Home Spirometry

Clinical Policy ID: CCP.1494

Recent review date: 8/2026

Next review date: 12/2027

Policy contains: Home; portable; spirometry.

First Choice VIP Care has developed clinical policies to assist with making coverage determinations. First Choice VIP Care's clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of "medically necessary," and the specific facts of the particular situation are considered by First Choice VIP Care, on a case by case basis, when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. First Choice VIP Care's clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. First Choice VIP Care's clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, First Choice VIP Care will update its clinical policies as necessary. First Choice VIP Care's clinical policies are not guarantees of payment.

Coverage policy

Home spirometry for monitoring of pulmonary disease is investigational/not clinically proven and, therefore, not medically necessary.

Limitations

No limitations were identified during the writing of this policy.

Alternative covered services

Facility-based spirometry

Background

Spirometry measures air volume and speed that can be exhaled over time following maximal inhalation. It is a key diagnostic test for many obstructive and restrictive pulmonary diseases. Spirometry can evaluate and monitor patient condition; assess disease severity, effects, and prognosis; and screen for pulmonary diseases (Lamb, 2023).

During the procedure, a mouthpiece is placed between the patient's teeth, after deep inhalation. Exhalation usually lasts at least six seconds, or as long as possible. The procedure is repeated in one-minute intervals until similar results are obtained. Spirometry can measure different variables, most often forced vital capacity and forced expiratory volume in one second (de Jong, 2020).

Spirometry can be performed in inpatient facilities, physician offices, emergency rooms, and specialty labs. Regular access to accurate, reliable pulmonary function data is essential to managing many chronic lung conditions. During the pandemic, alternatives to comprehensive pulmonary function testing, such as home-based electronic spirometry, became available to continue to diagnose and manage patients with lung conditions while minimizing infectious disease transmission. Technological advances allow for electronic data transmission to caregivers (Kouri, 2020).

The U.S. Food and Drug Administration (2025) has approved or cleared several spirometers for home use, including the GoSpiro Home Spirometer (Monitored Therapeutics Inc., Dublin, Ohio) and the Air Next wireless spirometer (NuvoAir, Stockholm, Sweden).

Findings

Guidelines

A technical statement from the American Thoracic Society and European Respiratory Society on spirometry notes that updated standards are required for unattended home spirometry (Graham, 2019). The Global Initiative for Chronic Obstructive Lung Disease (2026) states that personal electronic portable spirometers may be used to confirm airflow obstruction for the diagnosis of chronic obstructive pulmonary disease, especially during airborne viral epidemics. Video conferencing technology can be used to provide instruction and direct observation of spirometry testing.

The American Thoracic Society issued a research statement outlining the PANACEA (test ***p***erformance, disease m***ana***gement, ***c***ost, ***e***xperiences, ***a***ccess) framework for standardizing evaluation of home-based monitoring of individuals with chronic lung diseases. The items in the PANACEA checklist represent the information required to determine if a home-based monitoring technology, such as spirometry or pulse oximetry, is ready for clinical implementation. The statement identified several areas requiring additional research ranging from test performance to domains of disease management, costs, patient experiences, and equitable access provision (Khor, 2025).

Evidence review

There is increasing interest in home spirometry for its convenience and potential for early detection of exacerbations and improved self-management, infection control, and outcomes in patients with chronic lung conditions. Evidence from systematic reviews and large cohort studies suggests home monitoring is feasible in patients with various chronic lung diseases. Its use may reduce the need for follow-up clinic spirometry and influence clinical decision making. However, the published evidence raises concerns about quality control, clinical effectiveness, and clinical utility, and long-term outcomes have not been quantified (Althobiani, 2021; El Mokahal, 2026; le Rütte, 2025; Nakshbandi, 2025; Tan, 2026).

Education and training may increase the feasibility of unattended home monitoring, but underlying etiologies, low patient compliance, and differences in spirometry equipment appear to influence testing quality. Home spirometry was often a component of a multicomponent intervention, limiting the ability to evaluate home spirometry in isolation (Althobiani, 2021; Bell, 2022; Bindler, 2023; Fettes, 2022; Paynter, 2022). Some studies enrolling participants with cystic fibrosis predated the availability of cystic fibrosis transmembrane conductance regulator therapies that represent the current standard of care (Khor, 2025). Further research is needed to address patient and clinician barriers to its use.

