Coding & Documentation

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VAPING-RELATED ILLNESS

Q I am seeing patients with respiratory symptoms associated with vaping (e.g., cough or chest pain). What code should we report to indicate this?

A Assign a code for the patient's diagnosed condition or symptoms. For patients with acute lung injury but no further documentation of a specific condition, such as bronchitis or pneumonitis, you can assign ICD-10 code

J68.9 for "Unspecified respiratory condition due to chemicals, gases, fumes, and vapors." For symptoms attributed to exposure to vaping, also assign code Z77.29, "Contact with and (suspected) exposure to other hazardous substances." If the patient is nicotine-dependent and using electronic cigarettes (i.e., vaping a nicotine product), also assign a code from category F17.29- (sixth character required) for "Nicotine dependence, other tobacco product." At this time there is no diagnostic code specific to vaping, but that may change in the future.

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EDITOR'S NOTE

Reviewed by the *FPM* Coding & Documentation Review Panel. Some payers may not agree with the advice given. Refer to current coding manuals and payer policies.

BILLING "QUALIFIED MEDICARE BENEFICIARIES"

Q Our billing office has received calls from patients and families stating that our office is not allowed to bill them for the Medicare deductible and coinsurance amounts because the patient is a Qualified Medicare Beneficiary (QMB). Is this correct? If so, how do we identify these patients?

A This is correct. Federal law prohibits billing patients who are QMBs, which are Medicare recipients who meet certain income limits. This rule applies whether or not your practice accepts Medicaid (which covers out-of-pocket costs for some QMBs). QMBs may be covered by original Medicare Part B or a Medicare Advantage plan. For patients covered by Medicare Part B, your staff can verify QMB status prior to the first visit through the Centers for Medicare & Medicaid Services' HIPAA Eligibility Transaction System (HETS), or in the patient eligibility profile of your Medicare Administrative Contractor's provider portal. For patients covered by Medicare Advantage plans, you can contact the company that administers the plan to determine how to identify its QMB enrollees. Medicare remittance advice for claims paid for QMB patients also includes the following remark codes:

- N781 –Alert: Patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected deductible. This amount may be billed to a subsequent payer.
- N782 – Alert: Patient is a Medicaid/Qualified Medicare Beneficiary. Review your records for any wrongfully collected coinsurance. This amount may be billed to a subsequent payer.

Any amounts collected from QMB patients must be refunded. Billing office staff can learn more at https://go.cms.gov/2KSPxVz.

ELECTROCARDIOGRAM RECORDED BY A HOLTER MONITOR

Q How do you code the interpretation and reporting of findings from a Holter monitor's electrocardiogram readings?

A CPT code 93227, "External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; review and interpretation by a physician or other qualified health care professional," is appropriate for reporting when the physician provides only the review and interpretation of the data recorded by the Holter monitor. Append modifier 52, "Reduced services," if the device records fewer than 12 hours.

LUNG FUNCTION TESTS

Q We perform six-minute walk tests in our practice. Should we separately report spirometry performed before or after?

A Yes. CPT code 94010, "Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation," may be separately reported when performed and documented with a six-minute walk test. The walk test should be billed with CPT code 94618, "Pulmonary stress testing (e.g., six-minute walk test), including measurement of heart rate, oximetry, and oxygen titration, when performed." FPM

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