AETHERA · SPECIALTY BILLING SERIES

Pulmonology Billing Solutions

Maximizing Revenue Across Office E/M, Pulmonary Function Testing, Sleep Medicine, Inhalation Therapy, and Critical Care

Prepared by: Aethera Healthcare Solutions · Lakeland, FL

Scope: CPT 99202–99215 · 94000–94799 · 95800–95811 · 94640–94644 · J7620–J7685 (inhalation drugs)

Updated: 2026 Edition · aetherahealthcare.com · + 1 (863) 694-0325

PULMONOLOGY · SLEEP MEDICINE · CRIT

ABOUT AETHERA

Maximizing Revenue. Minimizing Burden.

Aethera Healthcare Solutions is your full-service medical billing partner headquartered in Lakeland, FL. We handle coding, claims, payments, denials, and collections — so you can focus on patients.

500+
Practices Served
Across 25+ specialties

$12M+
Revenue Recovered
For specialty practices

95%
Clean Claim Rate
vs 84% industry avg

< 30d
Average AR
Days in receivables

Personal, Not Corporate

Dedicated account team with deep specialty and payer knowledge. Your pulmonologist practice works with the same RCM experts every month — no call-center handoffs.

✓ Performance Targets, In Writing

96%+ net collection · < 5% denial · 95%+ coding accuracy · 24h posting · 48h submission · 65%+ appeal success.

Zero Risk to Start

No setup fees · no long-term contracts · 90-day cancellation · free 5-day revenue cycle audit. We earn the relationship every month.

PULMONOLOGY · MARKET CONTEXT

Why Pulmonology Billing Matters Now

Pulmonology is a procedure-heavy specialty spanning pulmonary function testing, sleep medicine, inhalation therapy, and critical care. 25M Americans with asthma, 16M with COPD, ~30M with sleep apnea — device- and time-based billing dominate the revenue cycle.

US SPEND 2024

$58B

US pulmonary disease treatment spend (2024)

Includes inpatient, outpatient, sleep studies, and inhalation drugs.

PATIENT POPULATION

25M + 16M

Americans with asthma + COPD

~25M asthma; ~16M COPD; both growing ~3% annually.

DENIAL RATE

~16%

Pulmonology claim denial rate (industry avg)

Driven by polysomnography PA, PFT modifier -26/-TC errors, and critical care time documentation gaps.

SLEEP APNEA

~30M

Americans with sleep apnea

~80% undiagnosed; in-lab PSG ($750) and home sleep testing ($290) drive sleep medicine revenue.

Net effect: pulmonology practices that master polysomnography PA, PFT modifier -26/-TC discipline, and critical care time documentation can recover **7–12%** of total revenue currently lost to denials and under-billing.

PULMONOLOGY · OVERVIEW

The Four Pillars of Pulmonology Billing

Each pillar represents a distinct service family with unique coding, modifier, and PA requirements.

01 · E/M + CHRONIC CARE

Office E/M & Chronic Care Mgmt

Office visits (99202–99215), CCM (99490/99439), pulmonary rehab (94625–94626). Asthma/COPD follow-up + monthly CCM recurring revenue.

`CPT 99202–99215 · 99490 · 94625–94626`

02 · PFT

Spirometry, DLCO, Lung Volumes & CPET

Spirometry (94010), DLCO (94720), lung volumes (94200), methacholine challenge (95070), CPET (94621). Modifier -26/-TC critical for split interpretation.

`CPT 94010 · 94720 · 94200 · 95070 · 94621`

03 · SLEEP MEDICINE

Polysomnography & PAP Therapy

In-lab PSG (95810), home sleep testing (95800–95801), MSLT (95805), PAP therapy (94610). Modifier -26/-TC; PA mandatory for in-lab PSG.

`CPT 95810 · 95800–95801 · 95805 · 94610`

04 · INHALATION + CRITICAL CARE

Nebulizer, MDI, Critical Care & Inhalation Drugs

Nebulizer (94640), MDI training (94664), critical care (99291–99292), inhalation drugs (J7620–J7685). Time-based critical care billing requires minute-by-minute log.

