



Asthma Coding Fact Sheet for Primary Care Pediatricians

Physician Evaluation & Management Services

Outpatient

★**99201** Office or other outpatient visit, *new patient*; self limited or minor problem, 10 min.

★**99202** low to moderate severity problem, 20 min.

★**99203** moderate severity problem, 30 min.

★**99204** moderate to high severity problem, 45 min.

★**99205** high severity problem, 60 min.

A new patient is one who has not received any professional services face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services reported by a specific CPT code(s) from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

★**99211** Office or other outpatient visit, *established patient*; minimal problem, 5 min.

★**99212** self limited or minor problem, 10 min.

★**99213** low to moderate severity problem, 15 min.

★**99214** moderate severity problem, 25 min.

★**99215** moderate to high severity problem, 40 min.

★**+99354** Prolonged physician services in office or other outpatient setting, with direct patient contact; first hour (*use in conjunction with time-based codes 99201-99215, 99241-99245, 99301-99350*)

★**+99355** each additional 30 min. (*use in conjunction with 99354*)

- Used when a physician provides prolonged services beyond the usual service (ie, beyond the typical time).
- Time spent does not have to be continuous.
- Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

Reporting E/M services using “Time”

- When counseling or coordination of care dominates (more than 50%) the physician/patient or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then time shall be considered the key or controlling factor to qualify for a particular level of E/M services.
- This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (eg, foster parents, person acting in loco parentis, legal guardian). The extent of counseling and/or coordination of care must be documented in the medical record.
- For coding purposes, face-to-face time for these services is defined as only that time that the physician spends face-to-face with the patient and/or family. This includes the time in which the physician performs such tasks as obtaining a history, performing an examination, and counseling the patient.
- When codes are ranked in sequential typical times (such as for the office-based E/M services or consultation codes) and the actual time is between 2 typical times, the code with the typical time closest to the actual time is used.
- Prolonged services can only be added to codes with listed typical times such as the ones listed above. In order to report prolonged services the reporting provider must spend a minimum of 30 minutes or supervised clinical staff 45 minutes beyond the typical time listed in the code level being reported. When reporting

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outpatient prolonged services only count face-to-face time with the reporting provider or clinical staff. When reporting inpatient or observation prolonged services you can count face-to-face time, as well as unit/floor time spent on the patient's care. However, if the reporting provider is reporting their service based on time (ie, counseling/ coordinating care dominate) and not key components, then physician prolonged services cannot be reported unless the provider reaches 30 minutes beyond the listed typical time in the highest code in the set (eg, **99205, 99226, 99223**). It is important that time is clearly noted in the patient's chart.

- Example: A physician sees an established patient in the office to discuss the current asthma medication treatment plan the patient was placed on. The total face-to-face time was 22 minutes, of which 15 minutes was spent in counseling the mom and patient. Because more than 50% of the total time was spent in counseling, the physician would report the E/M service based on time. The physician would report a **99214** instead of a **99213** because the total face-to-face time was closer to a **99214** (25 minutes) than a **99213** (15 minutes).

★**99406** Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

★**99407** ;intensive, greater than 10 minutes

Note you cannot report tobacco cessation codes (**99406-99407**) under the child when counseling the parent.

Physician Non-Face-to-Face Services

99339 Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (e.g., assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

99340 30 minutes or more

99358 Prolonged E/M services before or after direct patient care; first hour. *Note:* This code is now valued on the Medicare physician fee schedule. Many private payers and Medicaid will follow suit
+**99359** each additional 30 min. (*Use in conjunction with 99358*)

99367 Medical team conference by physician with interdisciplinary team of healthcare professionals, patient and/or family not present, 30 minutes or more

99374 Care plan oversight services requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports and related lab studies, communications, integration of new information into treatment plan, and/or adjustment of medical therapy, patient under care of home health agency, 15-29 min.