Many individual studies have small sample sizes or do not compare home spirometry to clinic spirometry, which is considered the standard of care. Where a comparison was conducted, there is inconsistent agreement between clinic and unattended home spirometry measurement, indicating that clinic and home spirometry results may not be interchangeable (Anand, 2023; le Rütte, 2025; Oppenheimer, 2023; Svedberg, 2025).

Clinical utility

The impact of home spirometry on clinical utility is uncertain. A Mayo Clinic observational study enrolled 116 lung transplant recipients in a 12-month remote patient monitoring program. By December 2025, 47 (40.5%) completed the program, 15 (12.9%) discontinued participation, and 54 (46.6%) remained monitored. Remote spirometry monitoring generated 470 escalation alerts, most commonly due to declines in forced expiratory volume in one second (58.3%). Most escalations (72.8%) were managed with continued monitoring, while 27.2% prompted changes in care, including expedited clinic visits, diagnostic testing, medication adjustments, or emergency evaluation. Nearly half of the 64 admissions with transmitted data were preceded by an escalation, but a substantial proportion was not, highlighting opportunities to optimize adherence and alerting thresholds (El Mokahal, 2026).

The Early Intervention in Cystic Fibrosis Exacerbation trial (ClinicalTrials.gov identifier NCT01104402), a randomized controlled trial of 267 participants older than age 14 with cystic fibrosis, compared pulmonary function outcomes using home spirometry to usual care. Home spirometry was measured twice weekly with automated notification if pulmonary exacerbation criteria were met. Participants in the usual care arm were seen every three months and asked to contact the site about any worsening pulmonary symptoms. No significant difference between groups occurred in the 52-week mean change in forced expiratory volume in one minute slope (P = .99). The early intervention group had more frequently detected exacerbations (P = .01). Adverse events were not significantly different (Lechtzin, 2017). Home spirometry lacked the precision of forced expiratory volume in one second measurement and the ability to detect subtle changes, particularly in patients who were on modulator therapy. There were no significant differences in outpatient utilization or overall health care costs (Franz, 2022; Paynter, 2022).

A prospective study randomized 60 Turkish children with cystic fibrosis between 6 and 18 years of age to receive four quarterly visits with or without twice-weekly home spirometry measurement using the SpiroHome device with mobile application. Participants were followed for one year. From baseline to the 12th month, there were no statistically significant differences between groups in the absolute (primary outcome) or relative (secondary outcome) change in forced expiratory volume in one second as a percentage of predicted value, or in the number of pulmonary exacerbations detected or change in lung clearance index. Among 22 participants who completed 70% of the measurements over 12 months, there was a significant difference in the primary outcome, favoring the home spirometry group (mean 5.56%, interquartile range −3.33 to 13.50 versus mean 2.46%, −7.57 to 4.24; P = .01). The authors suggested high adherence with home spirometry use may improve lung function. Among participants younger than 14 years of age, there was a significant increase in the social domain of the health-related quality of life questionnaire for patients with cystic fibrosis (from 59.1 to 76.2, P = .01) (Yanaz, 2024).

In 2023, we updated the Global Initiative for Chronic Obstructive Lung Disease annual report with no policy changes warranted.

In 2024, we updated the references and added several new studies with no policy changes warranted.

In 2025, we updated the references with no policy changes warranted.

In 2026, we updated the reference with no policy changes warranted.

References

On June 11, 2026, we searched PubMed and the databases of the Cochrane Library, the U.K. National Health Services Centre for Reviews and Dissemination, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services. Search terms were “spirometry (MeSH),” “vital capacity (MeSH),” “telemedicine (MeSH),” and “home spirometry.” We included the best available evidence according to established evidence hierarchies (typically systematic reviews, meta-analyses, and full economic analyses, where available) and professional guidelines based on such evidence and clinical expertise.

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Policy updates

8/2021: initial review date and clinical policy effective date: 9/2021

8/2022: Policy references updated.

8/2023: Policy references updated.

8/2024: Policy references updated.

8/2025: Policy references updated.

8/2026: Policy references updated.

Related codes

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy CCP.1494. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

Code	Code description
94014	Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and physician review and interpretation
94015	Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis and periodic recalibration)

Code	Code description
94016	Patient-initiated spirometric recording per 30-day period of time; physician review and interpretation only
A9284	Spirometer, nonelectronic, includes all accessories
E0487	Spirometer, electronic, includes all accessories
S8096	Portable peak flow meter