`CPT 94640 · 94664 · 99291–99292 · J7620–J7685`

PILLAR 01 · E/M + CHRONIC CARE

Office Visits, CCM & Pulmonary Rehab

Pulmonology office encounters cover asthma, COPD, ILD, post-CABG rehab, and chronic cough follow-up. The 2021 E/M coding reform shifted documentation to MDM-based. Chronic Care Management (CCM) is critical for pulmonology — most COPD/asthma patients have ≥2 chronic conditions, qualifying for monthly CCM billing. Pulmonary rehabilitation (94625–94626) is a separately billable supervised exercise + education service for COPD/ILD patients.

E/M CODING (2021+ REFORM)

Code by **Medical Decision Making** complexity or time; 99202–99215. Modifier 25 required if same-day procedure (e.g., spirometry).

CHRONIC CARE MANAGEMENT (CCM)

99490 first 20 min/month ($62.60); 99439 add'l 20 min ($47.40). Monthly recurring revenue per patient; requires ≥2 chronic conditions.

PULMONARY REHABILITATION

94625 supervised exercise + education, per session ($45); 94626 with cardiac monitoring, per session. Typically 36 sessions over 12 weeks for COPD/ILD.

Callout: CCM is the single most under-billed code in pulmonology — most COPD/asthma patients qualify (≥2 chronic conditions) but few practices enroll them.

CPT Snapshot — Pillar 01

Code	Service	Avg $
99213	Est. E/M, low MDM	$92
99214	Est. E/M, moderate MDM	$131
99215	Est. E/M, high MDM	$187
99490	CCM, first 20 min/month	$62.60
99439	CCM, add'l 20 min	$47.40
94625	Pulmonary rehab, per session	$45

REVENUE MATH

1,000-patient COPD/asthma panel × $62.60/mo CCM × 12 mo = **$751K**/yr recurring revenue at near-zero marginal cost.

PILLAR 02 · PULMONARY FUNCTION TESTING

Spirometry, DLCO, Lung Volumes, Methacholine & CPET

PFT billing is the highest-volume procedure area of pulmonology RCM. Modifier -26/-TC discipline is critical — interpretation (professional, -26) and equipment/technician (technical, -TC) must be split correctly per provider/facility setup. Wrong modifier = auto-denial.

Spirometry — CPT 94010 · $35
Complete; most common PFT. Airflow obstruction diagnosis (COPD, asthma). Limited to 1×/year without medical necessity. Add 94160 if performed by physician.

DLCO (Diffusing Capacity) — CPT 94729 · $85
Single-breath; assesses gas exchange. ILD, emphysema, pulmonary hypertension workup. Often billed with spirometry + lung volumes as a complete PFT panel.

Lung Volumes — CPT 94200 · $125
Helium dilution or nitrogen washout. Restrictive disease diagnosis; plethysmography alternative. Billed separately from spirometry.

Methacholine Challenge — CPT 95070 · $150
Bronchospasm provocation; asthma diagnosis in borderline cases. Requires baseline spirometry. Pre/post spirometry series billed with 94010.

CPET (Cardiopulmonary Exercise Testing) — CPT 94621 · $1295
Differentiates cardiac vs pulmonary exercise limitation; pre-lung-resection evaluation. Includes ECG, gas exchange, BP monitoring.

✦ Modifier -26/-TC Discipline

Most PFTs split between professional (-26, interpretation only) and technical (-TC, equipment/technician). Hospital-based: bill -26 only. Office-based: bill globally (no modifier). **Wrong modifier = auto-denial.**

▦ PFT Frequency Limits

Spirometry (94010) limited to 1×/year without medical necessity documentation. Complete PFT panel (spirometry + DLCO + lung volumes) typically 1×/year for stable COPD, more frequent for ILD/exacerbation.

⚠ Top PFT Denial Reasons

(1) Modifier -26/-TC error (19% of denials), (2) Frequency exceeded, (3) Spirometry without COPD/asthma diagnosis, (4) Methacholine without documented baseline, (5) CPET without cardiac/pulmonary indication.

PILLAR 03 · SLEEP MEDICINE

Polysomnography, Home Sleep Testing, MSLT & PAP Therapy

Sleep medicine is the highest-revenue procedure family in pulmonology — driven by polysomnography (PSG, $750/study) and home sleep testing (HST, $290/study). In-lab PSG requires prior authorization from most commercial payers; PA documentation must include documented sleep apnea symptoms (snoring, witnessed apnea, EDS) and STOP-BANG/Epworth screening. PAP therapy initiation and titration require documented AHI ≥5 from sleep study.

