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Internal Medicine Coding Alert

Break Down Nebulizer Session to Capture Allowable Services and Procedures

Although CPT 2003 clarified the nebulizer training codes, coders are still asking questions regarding how to report nebulizer sessions. By understanding how to code each service and recognizing that payer policies vary, you can bill these procedures and services with confidence.

Internists often treat patients for wheezing and difficulty breathing due to asthma, lung disorders or upper respiratory infections. These office visits can take a lot of time because they encompass many services including patient history, examination and medical decision-making and procedures such as spirometry, bronchodilation and training. This article focuses on the initial procedures.

Understand a Typical Session

During a typical session, a patient presents to an office for wheezing (786.07). The physician reviews the patient's history and examines the patient, concentrating on the lungs, upper airways, eyes, ears, nose (particularly the nasal passages) and throat.

The physician cannot evaluate the airways from the examination alone, so he performs pulse oximetry and uses a spirometer to measure pulmonary function. He administers a bronchodilator to the patient, followed by another pulse oximetry measurement and spirometry. He then compares the before and after readings to assess the bronchodilator's success.

The patient continues to exhibit respiratory symptoms, so the doctor administers a second bronchodilation followed by spirometry. The pulmonary reading shows that the patient's symptoms are subsiding. The doctor prescribes an inhaler and a spacer for the individual. Anurse demonstrates how to use the inhaler.

The physician and nurse perform seven procedures:

1. pulse oximetry x 2
2. spirometry before and after bronchodilation x 2
3. bronchodilation x 2
4. training

and two services:

1. established patient office visit
2. emergency service.

Bill Private Payers for Pulse Oximetry

Coverage for pulse oximetry (e.g., 94760, Noninvasive ear or pulse oximetry for oxygen saturation; single determination) depends on the payer. Medicare announced in January 2000 that it would no longer cover 94760 unless it is the only procedure provided. This means that if you bill any other code on that day, you cannot bill pulse oximetry as well because Medicare has bundled the oximetry codes into every other CPT code. If you perform pulse oximetry and nothing else, that is the only time you can bill and get paid for this procedure.

Carriers view pulse oximetry as similar to taking a patient's temperature. "Pulse oximetry is no more invasive and arguably less invasive than recording the patient's temperature, another example of a diagnostic service for which we do not make separate payment," according to Medicare's announcement. "If interpretation of pulse oximetry or temperature

data is complex, then that interpretation is clearly part of the medical decision-making included in the E/M services." And finally, Medicare adds that facility and practice expense payments cover the equipment costs.

Since then, various commercial payers have followed Medicare's lead. Some carriers, however, do not bundle pulse oximetry with other codes, so you can bill for it separately. Because carriers have made more than one determination in the above scenario, report 94761 (Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations [e.g., during exercise]), says **Kent J. Moore,** manager of healthcare financing and delivery systems for the American Academy of Family Physicians in Leawood, Kan.

Consequently, you should track commercial payers that bundle pulse oximetry and write off the charge before it goes out the door. Make sure to keep the code(s) on your superbill and put it on the claim form as well.

Bronchospasm Evaluation Includes Spirometry

For the spirometry before and after bronchodilation, report 94060 (Bronchospasm evaluation: spirometry as in 94010, before and after bronchodilator [aerosol or parenteral]). Bronchospasm evaluation describes the evaluation and respiratory function measuring (spirometry), and thus includes spirometry before and after bronchodilation. You should not bill separately for 94010 (Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement[s], with or without maximal voluntary ventilation) in this case. Note that 94010 specifies that the spirometer must display results graphically, which also applies to 94060.

Many practices think a peak flow reading that is written in the chart counts as spirometry, but it does not, says **Daniel S. Fick, MD,** director of risk management and compliance for the College of Medicine faculty practice at the University of Iowa in Iowa City. "You cannot bill for a peak flow." Assign 94060 for each before and after reading. Because the physician performed a third spirometry after a second bronchodi-lation, report 94060 twice.

Report Bronchodilation Per Treatment

For each inhalation treatment, report 94640 (Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes [e.g., with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device]).

