CODING Q&A

Inhalation Treatments, OSHA Required Respiratory Questionnaires, Preventive Care Services

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Q. Can nebulizer treatments and instructions for use of the nebulizer inhaler be billed together? Who can perform these services in an urgent care center?

A. There are two codes associated with nebulizer treatment and instruction:

- 94640, "Pressurized or non-pressurized 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"; and
- 94664, "Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device.

If the instruction is given in conjunction with the nebulizer treatment as described in 94640, you only bill the 94664 because it is a comprehensive procedure code that incorporates both services.

Medicare will not pay for both services if performed on the same day, but there is no CPT rule that prohibits coding both when billing other payors. According to CPT Assistant, code 94664 "has several facets and may be reported to describe:

- demonstration of a metered-dose inhaler or a nebulizer
- bronchodilator administration for the purpose of long-term management of bronchospasm
- bronchodilator administration to mobilize sputum for therapeutic purposes (i.e., movement of thick secretions)
- bronchodilator administration to mobilize sputum for sputum induction for diagnostic studies (e.g., culture, gram stain)"

You would want to check with the payor to see whether the payor has a specific rule regarding the billing of both services for the same day of service.

If applicable, you would submit the appropriate E/M code with a -25 modifier to indicate that it was a significant, separately identifiable service from the other services described.

These services can be performed and documented in any urgent care setting by any staff member who is trained to perform such services under the supervision of a physician. ■

An urgent care center that decides to perform preventive services must understand any limitations in its managed care contracts.

Q. What are the CPT codes required for compliant coding of the OSHA respiratory questionnaire assessment review and the respiratory fit test?

A. As specified in 29 CFR 1910.134(c)(4): "The employer shall provide respirators, training, and medical evalua-

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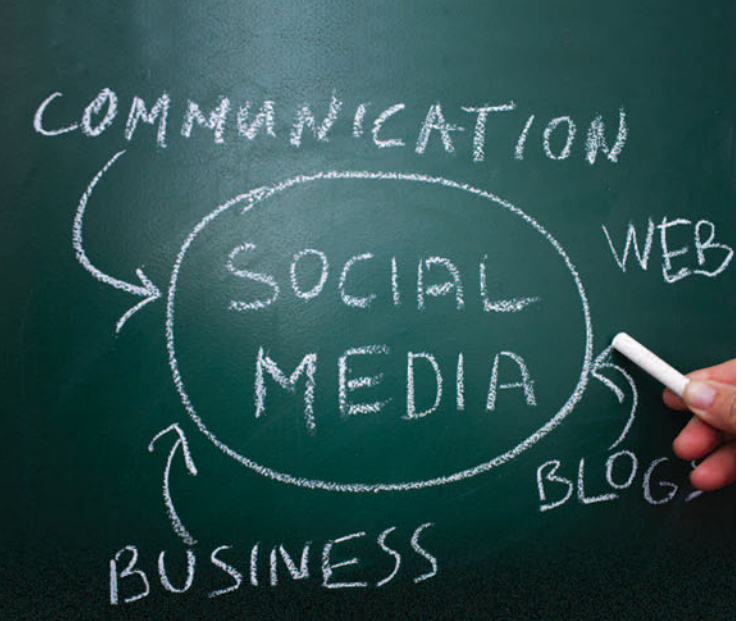

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tions at no cost to the employee." These services—including review and reporting of a completed medical evaluation questionnaire—would be conducted and billed as an employer-paid service (EPS) and cannot be billed to the employee's insurance provider. Billing, coding, and payment for these services are generally performed at pricing that is mutually agreed upon (regardless of codes billed.) Thus, normal coding compliance rules would not apply. In fact, very few employers will even note what codes (if any) are used. ■

Q. Is it typical for a payor to deny reimbursement when an urgent care center bills preventive medicine CPT code 99381-99397?

A. Preventive services are typically performed in a primary care setting. An urgent care center that decides to perform preventive services must understand any limitations in its managed care contracts. Patients also have a responsibility to be informed about when and where preventive services are covered. As with any denial, contacting the carrier for a detailed explanation of why the claim was denied is important. It is beneficial to have a good relationship with your insurance account representatives to help answer these types of questions.

Further, if an urgent care center decides to perform primary care services, it is important for both provider and patient to be clear about their obligations for follow-up, on-call services, and hospital admissions. Providers should seek legal advice about their obligations under payor contracts and government regulations.

For Medicaid preventive services, states operate under the federal Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Under that program, specific (and/or unique) codes for billing may be required by each state.

For non-Medicaid commercial insurers, the CPT codes for preventive medicine services are coded for the basic service (history, physical examination, and counseling/anticipatory guidance). Report separately all applicable CPT codes for additional screening (hearing, vision, and development), laboratory services, and immunization administration(s). ■

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