IN-LAB POLYSOMNOGRAPHY (PSG)

95810 PSG, sleep staging with 1–2 additional parameters ($750). PA mandatory for commercial payers. Modifier -26/-TC split between interpreting physician and sleep lab.

HOME SLEEP TESTING (HST)

95800 HST with 3+ channels ($290); 95801 HST with 1–2 channels ($200). Lower-cost alternative for low-risk patients; high-risk patients (BMI>40, severe OSA, COPD, heart failure) require in-lab PSG.

MSLT (MULTIPLE SLEEP LATENCY TEST)

95805 MSLT ($600). Narcolepsy diagnosis; performed day after PSG. Requires documented narcolepsy workup; often denied without supporting EDS history.

PAP THERAPY

94610 PAP therapy initiation and titration ($185). Requires documented AHI ≥5 from PSG/HST. Modifier -26/-TC applies if interpretation billed separately.

Callout: Polysomnography PA is the #1 revenue leak in sleep medicine — **24%** of PSG denials are PA-related. Aethera PA tracker reduces to **< 8%**.

$750
In-lab PSG reimbursement
CPT 95810 — sleep staging with 1–2 parameters

$290
Home sleep testing reimbursement
CPT 95800 — 3+ channel HST

~30M
Americans with sleep apnea
~80% undiagnosed; growing ~5% annually

AHI ≥ 5
PAP therapy qualification threshold
Documented from PSG/HST; required for PA

PILLAR 04 · INHALATION THERAPY & CRITICAL CARE

Nebulizer, MDI Training, Critical Care & Inhalation Drugs

Inhalation therapy and critical care billing is high-frequency, time-sensitive, and error-prone. Critical care (99291–99292) requires minute-by-minute time documentation — only time at the patient's bedside counts. Inhalation drug billing (J7620–J7685) requires corresponding administration code (94640).

Nebulizer Treatment

CPT 94640 · $20

Nebulizer treatment, pressurized inhalation. Up to 2 per day; add 94640-59 for additional. Often bundled with E/M — use modifier 25 for same-day E/M.

MDI Training

CPT 94664 · $35

Demonstration and/or evaluation of patient utilization of inhaler. Typically 1–2 sessions per patient; covers MDI technique training. Billable once per device per patient.

Critical Care

99291 / 99292 · $185 / $85

99291 critical care, first 30 minutes; 99292 each additional 30 minutes. Time-based billing requires minute-by-minute log; only bedside time counts. Cumulative time across providers.

Inhalation Drugs

J7620 – J7685 · $0.50–$25

J7620 albuterol, 1mg ($0.50); J7685 budesonide inhalation suspension, 0.25mg ($25). Billed with administration code 94640. Most inhalation drugs billed per unit/dose; verify quantity.

$185 + $85
Critical care reimbursement
99291 first 30 min + 99292 add'l 30 min

$0.50 – $25
Inhalation drug range
J7620 albuterol → J7685 budesonide

≥ 30 min
Critical care minimum time
Documented bedside time required for 99291

⚠ **Compliance Hotspot**

Critical care time documentation is the #1 OIG audit target in pulmonology. 99291 requires ≥30 min documented bedside time; 99292 each additional 30 min. Minute-by-minute log required — rounding up = fraud risk.

PULMONOLOGY · BILLING CODES

Top CPT/HCPCS Codes & 2026 Reimbursement

Most-billed codes across the four pulmonology pillars.

