

Billing Guide for Asthma and COPD Care

Diagnosis Coding Guide

Diagnosis Code	Clinic Description
Documentation should reflect the diagnosis code being submitted to the insurance carrier. Provider should be as specific as possible when documenting the type of COPD or asthma.	
J41.0	Simple chronic bronchitis
J44.0	COPD with (acute) lower respiratory infection
J44.1	COPD with (acute) exacerbation
J44.9	COPD, unspecified
J43	Emphysema, unspecified
J43.1	Panlobular emphysema
J43.2	Centrilobular emphysema
J43.8	Other emphysema
J45.20, .21 or .22	Mild intermittent asthma
J45.30, .31 or .32	Mild persistent asthma
J45.40, .41 or .42	Moderate persistent asthma
J45.50, .51 or .52	Severe persistent asthma
J45.901, .902 or .909	Other and asthma, unspecified
J45.990	Exercise-induced bronchospasm
J45.991	Cough variant asthma
J45.998	Other asthma
J68.9	Unspecified respiratory condition due to chemicals, gases, fumes, and vapors

Z codes can identify any documented factors influencing a patient's health status.
Can be coded when documented by any clinician in the record.

Environmental Factors

Z57.2	Occupational exposure to dust
Z57.31	Occupational exposure to environmental tobacco smoke
Z77.22	Contact with and (suspected) exposures to environmental tobacco smoke (acute)(chronic)



Evaluation and Management (E/M) Coding

Diagnosis Code	Clinic Service	Description
Level of visit is chosen based on documentation of total time or level of MDM.		
99202-99215	MD Clinic Visit	New and established E/M services

Level of visit is chosen **based on total amount of face-to-face time** if more than half the visit was spent in counseling and coordination of care:

New Patient	Established Patient	
99202 – 15-29 min.	99211 – 5 min. (nurse)	• Total face-to-face time
99203 – 30-44 min.	99212 – 10-19 min.	• Summary of discussion
99204 – 45-59 min.	99213 – 20-29 min.	• Any key elements (history, exam, MDM) performed
99205 – 60-74 min.	99214 – 30-39 min.	
99202 – 99215	99215 – 40-54 min.	
	MD Clinic Visit	New and established E/M services
	based on time	

- Report 99417 for the first hour of prolonged services
- The CPT code is per 15 minutes
- Report these codes in addition to the E/M code

Additional time spent with patient needs to be clearly documented. Ex: “I spent an additional 50 minutes discussing...”

Reference:

New patient is someone who has not received professional services from the physician or another physician in the same specialty and group practice within the last three years.

Established patient is someone who has received professional services from the physician or another physician in the same specialty and group practice within the last three years.

Therapeutic Procedures Guide

Diagnosis Code	Description
Pressurized or nonpressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device.	
This code should be used to report nebulizer treatments done in the office. For multiple treatments on the same day, use units or the -76 modifier (on the second line of 94640). If doing a pre- and post-spirometry with the nebulizer treatment, do not report 94640. Use Code 94060, which includes all of these elements.	
Nurse or provider must document the treatment provided including what inhalation drug was used.	
94640	Nebulizer treatment
94644	Continuous inhalation treatment with aerosol medication, first hour
94645	Continuous inhalation treatment each additional hour
This code should be used to report chest percussion by a respiratory therapist.	
Documentation should indicate the service rendered and whether it was initial or subsequent.	
94669	Mechanical chest wall oscillation, per session



Educational Services Guide

Diagnosis Code	Description
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Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler, or IPPB device.

This code should be used to report services of the nurse or provider demonstrating how to use the nebulizer machine or inhaler. Code should be reported only 1X/day. If reported by nurse, must be under direct physician supervision.

Nurse or provider must document what was discussed and the patient's response and ability to use the device.

94664	⋮	Bronchodilator administration—evaluate patient's use of inhaler
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Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal prep, safety procedures, and instruct in use of assistive technical devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes.

This code should be used to report services by the provider demonstrating how to use the nebulizer machine and overall asthma education. Code should be reported for each 15 minutes of demonstration and/or education.

Provider must document what was discussed, patient's response, and ability to use the machine. Because this is a time-based code, time spent face-to-face must be documented.

97535	⋮	Self-care/Home management training
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Education and training for patient self-management by a qualified, non-physician healthcare professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family), each 30 minutes: Individual patient, 2-4 patients, 5-8 patients. Self-management education and training services are not separately billable codes under Medicare and are not paid by Medicare when submitted for an outpatient bill type.

These codes should be used to report the education provided by the non-physician provider to reach the patient how to effectively self-manage their asthma. Qualifications of the healthcare provider and content of the program should be consistent with payer guidelines. NOTE: To date there have been no guidelines published on the use of these codes and no RVUs have been assigned.

Non-physician provider must document the amount of time spent and how many participants were involved in the education. Specific educational element should be documented.

98960	⋮	Individual face-to-face	Patient self-management education
98961	⋮	2-4 patients	
98962	⋮	5-8 patients	

Physician educational service rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions).

This code should be used to report services by the provider in a group setting for asthma education. Code should be reported once per session.

Provider must document discussion, patient's response, and participation in the group.

