FeNO by NIOX®

Circassia@thepinnaclehealthgroup.com
1-866-369-9290
Monday — Friday 8:30 AM — 6:00 PM EST

2022 Fractional Exhaled Nitric Oxide (FeNO)

This document is a quick coding reference for healthcare providers billing for FeNO testing and related services. Although the information has been checked for accuracy and completeness, Circassia does not accept responsibility or liability with regard to errors, omissions, misuse, or misinterpretation. It is the responsibility of the healthcare provider to select the codes that accurately reflect the supplies and services and procedures performed during each patient encounter. The codes listed in this document are not intended to be an exhaustive list of all possible codes.

CPT	DESCRIPTOR	2022 HOPPS			2022 PHYSICIAN	
		SI	APC	Payment	MPFS Facility	MPFS Non-Facility
FeNO Testing						
95012	Nitric oxide expired gas determination	Q1	5732	$34.57 or Packaged	N/A	$19.38
Mouthpiece						
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	$121.35	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 these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.	N/A			$49.49	$74.06
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.	N/A			$84.44	$113.85
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	N/A			$136.69	$169.57
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	N/A			$185.49	$224.25

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CPT	DESCRIPTOR	2022 HOPPS			2022 PHYSICIAN	
		SI	APC	Payment	MPFS Facility	MPFS Non-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. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.	N/A			$9.00	$23.53
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	N/A			$36.68	$57.45
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.	N/A			$67.48	$92.05
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.	N/A			$98.97	$129.77
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.	N/A			$147.08	$183.07

Notes:

SI Status Indicator

APC Ambulatory Payment Classification

QI Packaged APC payment if billed on the claim as a HCPCS code assigned status indicator “S,” “T” or “V;” otherwise payment made through separate APC

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 2022.

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REPORTING EVALUATION AND MANAGEMENT CODES* WITH FeNO TESTING

- The E/M service must be significant
- The problem must warrant physician work that is medically necessary
- This can be defined as a problem that requires treatment with a prescription or a problem that would require the patient or family to return for another visit to address it
- A minor problem or concern would not warrant the billing of an E/M 25 service
- The E/M service must be separate
- The problem must be distinct from the other E/M service provided (e.g., preventive medicine) or the procedure being completed
- Separate documentation for the E/M 25 problem is helpful in supporting the use of modifier 25 and especially important to support any necessary denial appeal
- The separately billed E/M service must meet documentation requirements for the code level selected
- May be based on time spent counseling and coordinating care for chronic problems
- AAFP states that the key is recognizing when your extra work is "significant" and, therefore, additionally billable. CPT does not define "significant," but the provider should consider the following:
  - Did you perform and document the key components of a problem-oriented E/M service for the complaint or problem?
  - Could the complaint or problem stand alone as a billable service?
  - Is there a different diagnosis for this portion of the visit?
  - If the diagnosis will be the same, did you perform extra physician work that went above and beyond the typical pre- or postoperative work associated?

FREQUENTLY ASKED QUESTIONS

IS FeNO TESTING COVERED AND REIMBURSED BY ALL PAYERS?

Currently all Medicare and Medicare Advantage plans, plus many private payers and Medicaid payers, cover and reimburse FeNO testing when medically necessary. FeNO testing and the list of covering payers continues to grow as they receive claims from healthcare providers and become more familiar with the test. Please contact either your local Circassia representative or The Pinnacle Health Group for specific payer coverage guidelines and information.

IS A MODIFIER REQUIRED WHEN REPORTING AN OFFICE VISIT WITH FeNO?

See the criteria outlined above for requirements when reporting an office visit code (established or new patient) with FeNO testing. Most plans will require the use of modifier 25, however, some private payers may require providers to report modifier 59. Providers should check the use of modifier criteria for each private plan.

WHAT SHOULD WE DO IF A PAYER DOES NOT COVER FeNO TESTING?

Contact your contracted insurance payer to determine if it allows benefits for FeNO. If a payer does not cover FeNO testing, physicians in your practice are in the best position to dispute any noncoverage policies. Circassia can provide information to your practice, such as a bibliography of clinical effectiveness evidence, which can be helpful in a request for FeNO coverage.

DO PAYERS REQUIRE THAT THE PATIENT HAVE AN ASTHMA DIAGNOSIS TO GET A FeNO TEST?

In most cases, no, but certain payers may restrict coverage to patients with an asthma diagnosis. FeNO testing is medically appropriate to identify the presence or absence of steroid-responsive airway inflammation in patients with asthma-like symptoms (such as chronic cough) or diagnosed asthma. If a payer denies coverage for a medically appropriate use of FeNO testing, a physician may elect to protest the payer's policy.

HOW MUCH WILL THE PHYSICIAN BE PAID FOR THE FeNO TEST?

The national average Medicare payment for CPT 95012 in CY2022 is $19.38 (including patient coinsurance). Please contact your local contracted payers to determine their allowable payments for private plans.

DOES THE FeNO PROCEDURE (CPT 95012) INCLUDE PHYSICIAN WORK?

This code does not include physician work. CPT 95012 has been assigned 0.55 practice expense relative value units (RVUs) and 0.01 malpractice RVUs for a total RVU value of 0.56.

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1. CY 2022 Changes to Hospital Outpatient Prospective Payment and Ambulatory Payment Systems — Finale Rule with Payment and Final CY2022 Payment Rates (CMS-1753-FC); Addendum B and ASC Addenda
2. CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; (CMS-1751-F); Addendum B. All MPFS Fee Schedules calculated using CF of $34.6062 effective January 1, 2022.
3. 2022 CPT Professional, © American Medical Association