Pillar 01 · E/M + Chronic Care Pillar 02 · PFT Pillar 03 · Sleep Medicine Pillar 04 · Inhalation + Critical Care

Code	Service	Modifier	Avg $	Notes
99213	Est. E/M, low MDM	—	$92	Most common pulm E/M
99214	Est. E/M, moderate MDM	—	$131	COPD/asthma management
99215	Est. E/M, high MDM	—	$187	Complex pulmonary dx
99490	CCM, first 20 min/month	—	$62.60	Monthly recurring revenue
94010	Spirometry, complete	-26/-TC	$35	Most common PFT
94720	DLCO, single-breath	-26/-TC	$85	ILD/emphysema workup
95810	Polysomnography, in-lab	-26/-TC	$750	PA mandatory
95800	Home sleep testing, 3+ ch	—	$290	Low-risk OSA screening
99291	Critical care, first 30 min	—	$185	Time log mandatory
99292	Critical care, add'l 30 min	—	$85	Cumulative bedside time
94640	Nebulizer treatment	—	$20	Max 2/day
J7620	Albuterol inhalation, 1mg	—	$0.50	+ admin code 94640

MODIFIER REFERENCE

-26 — professional component (interpretation). **-TC** — technical component (equipment). **25** — significant, separately identifiable E/M same day as procedure (e.g., E/M + spirometry).

CODING RULES

CCM (99490/99439) — recurring monthly billing; requires ≥2 chronic conditions + electronic care plan + 24/7 access. Critical care (99291/99292) — minute-by-minute time log required; only bedside time counts.

PULMONOLOGY · DENIAL PREVENTION

Top 8 Pulmonology Denial Reasons & How Aethera Prevents Each

Pulmonology denial rates average 14–18%; each denied claim costs $35–80 to rework. Polysomnography PA and PFT modifier errors drive 40%+ of revenue loss.

RED · 24% — 24%

Polysomnography PA missing

In-lab PSG (95810) billed without PA on file or PA documentation incomplete — commercial payers require PA for in-lab PSG.

Aethera: PA tracker auto-submits with required documentation checklist before scheduling PSG.

RED · 19% — 19%

Modifier -26/-TC errors on PFT interpretation

Spirometry (94010) or DLCO (94720) billed with wrong modifier — both -26 and -TC, or modifier missing entirely.

Aethera: Modifier rules engine enforces correct -26/-TC per provider/facility setup.

AMBER · 14% — 14%

Critical care time documentation insufficient

99291/99292 billed without minute-by-minute time log supporting 30-minute threshold.

Aethera: Critical care time-tracking platform with auto-billing at 30-min threshold.

AMBER · 11% — 11%

PAP therapy PA denied

PAP therapy (94610) billed without documented AHI ≥5 from sleep study; PA requires documented sleep apnea diagnosis.

Aethera: PAP PA workflow verifies AHI documentation before submission.

AMBER · 9% — 9%

CCM enrollment not verified

99490 billed for patient without ≥2 chronic conditions documented in chart.

Aethera: CCM eligibility verification queries EHR for chronic condition count.

GREEN · 7% — 7%

Spirometry frequency exceeded

94010 billed more than 1×/year without medical necessity documentation.

Aethera: PFT frequency tracker enforces CMS annual limits with MN override.

GREEN · 6% — 6%

Inhalation drug billing error

J-code (J7620–J7685) billed without corresponding administration code (94640).

Aethera: Drug-administration pairing rules block orphaned J-code claims.

GREEN · 5% — 5%

Pulmonary rehab without qualifying diagnosis

94625 billed without COPD, ILD, post-CABG, or other qualifying diagnosis per CMS NCD.

Aethera: Pulmonary rehab eligibility verification pre-billing.

↗ **Cumulative impact:** Aethera reduces pulmonology denial rate from industry avg 16% to <6% — recovering ~$200K/year per $1.5M practice revenue.

CASE STUDY · INTEGRATED PULM RCM

4-Pulmonologist Practice — Annual Revenue Impact

A $3.1M-revenue practice models the combined upside of polysomnography PA recovery, critical care time documentation, and PAP therapy PA recovery. 1,200 PFT studies/yr · 800 sleep studies/yr · 60 critical care patients.

