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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Inject New Life Into Your Inhaler Service Claims by Answering 3 Questions

Judicious use of modifiers 25 and 59 will pay you more -- if you know how to navigate the rules.

Your reimbursement success in reporting inhaler services hinges on three factors the purpose of the device used, use of correct modifiers and the fulfilling the documentation requirements. Answer these three questions competently to arm yourself with the knowledge for avoiding denial of payment for this service.

1. Was the Inhaler Service Used As Treatment Or Demonstration?

There may be two reasons why your physician or nonphysician practitioner (NPP) initiates inhaler services for a patient. First is for inhalation treatments that are used quite frequently for patients with breathing difficulties or COPD exacerbations, often receiving multiple treatments per day. A physician may also initiate inhalation treatment if a patient who is seen in clinic suddenly develops breathing problems or requires help in use of a prescribed inhaler.

For example, during an office visit, the physician decides to initiate nebulizer treatment due to the patient's worsening breathing problems. In such a case, you should submit the appropriate evaluation and management (E/M) office visit code (99201-99215), and the CPT® code for the nebulizer treatment 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]).You can support the treatment with ICD-9 diagnosis codes such as 493.02 (Extrinsic asthma with [acute] exacerbation) or 493.22 (Chronic obstructive asthma with [acute] exacerbation). The ICD-10 equivalents of these codes will be J45.21 and J44.1 respectively.

Code 94640 is mostly used in office settings where the treatment is less than an hour. For prolonged inhalation treatment scenarios, you should opt for 94644 (Continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour) and 94645 (Continuous inhalation treatment with aerosol medication for acute airway obstruction; each additional hour [List separately in addition to code for primary procedure]).

The second reason for providing inhaler services may be for a demo/evaluation of a nebulizer/inhaler that has been prescribed for a patient. "For example, a patient visits your physician's office and states that he is unsure of how to properly use the inhaler. The nurse provides detailed instructions to the patient, reinforces the instruction through demonstration, and evaluates his understanding of how to use an inhaler. You should report the code 94664 (Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device) and the correct J code for the supply of the nebulizer drug," informs **Carol Pohlig, BSN, RN, CPC, ACS,** Senior Coding & Education Specialist at the Hospital of the University of Pennsylvania.

Advair Diskus: Don't get confused if you come across term such as "The Advair Diskus" in the documentation. The diskus is an "aerosol generator," and if the nurse/medical assistant taught someone to use an Advair Diskus -- or any other diskus -- you should still report 94664.

Treatment and teaching are a package: Sometimes the physician may also administer medication dose during the teaching session. Code 94640 encapsulates both services (treatment + teaching), and so you shouldn't report them separately for the same encounter. This is because the administration was performed as part of the demonstration/evaluation, and the payment for the demonstration/evaluation is bundled into the payment for the administration.

2. Will Modifiers Enhance Your Inhaler Services Claims?

Modifier 25: CMS considers that modifier 25 applies only to E/M services performed with procedures that carry a global fee, which 94664 and 94640 do not have. "However, since NCCI bundles the E/M into 94664 and 94640, you will need to append modifier 25 to any separately identifiable E/M services reported to Medicare by the same provider/specialty group on the same day," cautions Pohlig. "It would be considered separately identifiable if the evaluation of the patient's condition resulted in the decision for the demonstration or inhalation treatment," she adds.

Similarly, different payers have different rules regarding including E/M services with inhaler services, and you should check with your local coverage rules before billing them. Best rule of thumb, if a patient visits your physician in an outpatient setting, you should bill the inhaler service and add modifier 25 (Significant, separately identifiable E/M service by the same physician or other qualified Health care professional on the same day of the procedure or other service) to any separately identifiable E/M visit codes.

Modifier 76: Usually, patients with increasing shortness of breath or wheezing are often given multiple treatments per day. For more than one inhalation treatment performed on the same date, you should append modifier 76 (Repeat procedure or service by same physician or other qualified health care professional). To report multiple treatments, separate line items of 94640 with modifier 76.

Modifier 59: Sometimes the patient may require separate education after receiving an inhalation treatment on the same day. Here, you can bill both services (treatment + education) by reporting 94640 and then adding 94664 with modifier 59 (Distinct procedural service), as the patient required additional instruction for his daily maintenance medication. This is different from the medication provided for immediate intervention (94640). The Correct Coding Initiative (CCI) has placed an edit on 94640 and 94664, indicating that 94664 is a component of 94640. 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.

3. Can You Correctly Justify the Medical Necessity For Inhaler Claims?

If payers would not pay your 94664 claim, you would need to support it with documentation indicating medical necessity to reimburse the service. 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. The nurse or provider must document what was discussed and the patient's response and ability to use the device.

Remember that code 94640 should only be reported once during a single patient encounter regardless of the number of separate inhalation treatments that are administered. If 94640 is used for treatment of acute airway obstruction, spirometry measurements before and/or after the treatment(s) would not be reported separately. Do not report code 94060 (Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration) in addition to code 94640 as it is considered a misuse.

For Medicare payers, and many private payers, don't report 94640 in addition to 94644 or 94645 if, for example, the patient required continuous nebulizer treatment and later in the same visit received a 10 minute aerosol breathing treatment. Billing edits bundle 94644 and code 94640, with 94644 as the more extensive procedure. The codes may not be reported together under any circumstances.

Do not submit 94664 for patients who routinely use the devices to provide treatments at home, unless there are unusual circumstances. Documentation in the patient's medical record should support providing patient education related to bronchodilator administration and should include comments about the patient's ability to correctly use the delivery device.