Propellant-Driven Inhaler Falls Under 94664

If there's confusion in your office over whether to use 94664 (Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler, or IPPB device) to report education/training with the Advair diskus, look no further for your answer.

Code 94664’s descriptor specifies demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device. Part of teaching the proper technique in using an inhaler (either propellant-driven [Advair Diskus] or dry powder) is to demonstrate and evaluate. In this respect, the code would seem appropriate to use for demonstration and evaluation.

The drawback: Not all payers will reimburse 94664. If practices abuse 94664, probably fewer payers will pay. To support reporting 94664, documentation should include an indication of medical necessity.

Clear Up Inhaler Code Confusion

Patients sometimes need multiple nebulizer treatments in the office to control acute asthma. If you’ve wondered whether to bill 94640 and J7613 multiple times, one time, or one time with modifiers for additional treatments, follow this advice and you’ll breathe easier.

Submit 94640 for Each Treatment

When a patient receives multiple aerosol treatments on the same date, you should use 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 first treatment.

Subsequent treatments will require modifier 76 (Repeat procedure by same physician), CPT® says. Therefore, you would code three nebulizer treatments as:

- 94640 — first treatment
- 94640-76 x 2 — two subsequent treatments.

A dose of coding: For the inhalation solution, report three units of J7613 (Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg). Because J7613 represents one unit dose, you should report per nebulizer treatment or, in our example, J7613 x 3.

E/M Might Also Be Acceptable

If the allergist meets the criteria, you should report the appropriate-level E/M code (such as 99214, Office or other outpatient visit for the evaluation and management of an established patient ...).

If the physician performs and documents a significant, separate E/M from the treatment (94640), append the E/M code with modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service).

Time is a factor: If the asthma treatment lasted at least an hour, you’d code it with 94644 (Continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour). Report code 94640 for intermittent or one-time treatments.

Clue In to 5th Digit for Asthma Diagnosis
When you submit an asthma diagnosis, don’t forget that ICD-9 requires you to use a fifth-digit subclassification with asthma codes (493.xx, Asthma). If you submit four digits for an asthma diagnosis, payers will probably reject the ICD-9 code as incomplete.

**Correct method:** Assign the fourth digit based on the asthma category:

- 493.0x, Extrinsic asthma
- 493.1x, Intrinsic asthma
- 493.2x, Chronic obstructive asthma
- 493.8x, Other forms of asthma
- 493.9x, Asthma, unspecified.

Then, identify the asthma’s current state with the appropriate fifth digit:

- 0, unspecified
- 1, with status asthmaticus
- 2, with (acute) exacerbation.

For patients who do not have status asthmaticus or acute exacerbation, use a fifth digit of 0. Code 493.x0 is appropriate when the patient’s asthma is controlled. A final digit of 1 indicates that the patient has status asthmaticus, which is a medical emergency and is usually treated in the emergency department. You should assign a 2 when something has caused the condition to flare up.

**Why it matters:** Without this level of specificity, the payer may deny your claim for lack of medical necessity.

**Example:** An extrinsic asthma patient has an acute exacerbation that requires a nebulizer treatment reported with code 94640. In this case, you should link 94640 to 493.02. Reporting a 2 as the fifth digit helps the payer understand why the patient needs the treatment. Without the final digit (or a fifth-digit of 0), the payer may assume that the patient’s asthma is under control, making the coded treatment unnecessary.

**Don’t Forget Your Right to Report Albuterol/Levalbuterol J Codes**

When your practice provides the Albuterol/Levalbuterol inhalation solutions, you are entitled to get paid for these supplies. You have the following J codes for your inhalation solution supplies:

- J7611 — Albuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, 1 mg
- J7612 — Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 0.5 mg
- J7613 — Albuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose, 1 mg
- J7614 — Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 0.5 mg.

**Focus on 2 J7611-J7614 Factors**

You can get the correct non-compounded solution supply code if you zoom in on two items:

- **Form** — concentrated (J7611, J7612) or unit dose (J7613, J7614).
- **Drug** — albuterol (J7611, J7613) or levalbuterol (J7612, J7614).

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