99375 30 min. or more

99377 Care plan oversight services, patient under care of hospice, 15-29 min.

99378 30 min. or more

99379 Care plan oversight, patient in a nursing facility, 15-29 min.

99380 30 min. or more

99441 Telephone evaluation and management to patient, parent or guardian not originating from a related E/M service within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

99442 11-20 minutes of medical discussion

99443 21-30 minutes of medical discussion

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99444 Online evaluation and management service provided by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient or guardian, no originating from a related E/M service provided within the previous 7 days, using the internet or similar electronic communications network

Non-Physician Services:

Prolonged Clinical Staff Services with Physician or Other Qualified Health Care Professional Supervision

Codes **99415, 99416** are used when a prolonged E/M service is provided in the office or outpatient setting that involves prolonged clinical staff face-to-face time beyond the typical face-to-face time of the E/M service, as stated in the code description.

+ **99415** Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour

+ **99416** each additional 30 minutes

Codes 99415-99416

- Must always be reported in addition to an appropriate office/outpatient E/M service (ie, **99201-99215**)
- Require that the physician or qualified health care professional is present to provide direct supervision of the clinical staff.
- Are used to report the total duration of face-to-face time spent by clinical staff on a given date providing prolonged services, even if the time spent by the clinical staff on that date is not continuous.
- Are not reported for time spent performing separately reported services other than the E/M service is not counted toward the prolonged services time.
- Requires a minimum of 45 minutes spent beyond the typical time of the E/M service code being reported. May require that the clinical staff spend more time if the physician does not meet the time criteria of the E/M service being reported
- May not be reported in addition to **99354** or **99355**.

Care management and transition care management are reported under the directing physician or other qualified health care professional, however, the time requirement can be met by clinical staff working under the direction of the reporting physician or other qualified health care professional.

Care Management Services:

Codes are selected based on the amount of time spent by clinical staff providing care coordination activities. CPT clearly defines what is defined as care coordination activities. In order to report chronic care or complex chronic care management codes, you must

1. provide 24/7 access to physicians or other qualified health care professionals or clinical staff;
2. use a standardized methodology to identify patients who require chronic complex care coordination services
3. have an internal care coordination process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner
4. use a form and format in the medical record that is standardized within the practice
5. be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

99490 Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;

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- comprehensive care plan established, implemented, revised, or monitored.

Do not report 99490 for chronic care management services that do not take a minimum of 20 minutes in a calendar month.

99487 Complex chronic care management services;

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
- establishment or substantial revision of a comprehensive care plan;
- moderate or high complexity medical decision making;
- 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

Do not report 99487 for chronic care management services that do not take a minimum of 60 minutes in a calendar month.

+99489 each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

Note: **99487** and **99489** are now valued on the Medicare physician fee schedule.

Complex chronic care management is reported by the physician or qualified health care professional who provides or oversees the management and coordination of all of the medical, psychosocial, and daily living needs of a patient with a chronic medical condition. Typical pediatric patients

1. receive three or more therapeutic interventions (eg, medications, nutritional support, respiratory therapy)
2. have two or more chronic continuous or episodic health conditions expected to last at least 12 months (or until death of the patient) and places the patient at significant risk of death, acute exacerbation or decompensation, or functional decline
3. commonly require the coordination of a number of specialties and services.

99495 Transitional care management (TCM) services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision-making of at least moderate complexity during the service period
- Face-to-face visit, within 14 calendar days of discharge

99496 Transitional care management services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision-making of high complexity during the service period
- Face-to-face visit, within 7 calendar days of discharge

These services are for a patient whose medical and/or psychosocial problems require moderate or high complexity medical decision-making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility to the patient's community setting (home, domiciliary, rest home, or assisted living). TCM commences on the date of discharge and continues for the next 29 days and

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requires a face-to-face visit, initial patient contact, and medication reconciliation within specified timeframes. Any additional E/M services provided after the initial may be reported separately. Refer to the *CPT* manual for complete details on reporting care management and TCM services.

Do not report for patients in the emergency department.