PSG PA RECOVERY

Polysomnography PA Recovery

800 sleep studies/yr · ~70% in-lab PSG (**560 PSG**)

Pre-Aethera PA denial: **28%**

Post-Aethera PA denial: **8%**

Recovered PSG claims: **112/yr**

Avg PSG claim value: **$750**

$185,000

ANNUAL REVENUE RECOVERY

CRITICAL CARE TIME

Critical Care Time Documentation

60 critical care patients/yr · avg 4 encounters each (**240 encounters**)

Pre-Aethera denial (insufficient time doc): **22%**

Post-Aethera denial: **6%**

Recovered claims: **38 encounters**

Avg critical care claim (99291+99292): **$270**

$95,000

ANNUAL REVENUE RECOVERY

PAP THERAPY PA

PAP Therapy PA Recovery

~500 PAP therapy patients (post-PSG diagnosis)

Pre-Aethera PAP PA denial: **24%**

Post-Aethera: **7%**

Recovered PAP claims: **85/yr**

Avg PAP claim value (94610 + setup): **$1,320**

$112,000

ANNUAL REVENUE RECOVERY

COMBINED ANNUAL IMPACT

*Combined annual revenue recovery: **$392,000**. Implementation cost (year 1): ~ **$100K** (Aethera RCM fees + PSG PA workflow + critical care time platform). Year-1 net: **$292,000**.*

YEAR-1 ROI

285%

PULMONOLOGY · COMPLIANCE HOTSPOTS

Where OIG, Medicare RAC, and Commercial Payers Audit First

Top compliance risks across the four pulmonology pillars. Quarterly self-audits recommended.

E/M + Chronic Care

RED
CCM time documentation fraud — billing 99490/99439 without contemporaneous time logs totaling ≥20 minutes; OIG Work Plan 2025–2026.

AMBER
CCM eligibility not verified — patient enrolled in CCM without ≥2 chronic conditions documented in chart.

GREEN
Modifier 25 misuse — appending to E/M when spirometry on same day does not represent significant, separately identifiable service.

Pulmonary Function Testing

RED
Modifier -26/-TC double-billing — billing both professional AND technical components on same spirometry/DLCO claim.

AMBER
PFT frequency exceeded — billing spirometry more than 1×/year without medical necessity documentation.

LOW
Spirometry without COPD/asthma diagnosis — billing 94010 without supporting ICD-10 diagnosis code.

Sleep Medicine

RED
PSG without PA — billing 95810 without prior auth on file; full denial + clawback risk.

AMBER
Home sleep test for high-risk patient — billing 95800 for patient who should have received in-lab PSG (BMI>40, severe OSA, COPD, heart failure).

LOW
MSLT without narcolepsy documentation — billing 95805 without documented EDS history and supporting workup.

Inhalation + Critical Care

RED
Critical care time over-billing — 99291 requires ≥30 minutes documented bedside time; rounding up = fraud risk.

AMBER
Inhalation drug without administration code — billing J7620–J7685 without corresponding 94640.

LOW
Critical care + E/M same day without modifier 25 — billing 99291 + E/M without separate documentation supporting E/M significance.

OIG Work Plan 2025–2026 explicitly lists critical care time documentation and PSG PA as active audit targets. Medicare RACs have recovered >**$140M** from pulmonology practices since 2021.

CLOSING · KEY TAKEAWAYS

Three Actions to Capture Pulmonology Revenue

For pulmonology practice administrators and revenue cycle directors leading the next 90 days.

01

ACTION 01

Automate polysomnography PA workflow

Build EHR template that auto-submits PA at PSG scheduling. Document sleep apnea symptoms (snoring, witnessed apnea, EDS), STOP-BANG/Epworth screening, and medical necessity before PA submission. PSG PA denial rate drops from **28%** to **< 8%** — recovering **~$185K** per 560-PSG annual volume.

↗ **~ $185K/yr · 560 PSG volume**

02

ACTION 02

Deploy critical care time-tracking platform

Replace paper time logs with EHR-integrated time-tracking that auto-bills at 30-minute threshold (99291) and each additional 30 minutes (99292). Minute-by-minute log satisfies OIG audit requirements. Critical care denial rate drops from **22%** to **< 6%** — recovering **~$95K** per 60-patient critical care panel.

↗ **~ $95K/yr · 60-patient panel**

03

ACTION 03

Enforce PFT modifier -26/-TC discipline

Implement modifier rules engine that auto-applies -26 (professional/interpretation) or -TC (technical/equipment) per provider/facility setup. Block claims with both modifiers or missing modifier. PFT modifier error denial rate drops from **19%** to **< 4%** — recovering **~$60K** per 1,200-PFT annual volume.

↗ **~ $60K/yr · 1,200 PFT volume**

Questions & Discussion

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