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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 4 Nebulizer Coding Tips Help Ensure Maximum Payment

Don't miss out on E/M, drug, and training reimbursement

You may watch valuable reimbursement evaporate if you don't know when and how to apply modifiers -59, -76 and -77 to your nebulizer treatment claims.

CPT provides two nebulizer codes: 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) for the actual service, and 94664 (Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulize, metered dose inhaler or IPPB device), for teaching the patient how to properly utilize the device.

Although these two codes seem simple, the truth is that nebulizer treatment claims unravel quickly without the appropriate modifiers, E/M Codes and J codes. Breathe easy with the following four expert tips for nebulizer coding:

1. Apply -59 Only For Separate Sessions.

According to the National Correct Coding Initiative (NCCI) edits, 94664 is a component of the nebulizer treatment code 94640, but the bundle has a modifier indicator of "1," meaning you may break the bundle and report both codes together if appropriate, says **Carol Pohlig, BSN, RN, CPC,** senior coding and education specialist at the **University of Pennsylvania's** hospital in Philadelphia.

If your physician performs two distinct services at two distinct sessions on the same day, you should append modifier -59 (Distinct procedural service) to 94664 to obtain separate payment for each code, Pohlig notes. "[But] if you're demonstrating to the patient while administering treatment, you can't justify the unbundling of the two services," she adds.

If the provider performs the nebulizer treatment and the demonstration on different days, then the bundling edit does not apply, says Pohlig, and you can bill the services individually.

Example: Your physician trains a patient on the nebulizer (94664) in the morning, and then the patient comes back in the afternoon in respiratory distress, and requires a nebulizer treatment (94640).

You code: These are two separate, distinct sessions, so you may bill for both services. You should append a modifier -59 to 94664 and bill this code second because even though the physician performed the training earlier in the day, 1) it is the lower RVU procedure and 2) you always append -59 to the procedure code that NCCI bundles as a component.

Another example: A 67-year-old patient comes into the office complaining of respiratory distress. The physician administers a nebulizer treatment and explains to the patient how to use the device. Two weeks later, the patient returns to the office because he is having difficulty understanding how to use the device. The physician performs a second demonstration for the patient.

You code: For the first visit, you would only bill 94640, because the physician performed both a treatment and a demonstration at the same session, and NCCI bundles the demonstration into the treatment.

For the second visit, you would bill only 94664 for the nebulizer training, as the physician performed no treatment. Do

not bill a separate E/M code for this visit if the patient received no other services.

2. Report E/M and Nebulizer Treatment Together

Along with 94640, you'll probably want to bill an E/M service. Patients usually don't come in just for a nebulizer treatment, explains Pohlig. "What's typically going to happen is the physician evaluates the patient and determines if the patient is in need of a nebulizer treatment."

You can bill the appropriate level E/M service without fear of denial because NCCI does not bundle E/M services into 94640. If you find you're getting denials for E/M services billed with 94640, you may need to append a modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the E/M code to indicate the physician did a significant, separately identifiable E/M service - in many cases making the decision to administer a nebulizer treatment. Although 94640 has a global period of XXX (Global surgical rules do not apply), some carriers may be applying the global rule to the code and thereby denying the E/M service.

3. Don't Dismiss Drug Dispension

Once you've decided on your nebulizer and E/M codes, turn your attention to the inhalation solution used. While the reimbursement may not be much, failing to bill the proper J codes could cost you hundreds of dollars over the course of a year.

In 2005, CPT replaced HCPCS drug codes J7618 (Albuterol, all formulations including separated isomers, inhalation solution administered through DME, concentrated form, per 1 mg [Albuterol] or per 0.5 mg [Levalbuterol]) and J7619 (Albuterol, all formulations including separated isomers, inhalation solution administered through DME, unit dose, per 1 mg [Albuterol] or per 0.5 mg [Levalbuterol) with four more detailed and descriptive codes:

J7611 (Albuterol, inhalation solution, administered through DME, concentrated form, 1 mg)

J7612 (Levalbuterol, inhalation solution, administered through DME, concentrated form, 0.5 mg)

J7613 (Albuterol, inhalation solution, administered through DME, unit dose, 1 mg)

J7614 (Levalbuterol, inhalation solution, administered through DME, unit dose, 0.5 mg.)

The big change: "We didn't have a separate code for Levalbuterol [before] and the codes didn't differentiate among formulations ", says **Vicki O'Neil, CPC, CCS-P,** Compliance Educator in St. Louis.

While all the nebulizer drugs are similar, Levalbuterol has fewer side effects, such as elevated heart rate and jitteriness, so providers often use it in pediatric cases, O'Neil explains.

"The new codes make reporting nebulizer medications easier," says **P. Lynn Sallings, CPC,** compliance officer for **Family Medical Center, Area Health Education Center-Northwest** in Fayetteville, AK. Previously, J7618 and J7619 had lumped Albuterol and Levalbuterol together as either concentrated form or unit dose.

"Using the same codes proved confusing because the doses for each medication are different," Sallings says.

To select the proper J code, follow these quick steps:

1. Identify the drug used in the nebulizer treatment: either Albuterol (J7611, J7613) or Levalbuterol (J7612, J7614).

2. Determine if the medication is unit dose (J7613, J7614) or concentrated premixed (J7611, J7612)

Don't forget: As the J code descriptors state, you must bill the drugs to your durable medical equipment regional carrier (DMERC) if you're dealing with a Medicare patient, reminds O'Neil.

4. Bill Multiple Treatments With -76, -77

Patients can often require multiple nebulizer treatments in one day - either multiple treatments in one session or in several sessions per day. If that's the case, the first nebulizer treatment code you report would have no modifier, and the subsequent treatment codes would need a modifier -76 (Repeat procedure by same physician), says O'Neil. Or if a different physician administers the subsequent treatments, you would use modifier -77 (Repeat procedure by another physician).

Example: A 21-year-old established patient comes in at 8:00 a.m. suffering from an asthma attack. The physician administers a nebulizer treatment with a total of two unit doses of Albuterol.

The patient returns at 4:00 p.m. wheezing and in distress. The physician administers another nebulizer treatment using a total of two unit doses of Albuterol.
You report:

94640 for the first nebulizer treatment,

94640-76 for the subsequent treatments, and

J7613 x 4 for the four unit doses of Albuterol.

If a different physician handled the second office visit, you would still report the codes with modifier 76 because physicians in the same practice usually have the same tax ID number - and carriers usually consider them the same provider for billing purposes.