Reimbursement for Spirometry

Spirometry CPT Codes

The following common procedure terminology codes (CPT) describe the various resting spirometry procedures and the national average reimbursement amount. They include but are not limited to:

CPT Code	Description	Nat'l Fee
94010	**Breathing Capacity Test** Including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without MVV.	$36.08
94014	**Patient Recorded Spirometry** 30 day period of time; includes reinforced education, transmission of spirometric tracings, data capture, analysis of transmitted data, periodic recalibration and physician review and interpretation	$47.31
94015	**Patient Recorded Spirometry** 30 day period of time; recording (includes hook up, reinforced education, data transmission, data capture, trend analysis and periodic recalibration) physician review and interpretation only	$23.49
94016	**Review Patient Spirometry** 30 day period of time; physician review and interpretation only	$23.83
94060	**Evaluation of wheezing** 30 day period of time; physician review and interpretation only	$60.93
94200	**Lung Function Test (MBC/MVV)** Maximum breathing capacity, maximal voluntary ventilation	$25.19
94375	**Respiratory Flow Volume Loop**	$39.14
94620	**Pulmonary Stress Test/Simple** (e.g., 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry)	$59.91

Source: Medicare Physician's Fee Schedule for Calendar Year 2012.

Spirometry ICD-9 Codes

The following ICD-9 Codes support the medical necessity for the use of a spirometer. It is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis or clinical suspicion must be present for the procedure to be paid. They include but are not limited to:

ICD-9 Code	Description	ICD-9 Code	Description
466-466.19	Acute Bronchitis and bronchiolitis	**490**	Bronchitis, not specified as acute or chronic
491-491.9	Chronic Bronchitis	**492-492.8**	Emphysema
493-493.31	Asthma	**494**	Bronchiectasis
496	Chronic airway obstruction, not elsewhere classified	**508-508.9**	Respiratory condition due to other an unspecified external agents
518.9	Other diseases of respiratory system, not elsewhere classified	**519.1**	Bronchospasm
780.51	Insomnia with sleep apnea	**786.2**	Cough
780.53	Hyper insomnia with sleep apnea	**793.1**	Abnormal chest x-ray
786	Abnormal chest sounds	**277**	Cystic Fibrosis
790.7	Chronic fatigue	**787**	Heartburn
E942.9	Other specified agents primarily affecting the cardiovascular system	**305.1**	History of tobacco abuse
V13.8	History of thyroid disorder		

Medicare

Medicare covers 80% of the fee schedule (Table 1) or the actual charge from the physician, whichever is lower. Physicians may bill the Medicare beneficiary and/or the secondary carrier for the remaining 20% of the allowed amount. Non-participating physicians may bill the patient a maximum of 115% of the Medicare physician fee schedule amount. Contact your local Medicare carrier to determine the exact payment methodology for these procedures under the Medicare fee schedule.

Private Insurance

Private payers may have different coding and reimbursement guidelines. Generally private payers offer significantly higher amounts than Medicare.

When discussing reimbursement with a physician…

When discussing the reimbursement for a particular procedure, use the National Average Fee (Table 1). This fee is an average and can be used as a guide when discussing reimbursement. Average reimbursements are based on nationwide data by the Medicare fee analyzer and other agencies that track reimbursement schedules. The National Average Fee cannot be used to calculate Medicare reimbursement without the composite components, regional geographic cost adjustment factors and conversion factors. In other words, use the National Average Fee as a guide for reimbursement – physicians should determine their own reasonable charges for tests based on their locale.

- *The information listed in this document is for information purposes only. QRS does not guarantee coverage or levels of reimbursement. It is the responsibility of the provider to determine the correct coding and coverage for services they provide.*
- *The National Average Fees listed are for Non-Facilities which includes all settings except hospitals (inpatient, outpatient and emergency department), ambulatory surgery centers (ASCs) and skilled nursing facilities (SNFs).*
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- **Centers for Medicare and Medicaid Services (CMS), Medicare Program: Medicare Physician Fee Schedule for CY, http://www.cms.gov/PhysicianFeeSched/. Please note: Medicare fee schedule is subject to change without notification.*

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