2024 FRACTIONAL EXHALED NITRIC OXIDE (FENO) CODING GUIDE

DISCLAIMER

The coding and reimbursement information provided is for educational purposes and does not assure coverage of the specific item or service in any given case. Information provided as part of this document is not intended to provide legal, patient specific coding or claims submission information and based upon the current landscape utilizing the information that is currently available.

Procedure coding should be based upon medical necessity. Methapharm and The Pinnacle Health Group make no guarantee of coverage or reimbursement of fees. All payment rates provided are the Medicare national average and subject to change. Contact your local Medicare Administrator Contractor (MAC) or CMS geographic adjusted rates. To the extent that you submit cost information to Medicare, Medicaid or any other reimbursement program to support claims for services or items, you are obligated to accurately report the actual price paid for such items, including any subsequent adjustments. Current Procedural Terminology numeric codes, descriptions, and modifiers are trademarks and copyrights of the AMA.

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THE VIVATMO *PRO* INTENDED USE / INDICATIONS OF USE

Vivatmo *pro* Nitric Oxide Test is a portable, non-invasive device to measure fractional exhaled nitric oxide (FeNO) in human breath. FeNO is increased in some airway inflammatory processes, such as asthma, and often decreases in response to anti-inflammatory treatment. Measurement of FeNO by Vivatmo *pro* is a method to measure the decrease in FeNO concentration in asthma patients that often occurs after treatment with anti-inflammatory pharmacological therapy as an indication of therapeutic effect in patients with elevated FeNO levels. FeNO measurements are to be used as an adjunct to established clinical assessments.

1. HOSPITAL OUTPATIENT CODING AND DESCRIPTORS

CPT[1]	Descriptor	HOPPS			Physician	
		SI	APC	Payment	MPFS[3] Facility	Non-MPFS[3] Facility
FeNO Testing with Vivatmo *pro*						
95012	Nitric oxide expired gas determination	Q1	5732	$38 or Packaged	N/A	$19
Mouthpiece (oxycap)						
A4617	Mouthpiece	N	N/A	Packaged	N/A	Contractor Priced
Clinic Visit (HOPPS Only)						
G0463	Hospital outpatient clinic visit for assessment and management of a patient	J2	5012	$126	N/A	N/A
Evaluation & Management Coding (New Patient) **If an E&M code is reported with CPT 95012 the 25 modifier must be appended**						
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.			N/A	$47	$71
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.			N/A	$81	$112
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.			N/A	$132	$167
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.			N/A	$180	$220

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CPT[1]	Descriptor	HOPPS			Physician	
		SI	APC	Payment	MPFS[3] Facility	Non-MPFS[3] Facility
Evaluation & Management Coding (Established Patient)						
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional			N/A	$9	$23
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.			N/A	$35	$57
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.			N/A	$65	$91
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.			N/A	$96	$128
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.			N/A	$143	$180

Use of Modifiers

Modifier	Descriptor
53	Diagnostic Procedure was started but discontinued
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 The separately billed E/M service must meet documentation requirements for the code level selected.

DESCRIPTION NOTES

In the hospital outpatient prospective payment system, CMS assigns all CPT and HCPCS codes a status indicator (SI) which indicates if and how a service is considered for payment. The status indicators that apply to the CPT and HCPCS codes listed in this guide and their definitions are provided below:

N Payment packaged with the primary procedure

APC Ambulatory Payment Classification

Q1 Packaged APC payment if billed on the claim as a HCPCS code assigned status indicator "S", "T" or "V".

J2 Comprehensive APC payment based on OPPS comprehensive-specific payment criteria. Payment for all covered Part B services on the claim is packaged into a single payment for specific combinations of services, except services with OPPS SI=F, G, H, L and U: ambulance services

HOPPS Hospital Outpatient Prospective Payment System

MPFS Medicare Physician Fee Schedule

All payment rates reflect the Medicare national average rates for 2024

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REFERENCES

1. 2024 CPT Professional, ©2023 American Medical Association
2. CY 2024 Hospital Outpatient Prospective Payment and Ambulatory Payment Systems – Final Rule (CMS-1786-FC); Addendum B and ASC Addenda.
3. CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; (CMS-1784-F); Addendum B. All MPFS Fee Schedules calculated using CF of $32.7442 effective January 1, 2024. Please note, payments rates may be subject to change pending legislation (H.R.6683 - Preserving Seniors' Access to Physicians Act of 2023).
4. Dweik RA et al. An official ATS clinical practice guideline: interpretation of exhaled nitric oxide levels (FeNO) for clinical applications. Am J Respir Crit Care Med. 2011;184(5):602-15.

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