Helpful hints for filing

CPT coding

Overview

The following information describes the terminology and coding language physicians may consider using when billing for procedures and services performed. Coding information and national Medicare fee schedules for specific procedures and services are listed on the following pages.* The fee schedules **do not** take into consideration the geographic practice cost indices.

Although accurate coding is essential to ensure prompt claims processing and reimbursement, inclusion of a specific code and fee schedule amount do not guarantee payment. It is critical to be aware of each payer's coverage guidelines. For information regarding specific reimbursement guidelines including coding, coverage, and payment, please consult your local payer, the *Federal Register* or the *Current Procedural Terminology (CPT), Fourth Edition*.[1] The Respironics Reimbursement Support Line is also available to assist in addressing your reimbursement issues.

CPT coding

When selecting a CPT code and descriptor, healthcare providers should choose the CPT code that most accurately identifies the procedure or service performed. In addition to diagnostic or therapeutic procedures, the physician may also report other procedures performed or pertinent special services plus any modifying or extenuating circumstances. All procedures or services should be accurately documented in the patient's medical record.

[1]*Current Procedural Terminology (CPT), Fourth Edition, 2011.* ©2010, American Medical Association (AMA). All rights reserved. Inclusion in CPT or representation here does not suggest endorsement by the American Medical Association or Philips Respironics for any particular diagnostic or therapeutic procedure. Inclusion or exclusion of a procedure does not imply any health insurance coverage or reimbursement policy. In several instances, the AMA has provided additional coding guidance, either verbally through the CPT Information Help Line or in writing via the CPT Assistant newsletter. Please refer to the Current Procedural Terminology, Fourth Edition, for complete CPT descriptions.

The Medicare and Medicaid Extenders Act (MMEA) of 2011. The MPFS conversion factor is $33.9764 effective for dates of service on or after January 1, 2011. Medicare Hospital Outpatient Prospective Payment Amounts: Addendum B.-OPPS Payment by HCPCS Code for CY 2011, January 2011. Medicare Hospital Outpatient Prospective Payment System reflects unadjusted payment rate.

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Definitions

A status indicator shows how Medicare reimburses for CPT/Level 1 HCPCS codes under the Medicare Physician Fee Schedule. The following status indicators are applicable to the codes listed in this document:

A = Active:	Medicare carriers remain responsible for coverage decisions in the absence of a national Medicare policy.
B = Bundled:	Medicare payment for covered services is always bundled into payment for other services not specified.
C = Carrier-priced:	Medicare generally pays for this code on a case-by-case basis following review of documentation, such as a pulmonary service/ procedure. Medicare contractors will establish RVUs and payment amounts for the services on a case-by-case basis following review of documentation.
I = Invalid:	Code not valid for Medicare purposes. Medicare uses another code for the reporting of and payment for these services.

Modifiers

A modifier allows a physician to report or indicate that a service or procedure performed has been changed or altered by some circumstance, but not beyond the scope of the current code description. For example, if a particular code represents the global service performed (includes both the technical and professional components of the procedure), a modifier may not be required for billing. However, if a provider performs only the technical portion, or only the professional component of a procedure, it will be necessary to add a modifier to the code billed.

Modifiers are typically two-digit codes added to claims as "add-on" codes next to the five-digit CPT code. The procedures and services listed in this document may be modified under certain circumstances.

If...	And...	Then use modifier...
A service has distinct technical and professional components to bill for the professional portion.	Professional component (interpretation only)	-26
A service has distinct technical and professional components to bill for the technical portion.	Technical component (technical service only)	-TC*
The service is partially reduced or eliminated at the physician's discretion.	Reduced services	-52

CMS has established this Level II HCPCS modifier for billing Medicare. When billing Medicare for the technical component of a code, physicians must own the equipment. As confirmed by AMA, leasing or renting the equipment* ***does* *meet this ownership criterion. Please note that in addition to Medicare, many private payers will also accept the technical component modifier.*

Evaluation and management (E/M) codes

The following codes may be used to report time spent with a patient through E/M services provided in a variety of settings, including hospital, physician office and home. Evaluation and Management (E/M) codes are only reported on the same day as a procedure or other service when they are significant and separately identifiable. They must meet criteria for reporting an E/M service and the E/M service is beyond the usual scope and nature of what is ordinarily done for the procedure or service in question. Significant and separately identifiable E/M services are indicated by reporting modifier -25 with the appropriate code that matches documentation in the medical record.

