Hillrom™

2019 Spirometry Reimbursement Information

CPT® CODING RESOURCE

Spirometry Procedures & Medicare Physician Fee Schedule

Code	Description	2019 National Averages[1]	
		Facility[2]	Non-Facility[3]
94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation	$36.72	$36.72
94010 TC[4]	Technical Component	$25.89	$25.89
94010 26[5]	Professional Component	$8.40	$8.40
94060	Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration	$57.75	$57.75
94060 TC	Technical Component	$44.72	$44.72
94060 26	Professional Component	$13.03	$13.03
94070	Bronchospasm provocation evaluation, multiple spirometric determinations as in 94010, with administered agents (e.g., antigen(s), cold air, methacholine)	$58.43	$58.43
94070 TC	Technical Component	$29.66	$29.66
94070 26	Professional Component	$28.77	$28.77
94150	Vital capacity, total (separate procedure)	$24.52	$24.52
94150 TC	Technical Component	$2.76	$2.76
94150 26	Professional Component	$3.76	$3.76
94200	Maximum breathing capacity, maximal voluntary ventilation	$26.65	$26.65
94200 TC	Technical Component	$21.10	$21.10
94200 26	Professional Component	$5.55	$5.55
94375	Respiratory flow volume loop	$38.65	$38.65
94375 TC	Technical Component	$23.84	$23.84
94375 26	Professional Component	$14.81	$14.81

Rates are subject to change. Effective 1/1/2019.
For reference only. Information does not constitute a guarantee of coverage or payment.

MEDICARE

Providers should refer to their Medicare Contractor's Local Coverage Determination (LCD) for specific coverage and billing guidelines.

MEDICAID AND PRIVATE PAYERS

Spirometry procedures may be covered by Medicaid and private payers when medically necessary. Coverage guidelines and payment levels vary by payer and specific plan. Providers should contact each specific plan to determine coverage and payment for the use of Welch Allyn® spirometry products.

OTHER CONSIDERATIONS

- Include documentation in the patient's records to indicate medical necessity for a separate service.
- Confirm that proper ICD-10-CM diagnosis codes are reported to justify medical necessity of spirometry procedure(s).
- When appropriate, a modifier may be reported and support documentation should be provided with the claim.
- Some payers may have specific requirements for using certain codes, including prior authorization, restricted medical diagnoses or specialty provider types.
- Contractors publish LCDs to provide guidance to the public and medical community within their jurisdictions. It's important that you verify with your Local Contractor as they typically have their own set of rules associated with each CPT code.

For additional questions, contact Hillrom Customer Care at 1.800.535.6663.

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hillrom.com/welchallyn/reimbursement

[1] National Average from the 2016 Centers for Medicare and Medicaid Services Physician Fee Schedule.
[2] Facility—Includes hospitals (inpatient, outpatient and emergency department), ambulatory surgery centers (ASCs) and skilled nursing facilities (SNFs).
[3] Non-Facility—Includes all other settings.
[4] TC—Technical Component; for diagnostic tests, the portion of a procedure that does not include a physician's participation.
[5] 26—Professional Component; the portion of diagnostic test that involves a physician's work and allocation of the practice expense.

The information contained in this document is provided for convenience only and represents no statement, promise or guarantee by Hillrom concerning coverage or levels of reimbursement. Payment will vary by geographic locality. It is always the provider's responsibility to determine accurate coding, coverage and claim information for the services that were provided.

Centers for Medicare & Medicaid Services (CMS), Medicare Program: Medicare Physician Fee Schedule for CY 2019, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched. Please note: Medicare fee schedule corrections and changes occur periodically.