99078	⋮	Physician Group Education
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Educational Services Guide

Diagnosis Code	Description
Patient education, not otherwise classified, non-physician provider, group, per session.	
This code should be used to report group asthma educational services of the nurse including: basic facts, inhaler technique, home peak flow monitoring, environmental control measures, and follow-up plan. Code should be reported 1X/session. Currently only Medica's Minnesota Care and Choice Care plans allow reimbursement for S9446. Nurse must document the specific content of the education and patient's response and participation in the group.	
S9446	• Group Education
94625	• Pulmonary Rehabilitation without continuous oximetry monitoring
94626	• Pulmonary Rehabilitation with continuous oximetry monitoring

Diagnostic Procedures Guide

Diagnosis Code	Clinic Description
Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation.	
This code should be used to report a diagnostic spirometry service.	
94010	• Spirometry
Patient initiated spirometric recording per 30 day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration, and physician review and interpretation.	
94014	• Patient initiated spirometric recording
Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration	
This code should be used to report bronchodilation responsiveness services. Codes 94010 and 94640 are included and should not be reported in addition to 94060.	
94060	• Bronchodilation responsiveness
Bronchospasm provocation evaluation, multiple spirometric determinations as in 94010, with administered agents (e.g., antigen(s), cold air, methacholine)	
This code should be used to report a bronchospasm provocation evaluation. Several units of 94010 are included and should not be reported in addition to 94070.	
94070	• Bronchospasm provocation evaluation
Vital capacity, total	
This code should be used to report vital capacity.	
94150	• Vital capacity
Maximum breathing capacity, maximal voluntary ventilation	
This code should be used to report maximum breathing capacity.	
94200	• Maximum breathing capacity
Nitric oxide expired gas determination	
This code should be used to report nitric oxide expired gas determinations. If done by spectroscopy, use category III Code 0064T. There may be coverage issues with this diagnostic service. This code does not have professional/technical components and should not be reported with -TC or -26 modifiers.	
95012	• Exhaled nitric oxide (ENO)



Diagnostic Procedures Guide

Diagnosis Code	Clinic Description
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Inhalation bronchial challenge testing (not including necessary pulmonary function tests), with histamine, methacholine, or similar compounds

95070	Inhalation bronchial challenge testing
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Not including necessary pulmonary function tests, with histamine, methacholine, or similar compounds

95070	Inhalation bronchial challenge testing
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Noninvasive ear or pulse oximetry for oxygen saturation:

- **single determination**
- **multiple determinations**
- **by continued overnight monitoring**

These codes can be used to report pulse oximetry testing. If multiple determinations are made, use Code 94761. Many carriers do not reimburse separately for 94760.

Documentation should indicate the measurements described in the code and an order for the diagnostic test.

94760-Single Determination	Pulse oximetry
94761-Multiple Determinations	
94762-Continuous Overnight Monitoring	

Arterial puncture, withdrawal of blood for diagnosis

This code can be used to report the blood draw in addition to the code(s) for arterial blood gases.

Documentation should show the method of the blood draw.

36600	Arterial puncture
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Holding chamber or spacer for use with an inhaler or nebulizer:

- **without mask**
- **with mask**

This code should be used when this item is given to the patient to take home. If supply was provided to the clinic free of charge, this code should not be reported. Use other HCPCS code if a comparable A code is available. S code not valid for Medicare.

Documentation should show the specific supply or supplies that were given to the patient.

S8100-without mask	Spacer for inhaler
S8101-with mask	

Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler

This code should be used when this item is given to the patient to take home. If supply was provided to the clinic free of charge, this code should not be reported.

Documentation should show the specific supply or supplies that were given to the patient.

A4627	Spacer for inhaler
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Diagnostic Procedures Guide

Diagnosis Code : Clinic Description

Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen

These codes should be used when these items are given to the patient to take home. If supplies were provided to the clinic free of charge, these codes should not be reported. Patient/family should be encouraged to obtain durable medical equipment (DME) directly from supplier or have supplier bill for the equipment. For consignment arrangements, the supplier should bill for the equipment, not the clinic.

Documentation should show the specific supply or supplies that were given to the patient.

A7017 : Nebulizer (DME)

Aerosol mask, used with DME nebulizer dome and mouthpiece used with small volume ultrasonic nebulizer

These codes should be used when these items are given to the patient to take home. If supplies were provided to the clinic free of charge, these codes should not be reported. Patient/family should be encouraged to obtain durable medical equipment (DME) directly from supplier or have supplier bill for the equipment.

Documentation should show the specific supply or supplies that were given to the patient.

A7015 : Nebulizer mask (DME)

A peak flow meter is covered as a supply when furnished in the physician office setting for home use by the patient.

A4614 : Peak flow meter—peak expiratory flow rate meter, hand held

Flutter device

This code should be used when this item is given to the patient to take home. If supply was provided to the clinic free of charge, this code should not be reported. Patient/family should be encouraged to obtain durable medical equipment (DME) directly from supplier or have supplier bill for the equipment. S code not valid for Medicare.

Documentation should show the specific supply or supplies that were given to the patient.

S8185 : Flutter device

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