When selecting a level of E/M, healthcare providers must assess the levels of history, physical examination, and medical decision making per the 1995 or 1997 E/M guidelines. Providers must code a level of service that is also documented in the patient's medical record. The following table provides examples of E/M services. Providers should review the E/M codes to see if a different level E/M is more appropriate based on the E/M guidelines.

Site of service	If...	And...	Then use code...	2011 MPFS national average*
Emergency department	Patient undergoing evaluation and management	High severity and pose an immediate/significant threat to life or physiologic function	99285	$169.20
Acute care facility initial observation care	Per day, for evaluation and management	High severity "observation status"	99220	$150.18
Acute care facility initial hospital care	Per day, for evaluation and management	High severity, spending 70 min. at bedside and on the patient's hospital floor or unit	99223	$194.01
Acute care facility subsequent hospital care	Established patient undergoing counseling and/or coordination of care per day	Spending 15 min. at the bedside and on the patient's hospital floor unit, patient is stable, recovering or improving	99231	$38.39
Nursing facility subsequent nursing care	New or established patient undergoing evaluation and management per day	Significant new problem or complication requiring immediate physician attention; spending 35 min. with patient and/or family or caregiver	99310	$126.39
Physician's office or other outpatient services	New patient undergoing evaluation and management	Moderate-to-high severity, spending 60 min. with patient and/or family	99205	$197.06 *(subject to site-of-service differential)*
Physician's office or other outpatient services	Established patient undergoing evaluation and management	Moderate-to-high severity, spending 40 min. with patient	99215	$137.60 *(subject to site-of-service differential)*
Home services	Home visit for evaluation and management of a new patient	Moderate-to-high severity, spending 45 min. face-to-face with patient and/or family	99343	$129.79

**Represents non-facility Medicare payment allowance*

Site of service	If...	And...	Then use code...	2011 MPFS national average*
Home services	Established patient for evaluation and management	Moderate-to-high severity, spending 40 min. face-to-face with patient and/or family	99349	$121.64
Home services	Care plan oversight services; physician supervision of patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment	Including physician development/revision of care plans, review of subsequent reports of patient status, review of laboratory and related studies, communication with health care professionals, family members, and other individuals involved in patient's care, within a calendar month, 15-29 min.	99374*	Bundled code
Home services	Care plan oversight services; physician supervision of patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment	Including physician development/revision of care plans, review of subsequent reports of patient status, review of laboratory and related studies, communication with health care professionals, family members, and other individuals involved in patient's care, within a calendar month, 30 min. or more	99375*	Not valid for Medicare
Not applicable	Unlisted evaluation and management services	Include a special report to describe the procedure itself, need for the procedure, and time, effort and equipment required. Also include patient's symptoms, concurrent problems and follow-up care	99499**	Medicare contractor-priced

**99374 and 99375 are not used to report Medicare services. When billing Medicare for these services, providers may report HCPCS procedure code G0181. This code is specific to Medicare-covered services and is specific to "30 minutes or more."*
***According to the AMA, this is a coding option when reporting physician review of a downloaded data management report from a device (i.e., CPAP, SmartMonitor). Billing this code requires the physician to complete a written report to be included in the medical record.*

Procedures

When billing for the performance of certain procedures and diagnostic tests/studies for which specific CPT codes are available, billing is not included under E/M. However, in most cases, E/M codes may be reported separately, as long as a significant and separately identifiable E/M procedure is performed. The following codes may be appropriate in combination with and when using a variety of Respironics products.

