Part B Insider (Multispecialty) Coding Alert

PART B CODING COACH: 4 FAQs Get Your Pulmonary Rehab Coding on the Straight and Narrow

This Q&A gets you up to speed on correct coding and documentation for pulmonary rehabilitation payments.

Whether your physician oversees an outpatient pulmonary rehabilitation (PR) program, or aims to expand in-office PR services under the anticipated national coverage determination (NCD), your reimbursement could come up short unless you know exactly who should bill each code.

While your local Medicare Administrative Contractor (MAC) still has the final word on PR specifics in your area, there are common threads on which Medicare is likely to base the NCD, expected on Jan. 1, 2010.

Read on for the answers to common PR coding questions.

Q:What Can I Report if the Physician Doesn't Deliver PR?

Even if your physician is not directly involved in the provision of PR care, that doesn't mean you don't have anything to code. You can report E/M codes for periodic visits to evaluate the patient's underlying condition, any exacerbations, and response to therapy, explains **Carol Pohlig, BSN, RN, CPC,** senior coding and education specialist at the University of Pennsylvania department of medicine in Philadelphia.

Example: After reporting 99201-99205 or 99241-99245 for the initial outpatient visit, report follow-ups with an E/M code, such as 99214 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity).

Don't overlook reporting associated services and equipment. Add on any pulmonary function tests (94010-94621, 94680-94750, and 94770) the physician performs. And don't forget to report any equipment you provide in the office setting with these HCPCS codes, when permitted by the insurer:

• A4614 -- Peak expiratory flow rate meter, hand held

• A4627 -- Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler

• A7003 -- Administration set, with small volume nonfiltered pneumatic nebulizer, disposable.

Q: Can We Code for PR When an NPP Provides Care?

While a physician must provide the initial service to begin the course of treatment, your program's nonphysician practitioners (NPPs), such as respiratory care practitioners, registered nurses, physical therapists, and occupational therapists who are licensed to perform the procedures, can fill in for the physician on subsequent PR care, reports a recent pulmonary rehabilitation bulletin on the American Association for Respiratory Care's Web site.

Key: To avoid denials, use the appropriate code for the type of provider who is providing the service, says Pohlig. Here's how:

• If a PT or OT is involved, you use 97001-97799 (Physical Medicine and Rehabilitation) since the care involves the patient's overall strength and conditioning, notes **Alan L. Plummer, MD,** professor of medicine, division of pulmonary, allergy, and critical care at Emory University School of Medicine in Atlanta. For respiratory therapists who focus solely on pulmonary function, you must choose from one of the G codes:

• G0237 -- Therapeutic procedure to increase strength or endurance of respiratory muscles, face-to-face, one-on-one, each 15 minutes (includes monitoring)

• G0238 -- Therapeutic procedures to improve respiratory function, other than described in G0237, one-on-one, face-toface, per 15 minutes (includes monitoring)

• G0239 -- Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring).

Q: How Do I Justify PR?

For PR to be covered, the patient's diagnosis must be a chronic, stable respiratory disorder with disabling symptoms that impair function but do not impede convalescence, such as chronic obstructive pulmonary disease (COPD).

Standards: The majority of MACs assess current need for PR by either carbon monoxide diffusing capacity (DLCO) or forced expiratory volume in one second (FEV1) less than 65 percent predicted on pulmonary function testing within one year of initiating PR), says **Lana Hilling, CRT, RCP,** coordinator of lung health services at John Muir Health System in California.

Since PR is meant to improve respiratory function, auditors also want to see documentation that the patient is making progress toward goals, says Hilling.

Important: Ensure that goals are specific -- you can't just say the patient wants to breathe better, you must specify the activity. For example, the patient wants to take a shower with less shortness of breath, Hilling explains.

You can also demonstrate gains by improvements in exercise tolerance, decreased shortness of breath, improved activities of daily living (ADLs), and decreased signs and/or symptoms of cough, dyspnea, etc.

Q:What Documentation Is Necessary for Reimbursement?

To avoid a denial, the doctor's orders must specify the PR type, frequency, and duration. Instead of prescribing a six-week program, the physician should outline the schedule: The patient should attend a six-week PR program, two days per week for four weeks, and three days per week for two weeks, for two to four hours each day, Hilling says.

The physician's notes should also indicate the time of instruction needed, such as ADL, inhaler, medication management, and/or infection control education.

Crucial: Payers want to observe that you are tailoring the PR program to the individual, explains Hilling. Auditors will pull Medicare charts for certain groups and look to see what you did with each patient to determine whether it was unique, she adds.