Part B Insider (Multispecialty) Coding Alert

Pulmonary Coding: 3 PFT Focused Cases Show You How to Report Lung Testing

Bill 94010 and 94060 together at your own peril.

Dealing with pulmonary function test (PFT) codes can be deceptive as you navigate through simple looking codes that may come back to haunt you if make single slip and lose valuable dollars. Familiarize yourself with when to use the right CPT® codes for PFT by busting these myths.

Background: Whenever your pulmonologist treats a patient with suspected or known lung disease (such as emphysema), you are definitely in the mix for a possible use of PFT codes. The physician will need the PFTs along with meticulous history and physical examination for diagnosing the patient's lung condition and pinpointing the disease from many.

What it is: PFT is a collective term loosely translated to a group of procedures namely, spirometry, lung volume test, diffusion capacity test, lung compliance test, and exercise tolerance testing.

The fundamental PFT is a spirometry that measures lung volume and function (the rate at which you blow air in and out). You normally report spirometry with code 94010 (Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement[s], with or without maximal voluntary ventilation).

Another common test is the bronchospasm test, an extended form of spirometry. First, a spirometry test is performed, then the physician administers a bronchodilator (such as an albuterol inhaler) to dilate the airways, after which another spirometry would be done. The code for this procedure is 94060 (Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration).

The following case studies illustrate how to code for PFTs:

Insert All Possible Diagnoses to Justify Visit and Tests

Case #1: A patient with chronic obstructive pulmonary disease presents to the office with a variety of symptoms, including shortness of breath, wheezing, and breathlessness. After a thorough patient interaction, the pulmonologist decides to perform numerous in-office tests to properly diagnose the severity of the disease, including bronchospasm evaluation, diffusing capacity test, and thoracic gas volume test. He also orders a chest x-ray.

Code this: In this case, you should report the following:

- 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.) along with modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) for the office visit. You would use the modifier to indicate that the E/M was a distinct and separate service since the evaluation resulted in the need for additional same-day testing;
- 94060 for the bronchospasm evaluation;

- 94729 (Diffusing capacity [e.g., carbon monoxide, membrane] [List separately in addition to code for primary procedure]) for the diffusing capacity test;
- 94726 (Plethysmography for determination of lung volumes and, when performed, airway resistance) for the lung volume test;
- 786.05 (Shortness of breath), 786.07 (Wheezing), and 786.09 (Other respiratory abnormalities) -- presenting symptoms [In ICD-10, these will convert into R06.02 (Shortness of breath), R06.2 (Wheezing), and R06.89 (Other abnormalities of breathing)]
- 491.21 (Obstructive chronic bronchitis with [acute] exacerbation) linked to the CPT® codes for the diagnostic support code. When ICD-10 goes into effect, you will report J44.1 (Chronic obstructive pulmonary disease with [acute] exacerbation) instead.

Caution: "The radiologist should bill for the x-ray (71010, Radiologic examination, chest; single view, frontal), but you should include your informal physician's review of the x-ray interpretation in your documentation for credit in the complexity of your medical decision making," informs **Carol Pohlig, BSN, RN, CPC, ACS,** Senior Coding & Education Specialist at the Hospital of the University of Pennsylvania.

Remember to Include Inhalation Solution Codes While Billing

Case #2: A 55-year-old new patient who has been smoking for 30 years with shortness of breath is referred to your pulmonologist for consult. The physician performs a detailed history and an expanded problem-focused exam, and decides that spirometry would help diagnose COPD. The patient has non-optimal readings on the first spirometry, so the physician administers albuterol and re-performs the spirometry. Readings from the second test are greatly improved. The pulmonologist diagnoses the patient with reactive airway disease and probable COPD.

Code this: You should bill:

- 99241-99245 (Office consultation for a new or established patient office ...) for the consult services (if accepted by the payer) or 99201-99205;
- 94060 for the albuterol-induced spirometry;
- 493.12 (Intrinsic asthma; with [acute] exacerbation) because the patient is having an acute exacerbation (shortness of breath). A secondary code is not necessary in this case because shortness of breath is intrinsic to asthma and the COPD is not a definitive diagnosis. When ICD-10 goes into effect, you will report from J45.-- (Asthma ...) depending upon the quality of the asthma and the acuteness of attack.
- J7609-J7613 (Albuterol, inhalation solution,...) for the bronchodilator medication, such as Albuterol, if your pulmonologist performs the test in the office.

Hint: The correct code here is 94060 because the spirometry has turned into a bronchospasm test because the physician used an albuterol inhaler during the evaluation. The bronchospasm evaluation (94060) involves spirometry (94010) taken before and after your physician administers bronchodilation (94640, Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes [e.g., with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device]) to dilate the airways. "This means that although the physician performed both test components, you cannot report either component separately spirometry administration of bronchodilator," adds Pohlig.

Be Careful in Coding Bronchodilator Administration

Case #3: A new asthmatic patient presents in your office with difficulty breathing. The physician administers peak flow to make sure the problem is not serious. The measurement, however, is high, and the physician gives the patient a bronchodilator to open up his airways and takes another peak-flow measurement.

Code this: Because the peak-flow measurement is such a quick and simple test, it is not reimbursable as a standalone test. Code 94060 cannot be used here because a spirometry was not given before and after the bronchodilator; rather, the pulmonologist performed a peak flow. You should report code:

- 99201-99205 (Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components:...) for the office visit along with modifier 25;
- 94640 to represent the bronchodilator administration because it is considered a nebulizer treatment in this case.