If...	And...	Then use code...	2011 MPFS national average*	2011 APC	2011 OPPS
Ventilation assist and management	Initiation of pressure or volume preset ventilator for assisted or controlled breathing; hospital inpatient/ observation, initial day	94002	$ 90.72	0079	$200.07
Ventilation assist and management	Hospital inpatient/observation, each subsequent day	94003	$ 65.23	0079	$200.07
Ventilation assist and management	Nursing facility, per day	94004	$ 47.57	Code for SNF only	
Home ventilator management care plan oversight	Patient in home, domiciliary, or rest home requiring review of status, review of labs and other studies and revision of orders and respiratory care plan, within a calendar month, 30 min. or more	94005	Code for home setting of care		
Spirometry	Includes graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation	94010	$ 35.34	0368	$ 59.63
Patient initiated spirometric recording, per 30-day period of time	Includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration, and physician review and interpretation	94014	$ 48.93	0367	$ 40.58
Patient initiated spirometric recording, per 30-day period of time	Includes hook-up, reinforced education, data transmission, data capture, trend analysis and periodic recalibration (technical component only)	94015	$ 24.46	0367	$ 40.58
Patient initiated spirometric recording, per 30-day period of time	Physician review and interpretation only	94016	$ 24.46	Not paid under OPPS; paid under MPFS	
Bronchodilation responsiveness	Includes spirometry as in 94010 pre- and post-bronchodilator administration	94060	$ 60.82	0078	$ 98.62
Respiratory flow		94375	$ 38.39	0368	$ 59.63
Pulmonary stress testing	Simple (e.g., six minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry)	94620[1]	$ 63.54	0368	$ 59.63
Pulmonary stress testing	Complex (including measurements of CO_2 production, O_2 uptake, and electrocardiographic recordings)	94621	$162.75	0369	$207.62
Inhalations	Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes	94640	$ 15.97	0077	$ 28.73
Bronchospasm provocation evaluation	Multiple spriometric determinations as in 94010 with administered agent (e.g., antigens); cold air; methacholine	94070	$ 59.80	0369	$207.62
Continuous inhalation treatment	With aerosol medication for acute airway treatment obstruction, first hour	94644	$ 40.09	0340	$ 46.23
Continuous inhalation treatment	Each additional hour (use with 94644)	94645	$ 14.61	0340	$ 46.23
Demonstration and/or evaluation	Patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device	94664	$ 15.97	0077	$ 28.73
Continuous positive airway pressure ventilation (CPAP)	Initiation and management	94660[2]	$ 59.46 *(subject to site-of-service differential)*	0078	$ 98.62
Noninvasive ear or pulse oximetry for O_2 saturation	Single determination	94760	$ 2.72 Status indicator "T"	Packaged into other APC payment rates reported on claim	
Noninvasive ear or pulse oximetry for O_2 saturation	Multiple determinations (e.g., during exercise)	94761	$ 4.42 Status indicator "T"	Packaged into other APC payment rates reported on claim	
Noninvasive ear or pulse oximetry for O_2 saturation by continuous overnight monitoring (separate procedure)	12-24 hours continuous recording, infant	94762	$ 20.05	0097	$ 66.25
Carbon dioxide	Carbon dioxide, expired gas determination by infrared analyzer	94770	$ 23.10	0367	$ 40.58
Circadian respiratory pattern recording (pediatric pneumogram)	12-24 hours continuous recording, infant	94772*	Medicare contractor-priced	0369	$207.62
Pulmonary service not listed elsewhere	Unlisted service or procedure	94799*	Medicare contractor-priced	0367	$ 40.58

[1]Medicare contractor guidelines vary as to whether spirometry is a required component of this procedure. Please contact your local Medicare contractor directly to determine specific coverage and billing guidelines. [2]According to AMA CPT Information Services, this is the most appropriate code for "initiating and managing" CPAP and bi-level sleep therapy devices. *This code is contractor-priced under the Physician Fee Schedule. Please contact your local Medicare contractor for payment amounts.

Pulmonary – Pediatrics

If...	And...	Then use code...	2011 MPFS national average*	2011 APC	2011 OPPS
Pediatric home apnea monitoring event recording	Including respiratory rate, pattern and heart rate per 30-day period of time; includes monitor attachment, download of data, physician review, interpretation, and preparation of a report	94774	Medicare contractor-priced	Not paid under OPPS	
Pediatric home apnea monitoring event recording	Monitor attachment only (includes hook-up, initiation of recording and disconnection)	94775	Medicare contractor-priced	0097	$ 66.25
Pediatric home apnea monitoring event recording	Monitoring, download of information, receipt of transmission(s) and analyses by computer only	94776	Medicare contractor-priced	0097	$ 66.25
Pediatric home apnea monitoring event recording	Physician review, interpretation and preparation of report only	94777	Medicare contractor-priced	Not paid under OPPS	

