MedGem®
Indirect Calorimeter

Possible Reimbursement Coding Options

A handheld, self-calibrating calorimeter which allows for accurate measurement of oxygen uptake (VO2) to determine a patient's Resting Metabolic Rate (RMR).

Medical Necessity Criteria

Medical necessity must be established in order for indirect calorimetry to be considered for payer reimbursement. Individual payers develop their own criteria for medical necessity. Payers should be consulted for their guidelines.

Note: The MedGem measurement (CPT 94690) may not be considered medically necessary for asymptomatic overweight individuals. However, coverage potential is higher if there is an underlying medical need. The use of indirect calorimetry is indicated for the following reasons:

- To determine the extent of abnormalities and the causative disease process.
- To determine the progression of the disease.
- To determine a course of therapy in the treatment of a particular condition.

ICD-10-CM Codes

According to Center for Medicare Services (CMS), indirect calorimetry is designed to evaluate the status of structural components of the lung in an indirect overlapping way. Medicare specifically excludes screening test for an asymptomatic patient, with or without high risk of lung disease. The following ICD-10-CM codes that support medical necessity by CMS include:

G47.30-G47.37	Sleep Apnea, Hypoventilation
I27.0-I27.9	Chronic Pulmonary Heart Disease
I50.10-I50.9	Heart Failure
J45.20-J45.902	Asthma
J44.9	Chronic Airway Obstruction (COPD)
J99	Lung involvement in other diseases classified elsewhere
G47.30-G47.90	Sleep Disturbances
R06.90-R09.89	Dyspnea and Respiratory Abnormalities, Shortness of Breath
R09.09	Hypoxemia

Alternative ICD-10-CM codes that may support medical necessity by private payers include:

E03.9	Hypothyroidism	E88.81	Metabolic Syndrome
E10.65	Diabetes Mellitus	E66-E66.9	Obesity
E78.1	Hypercholesterolemia	I10-I11	Hypertension
E78.4-E78.5	Hyperlipidemia	I25.9	Cardiovascular Disease

The above codes are possible coding options for CPT 94690. Other coding options may apply based on a patient's diagnosis. For a complete list of coding options and description, consult the current ICD-10-CM manual.

Physician Coding

94690	Oxygen uptake, expired gas analysis; rest, indirect (separate procedure).
Office Visits	**Note:** Contact your payer for their coding guidelines to determine if the MedGem measurement should be billed separately or in conjunction with an office visit.[1]
99201-99205	Office or other outpatient visit for the evaluation and management of a new patient.
99211-99215	Office or other outpatient visit for the evaluation and management of an established patient.

Dietitian Coding

94690	Oxygen uptake, expired gas analysis; rest, indirect (separate procedure).
MNT	**Note:** Contact your payer for their coding guidelines to determine if the MedGem measurement should be billed separately or in conjunction with medical nutrition therapy.[2]
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes.

1 Payer policies vary concerning Evaluation & Management Services. The provider should clarify requirements pertaining to the MedGem measurement during the preauthorization process or prior to claim submission.

2 Payer policies vary concerning MNT and dietitian services. The provider should clarify requirements pertaining to the MedGem measurement during the preauthorization process or prior to claim submission.

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Pre-authorization

Q. Should we obtain preauthorization for the MedGem measurement?

Yes, we recommend preauthorization of the MedGem measurement. Preauthorization clarifies benefits and payment rates in advance, allowing you and your patient to make informed decisions about their care. The only notable exception to this general rule is Medicare. Traditional Medicare does not preauthorize medical procedures. You should verify the patient's insurance benefits as well as their current eligibility by calling the Customer/Member Services phone number indicated on the patient's insurance card. You may be asked to provide diagnosis and procedure code(s) at that time. See the reverse side of this card for possible coding options related to the MedGem.

Many payers no longer require preauthorization for outpatient procedures or for services under a specified dollar amount. Instead, services are reviewed for medical necessity and coverage when the claim is received. Accordingly, we strongly recommend that the patient sign a Waiver of Financial Liability in the event of a non-coverage or partial coverage decision.

Coding

Q. CPT Code 94690 is listed under the pulmonary section of the CPT book – why would I use it for obese patients?

The AMA CPT Information Services has verbally confirmed that CPT 94690 is an appropriate code for the MedGem measurement. If you feel the code does not accurately describe the procedure performed, You should contact the payer and discuss your concerns. In some cases, they may recommend use of an unlisted code. Coding is ultimately the decision of the physician and the payer and should appropriately reflect the procedure as documented in the patient's medical record.

Q. Will our claim be denied if we use an unlisted CPT code?

Not necessarily. Unlisted codes are used when a service or procedure provided is not described by existing CPT codes. The payer will review your claim individually and base their decision for payment on their coverage guidelines and the documentation submitted. Appropriate documentation will assist the payer in determining medical appropriateness for the procedure. We recommend submission of a SPECIAL REPORT with all unlisted claims. The SPECIAL REPORT should describe the nature, extent and need for the procedure as well as the time, effort and equipment necessary to perform the procedure.

Coverage

Q. Which insurance companies are covering the MedGem measurement?

It is difficult to make generalizations regarding insurance coverage as insurance plans vary and are specific to policies negotiated by the employer group. However, if medical necessity exists, most insurance carriers including Medicare will consider coverage. The average reimbursed cost is between $ 70.00 and $ 80.00.

Q. What if the payer denies coverage for 94690 because the code is limited to pulmonary function tests or the diagnosis is not of a pulmonary nature?

We recommend challenging the denial based on medical necessity and the AMA CPT Information Services' confirmation of CPT coding. If this is unsuccessful, ask the payer if they prefer the claim be resubmitted with an alternative code which they specify.