Some coders mistakenly include additional services, such as spirometry and training, in 94640. The April 2002 CPTAssistant clearly states, "94640 is reported for an inhalation treatment for an acute airway obstruction, such as asthma or croup, and can represent an aerosol or nebulized administration of the appropriate medication, as prescribed by the physician."

Spirometry and inhalation treatment are different procedures performed for different reasons. You should report both procedures, says **Susan Callaway, CPC, CCS-P,** an independent coding auditor and trainer in North Augusta, S.C. Spirometry is diagnostic, and inhalation treatment is therapeutic.

However, you may run into problems reporting both procedures. The National Correct Coding Initiative (NCCI) bundles 94640 into 94060. Medicare interprets 94060's definition of pre- and postbronchodilation as a global code, meaning the bronchospasm evaluation includes the inhalation treatment. For payers that follow Medicare's lead and NCCI edits, you cannot report 94640 with 94060. If the family physician performs both, bill 94060, which has a higher relative work value.

"Bundling issues are payer-specific," Callaway says. So, don't stop reporting the treatment until you review your carriers'policies. Submit claims with both procedures. When you receive the explanation of benefits, note the insurers' payments and track their preferences so you can tell which rules the insurers follow.

If a payer includes the inhalation treatment in the bronchospasm evaluation, remember that you can still report these procedures if the physician performs them at different sessions. For instance, the child in the above scenario returns to the office later the same day because he cannot use the at-home treatment and has an acute exacerbation. The FP performs a nebulizer treatment.

In this case, you should report 94640 for the inhalation treatment appended with modifier -59 (Distinct procedural service) to indicate a separate session from the spirometry that he performed earlier. Although the carrier may bundle 94060 and 94640 when the doctor performs them together, you can still report them when he or she performs them at separate sessions.

Practices report varying success when coding multiple treatments. But according to CPT 2003, "For more than one inhalation treatment performed on the same date, append modifier -76 (Repeat procedure by same physician)." Some carriers may prefer you to bill nebulizer treatments per unit. To complicate issues, some coding experts report needing to use modifier -51 (Multiple procedures) for payment of multiple nebulizer treatments. (Remember, modifier -51 will reduce reimbursement for the second procedure by 50 percent based on standard multiple-procedure rules.) CPT 2003's directive may help payers recognize modifier -76, but you should still follow individual carriers'guidelines.

Based on these recommendations for the two inhalation treatments, you could report one of three options, based on the payer:

1. option 1: 94640, 94640-76
2. option 2: 94640, 94640-51
3. option 3: 94640 x 2 (some carriers allow billing for multiple aerosol treatments without a modifier).

Or, if the carrier follows NCCI, you may report 94060 only and not 94640.

Note: Some practices cite success in appending modifier -59 to all procedures (94760-59 x 2, 94060-59, 94010-59, 94640-59 x 2).

Don't Bundle Every Code Into Critical Care

Stick to your guns: If your physician performs a separately billable procedure while rendering critical care, make sure you get paid for it.

Although the 2003 CPT guidelines clearly state all the bundled procedures included in critical care, other private insurance companies sometimes try to bundle other services, says **Nettie McFarland, RHIT, CCS-P,** with Healthcare Billing Systems Inc.

If you receive denials for services not listed in the bundled services, appeal the claims and send your insurance companies regulatory information, McFarland says. The time and hassle are "worth the effort" because you usually receive correct reimbursement after the appeal, she says.

These services are bundled under critical care:

4. Indicator dilution studies for cardiac: 93561, 93562

5. Chest x-rays, one and two views: 71010, 71015, 71020

6. Pulse oximetry: 94760, 94761, 94762

7. Blood gases

8. Information data stored in computers (including EKGs, blood pressures, hematologic data): 99090. This bundle does not include 93010 (Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only) or 93042 (Rhythm ECG, one to three leads; interpretation and report only).

9. Gastric incubation: 43752, 91105

10. Temporary transcutaneous pacing: 92953

11. Ventilatory management: 94656, 94657, 94660, 94662

12. Vascular access procedures: 36000, 36410, 36415, 36540, 36600.