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Part B Insider (Multispecialty) Coding Alert

94664: Have You Mastered the Do's and Don'ts of Inhaler Service Claims?

Inhaler demo could pay you $14 or more -- if you know how to navigate the rules.

Three things you should keep in mind when reporting for inhaler demo/evaluation: (1) the type of device used, (2) documentation requirements and (3) qualifying modifiers. The following do's and don'ts show you why some payers would deny payment for this service -- and what you should do to outsmart them.

Don't: Misjudge Advair Diskus

The Advair Diskus is an "aerosol generator." If the nurse/medical assistant taught someone to use an Advair Diskus -- or any other diskus -- you should report 94664 (Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device).

Example: A pulmonologist starts a patient with asthma (493.00, Extrinsic asthma; unspecified or 493.20, Chronic obstructive asthma; unspecified) on Advair. A nurse then teaches the patient how to use the Diskus. As per CPT guidelines, you should report 99201-99215 for the office visit and 94664 without a modifier, says **Alan L. Plummer, MD**, professor of medicine, Division of Pulmonary, Allergy, and Critical Care at Emory University School of Medicine in Atlanta. In addition, CMS transmittal R954CP also indicates that modifier 25 (Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) applies only to E/M services performed with procedures that carry a global fee, which 94664 does not have. Nonetheless, many payers will only pay for the service if you append modifier 25 to the visit code. It's always best to check with your major insurers' policy first.

Do: Bundle Dose in Teaching Session

The patient may administer medication dose during the teaching session. Both services (treatment + teaching) are bundled into one CPT: 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]), so you shouldn't report them separately.

Why: The administration was performed as part of the demonstration/evaluation.

Don't: Report Separate Education Without Modifier 59

Suppose that during an outpatient visit, an asthmatic patient is wheezing and having difficulty breathing, which requires one or more bronchodilator treatments for intervention:

493.01, Extrinsic asthma; with status asthmaticus; 493.02, Extrinsic asthma; with (acute) exacerbation; 493.21, Chronic obstructive asthma; with status asthmaticus;

or 493.22, Chronic obstructive asthma; with (acute) exacerbation. The patient didn't use his MDI device, nebulizer, etc., properly prior to visit, so he was given an education about the use of these devices after the treatment.

Code it: First, code 94640 (adding modifier 76, Repeat procedure or service by same physician, to separate line items of 94640 for multiple treatments) in addition to the appropriate E/M code without a modifier, unless the payer requires modifier 25 with the E/M.

Then report 94664 with modifier 59 (Distinct procedural service), as the patient required additional instruction for his

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daily maintenance medication. This is different from the medication provided for immediate intervention (94640).

In short: If the patient required separate education after receiving an inhalation treatment on the same day, you would bill both services (treatment + education), appending modifier 59 to 94664.

Logic: The Correct Coding Initiative (CCI) places a levelone edit on 94640 and 94664. So Medicare and payers that follow CCI edits may require modifier 59 on the component code (94664) to indicate that the teaching is a distinct procedural service from the inhalation treatment.

Do: Prove Medical Necessity

If payers would not pay your 94664 claim, you would need to support it with documentation indicating medical necessity to reimburse the approximately $14 national rate. For instance, you might need to state in the Plan or Treatment portion of the written record that the patient requires a teaching session on the use of his MDI, diskus, nebulizer, etc. In addition, don't forget to note why the session is needed.

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