Neurology

If...	And...	Then use code...	2011 MPFS national average*	2011 APC	2011 OPPS
Multiple sleep latency or maintenance of wakefulness testing	Recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness	95805	$410.43	0209	$780.77
Sleep study	Simultaneous recording of ventilation, respiratory effort, or ECG or heart rate and oxygen saturation unattended by a technologist	95806	$182.11	0213	$166.64
Sleep study	Simultaneous recording of ventilation, respiratory effort, or ECG or heart rate and oxygen saturation attended by a technologist	95807	$469.89	0209	$780.77
Polysomnography	Sleep staging with 1-3 additional parameters of sleep, attended by a technologist	95808*	$649.63	0209	$780.77
Polysomnography	Sleep staging with 4 or more additional parameters of sleep, attended by a technologist	95810*	$694.14	0209	$780.77
Polysomnography	Sleep staging with 4 or more additional parameters of sleep, with the initiation of CPAP or bi-level ventilation, attended by a technologist	95811*	$749.18	0209	$780.77
Home sleep study test	Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation	G0398	Medicare contractor-priced	0213	$166.64
Home sleep study test	Home sleep test (HST) with type III portable monitor unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation	G0399	Medicare contractor-priced	0213	$166.64
Home sleep study test	Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels	G0400	Medicare contractor-priced	0213	$166.64

For an unattended polysomnograpy, CPT code 94799 may be reported. It is assigned, however, to APC 0367 which has an unadjusted 2011 APC payment rate of $40.58.

**For a study to be reported as polysomnography, sleep must be recorded and staged.*

Cardiography

If...	And...	Then use code...	2011 MPFS national average*	2011 APC	2011 OPPS
Electrocardiographic monitoring	For 24 hours by continuous original waveform recording and storage, with visual superimposition scanning; includes recording, scanning analysis with report, physician review and interpretation	93224*	$ 96.83	Not valid for outpatient reporting	
Electrocardiographic monitoring	Recording (includes connection, recording, and disconnection)	93225*	$ 28.20	0097	$ 66.25
Electrocardiographic monitoring	Scanning analysis with report	93226*	$ 41.45	0097	$ 66.25
Electrocardiographic monitoring	Physician review and interpretation	93227*	$ 27.18	Not valid for facility billing	

**When appropriate to download ECG data, these CPT codes may be appropriate for use in conjunction with the SmartMonitor device. Provider must show medical necessity for ECG downloads. According to the AMA, a physician must lease, rent or own the equipment being used in order to bill for the technical component of a code; therefore, if a physician does not own the monitor, only 93227 may be billed.*

Miscellaneous services

If...	And...	Then use code...	2011 MPFS national average*	2011 APC	2011 OPPS
Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drug, trays, supplies, or materials provided)	Include a special report to describe the procedure, need for the procedure, and time, effort and equipment required. Also include patient's symptoms, concurrent problems and follow-up care.	99070	Bundled code	Not paid under OPPS	
Analysis of information data stored in computers (e.g., ECGs, blood pressure, hematologic data)	Include a special report to describe the procedure, need for the procedure, and time, effort and equipment required. Also include patient's symptoms, concurrent problems and follow-up care.	99090*	Bundled code	Not paid under OPPS	
Collection and interpretation of physiologic data (e.g., ECG blood pressure, glucose monitoring)	Digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthcare professionals, requiring a minimum of 30 min. of time.	99091*	Bundled code	Packaged into other APC payment rates reported on claim	

**According to AMA, this is a coding option when billing for physician review of a downloaded data management report from a device (i.e., CPAP). Billing this code requires the physician to complete a written report to be included in the medical record.*

Laboratory/chemistry and other related procedures

If you are CLIA certified and perform...	Then use code...	2011 Clinical Laboratory National Limitation Amount (NLA)	2011 APC	2011 OPPS
Gases, blood, any combination of pH, pCO_2, pO_2, CO_2, HCO_3, (including calculated O_2 saturation) for two or more of above listed analyses	82803	$ 27.22	Not paid under OPPS	
Bilirubin, total, transcutaneous	88720**	$ 7.06	Not paid under OPPS	
Unlisted chemistry procedure	84999*	Individually priced, based on charges and review of supporting documentation	Not paid under OPPS	

**You must be CLIA certified to perform this procedure.*
*****This is the appropriate procedure code for reporting bilirubin testing using the BiliChek. This code was effective as of 1/1/09. Previously (from 1/1/01 through 1/1/09) the code was 88400.*

This information should not be considered to be either legal or reimbursement advice. Given the rapid and constant change in public and private reimbursement, Philips Respironics cannot guarantee the accuracy or timeliness of this information and urges you to seek your own counsel and experts for guidance related to reimbursement, including coverage, coding and payment.

For more information from Philips Respironics

Reimbursement	Customer service	Website
Information & fee schedules Educational materials & questions (coding, coverage and payment)	1-800-345-6443; listen to the instructions and follow prompts to select the insurance reimbursement information option	www.philips.com/respironics

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eDoc SB 11/13/13 MCI 4105947

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