voluntary ventilation, and
- 94375 - Respiratory flow volume loop.

Additionally, as **Mary I. Falbo, MBA, CPC**, CEO of Millennium Healthcare Consulting Inc. in Lansdale, Pennsylvania notes, "because 94150 is a component of any other pulmonary function code, it is only billable when performed alone," hence the parenthetical "separate procedure" in the code's descriptor.

Tip 2: Know the kinds of tests you report separately ...

Coding some tests, such as 94760 (Noninvasive ear or pulse oximetry for oxygen saturation; single determination) and 94727 (Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes), presents little problem for coders. And though bronchodilation and methacholine tests also involve the use of spirometry, coding them accurately is also pretty straightforward, as the descriptors for both reference 94010.

So, 94060 (Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration) involves the patient inhaling a bronchodilator drug, such as Albuterol, before and after the provider performs the spirometry test, while 94070 (Bronchospasm provocation evaluation, multiple spirometric determinations as in 94010, with administered agents [eg, antigen[s], cold air, methacholine]) works in a similar way by using a stimulant to induce a bronchospasm.

But another test, 94728 (Airway resistance by impulse oscillometry) involves using a kind of spirometer known as a pneumotachograph. Consequently, as "94728 involves spirometry," Moore cautions coders that "it is not separately

reportable from 94010 and 94060 for a given patient on a given date," an interpretation reinforced by Correct Coding Initiative edits.

Coding alert: Falbo offers the reminder that you need to know whether your physician is performing the technical component ("the output from the equipment"), the professional component ("the physician's interpretation"), or both when administering 94070 or 94728. Depending on the circumstances, coders should append either modifier TC (Technical component), modifier 26 (Professional component) or no modifier at all if your provider performs both components.

Tip 3: ... and which one is added on.

One common procedure that is not bundled in with 94010, 94060, 94070, 94375, 94727, 94728, and several other codes is 94729 (Diffusing capacity (eg, carbon monoxide, membrane) (List separately in addition to code for primary procedure)), which your provider might perform to assess a patient for emphysema or interstitial lung disease. As the descriptor notes, this is an add-on code, which means that payers will not pay you for it unless you report the code along with the appropriate primary lung volume or spirometry test code.

Also, like 94070 or 94728, Falbo notes that you may need to append modifier TC, modifier 26, or no modifier at all to the test depending on your provider's role in performing it.

Tip 4: Know this therapeutic Tx can be a diagnostic test

Moore advises that one other code, 94640 (Pressurized or nonpressurized 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), can also be a cause of coding confusion for several reasons.

Aside from being used as both a diagnostic tool and a treatment, the notes for 94640 indicate that it should only be used for a single treatment lasting less than an hour. You should report any subsequent treatments by appending modifier 76 (Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional). And don't forget to keep your eye on the clock and report 94644 (Continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour) for a full hour and 94645 (Continuous inhalation treatment with aerosol medication for acute airway obstruction; each additional hour (List separately in addition to code for primary procedure) in conjunction with 94644 for an additional hour.