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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 94640: Take This Quick Short-Interval Inhalation Therapy Quiz to Aid Your Coding

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Does your physician administer airway inhalation therapy treatment several times a day at short intervals (e.g., 10 minutes)? If you don't know the distinction between 94640 and other inhalation treatment codes, you may find your claim in limbo land.

Here's an opportunity to test your skill with some tricky 94640 situations. Check out the scenarios and figure out how you'd code these examples before reading the answers below.

Scenario 1: When an established patient with emphysema presents complaining of shortness of breath, the physician administers inhalation treatment. During the therapy, the physician trains the patient on using the nebulizer at home, and provides an expanded problem-focused examination and medical decision-making of low complexity. How should you report it?

Scenario 2: Say the physician from the first scenario -- after performing an inhalation treatment -- determines that the patient's plan of care should include inhalation therapy. The patient is new to this therapy and does not know the administration techniques involved in the procedure, so the physician provides a demo. This warrants both 94664 and 94640 on the same day, but does Medicare allow pairing?

Scenario 3: The patient receives nebulizer treatment followed by a bronchodilation responsiveness test to measure the patient's response to the treatment. Should you report only the nebulizer treatment?

Quiz Solutions:

E/M will usually comprise diagnostic inhalation treatment provided in the office, but your best bet on properly billing 94640 when a demo takes place includes discussing with the physician the medical necessity of providing tutoring service.

Find out if you're all set to accurately code your physician's inhalation treatment services by checking your answers to the three scenarios on page 76 against the following solutions.

Don't Limit CPT® to 94640 When E/M Is Identifiable

Solution 1: First, 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]) to cover the comprehensive service the physician provided.

Don't stop there yet. Because the physician also performed an office visit to assess the patient's acute condition which resulted in the decision for the nebulizer treatment, report 99213 (Office or other outpatient visit for the evaluation and management of an established patient ...), based on your documentation of an expanded problem-focused exam with low-complexity decision-making. Treat the how-to discussion with the patient as part of the E/M. Attach modifier 25 to 99213 to indicate that the E/M service was significant and separately identifiable from 94640.

Don't report 94664 (Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device). The physician's primary intent is to treat the obstruction, so 94640 will suffice.

Overrule 94640, 94664 Edits With Modifier 59

Solution 2: Medicare allows this pairing -- but there's a catch. If you bill 94664 along with 94640 on the same day to Medicare, make sure you justify that the physician provided 94664 distinctly separate from the airway inhalation treatment by appending modifier 59 (Distinct procedural service). This will notify the payer that the physician performed 94664 separate from 94640.

The documentation should include details on the medical necessity for separately providing this separate service. Specifically, the physician's note should clearly identify that the physician demonstrated the inhaler to the patient separate from the administration for treatment. Otherwise, the insurer may think the service is redundant. Expect a request for documentation by the payer to review the documentation and ensure appropriate payment.

CPT® 94664 is appropriate to use for [inhaler] demonstration and evaluation, says **Gary N. Gross, MD,** executive vice president of the Joint Council of Allergy, Asthma & Immunology. As with the first scenario, you would report 99213 and 94640 in addition to 94664.

You may link separate diagnosis codes to the E/M and the nebulizer treatment (94640). For instance, you could link 786.05 (Shortness of breath) to 99213, and link the emphysema code (492.8, Other emphysema) to 94640.

Bundle 94060 Into Spirometry Test

Solution 3: No. You should code 94060 (Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration) inclusive of the nebulizer treatment. Correct Coding Initiative (CCI) Edits bundles the inhalation treatment (94640) into 94060 where 94640, in fact, shows up in column 2. The training/demo (94664) is bundled into 94060, as well.

CPT® 94060 describes the spirometric evaluation procedure -- the measuring of the respiratory gases -- not evaluation of the patient's condition, when performed. You would not use an E/M code (99211-99215, Established patient office visit) if the patient solely received the bronchodilation responsiveness test since evaluation the patient's immediate condition pre-and post-procedure is a inherent part of the procedural service.

Coders would sometimes confuse 94640 to include the drug (e.g., albuterol). Beware of this misunderstanding. If the drug represents a cost to your physician's practice, and the service was performed in a private office setting, report 94640 and the drug separately (e.g., J7620, Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per 1 mg [albuterol] or per 0.5 mg [levalbuterol]).