98960 Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient

98961 ; 2-4 patients

98962 ; 5-8 patients **98966** Telephone assessment and management service provided by a qualified nonphysician healthcare professional to an established patient, parent or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

98967 ; 11-20 minutes of medical discussion

98968 ; 21-20 minutes of medical discussion

Procedures

94010 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

94014 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

94015 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

94016 Patient initiated spirometric recording per 30-day period of time; physician review and interpretation only

94060 Bronchodilation responsiveness, spirometry, as in **94010**, pre- and post-bronchodilator administration

94150 Vital capacity, total (separate procedure) Note: requires hook-up to spirometer

94640 Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum indication for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] devise)

94644 Continuous inhalation treatment with aerosol medical for acute airway obstruction; first hour (for less than an hour report **94640**)

94664 Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device.

94760 Noninvasive ear or pulse oximetry for oxygen saturation; single determination

94761 Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (Do not report in conjunction with **94760**)

S8110 Peak expiratory flow rate (physician services)

Please note that oxygen administration does not have a separate CPT code and is reported under the E/M service. Supplies may be billed, however.

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Health Risk Assessment – Asthma Control Test

96160 Administration of patient-focused health risk assessment instrument with scoring and documentation, per standardized instrument

Special Services

Use all of the following “Special Services” in addition to the E/M code and/or other primary procedure

99050 Service(s) provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday) in addition to basic services

99051 Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic services

99058 Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service

Visit https://www.aap.org/en-us/Documents/coding_factsheet_afterhrsspecialservices.pdf for more information on billing “special services”

Supply Codes

99070 Supplies and materials supplied by the physician over and above those usually included with the office visit or other services rendered

A4614 Peak expiratory flow rate meter, hand held

A4615 Cannula, nasal

A4616 Tubing (oxygen), per foot

A4617 Mouthpiece

A7015 Aerosol mask, used with DME nebulizer

J7611 Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, **1mg** (Albuterol Sulfate, Proventil, Ventolin)

J7612 Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, **0.5mg** (Xopenex)

J7613 Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, **1mg** (Albuterol Sulfate, Proventil, Accuneb)

J7614 Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, **0.5mg** (Xopenex)

J7626 Budesonide inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, **up to 0.5mg** (Pulmocort Respules, non-compounded, concentrated)

J7627 Budesonide inhalation solution, compounded product, administered through DME, unit dose form, **up to 0.5mg** (Pulmocort Respules)

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Modifiers

25 Significant and separately identifiable E/M service from another procedure or service

59 Distinct procedural service from another non-E/M service

76 Repeat procedure by the same physician on the same day

Please note that the modifiers below are subsets of modifier 59 and are only to be reported when directed by your payers. You would report one of these modifiers below in lieu of modifier 59 as appropriate.

XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter

XS Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure

XP Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner

XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) Codes

- Use as many diagnosis codes that apply to document the patient's complexity and report the patient's symptoms and/or adverse environmental circumstances.
- Once a definitive diagnosis is established, report the appropriate definitive diagnosis code(s) as the primary code, plus any other symptoms that the patient is exhibiting as secondary diagnoses that are not part of the usual disease course or are considered incidental.

For **J44** codes

Code also type of asthma, if applicable (**J45.-**)

For **J44** and **J45** codes

Use additional code to identify:

exposure to environmental tobacco smoke (**Z77.22**)

history of tobacco use (**Z87.891**)

occupational exposure to environmental tobacco smoke (**Z57.31**)

tobacco dependence (**F17.-**)

tobacco use (**Z72.0**)

J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection

Use additional code to identify the infection

J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation

J44.9 Chronic obstructive pulmonary disease, unspecified (Chronic obstructive airway disease NOS
Chronic obstructive lung disease NOS)

J45.20 Mild intermittent asthma, uncomplicated (NOS)

J45.21 Mild intermittent asthma with (acute) exacerbation

J45.22 Mild intermittent asthma with status asthmaticus

J45.30 Mild persistent asthma, uncomplicated (NOS)

J45.31 Mild persistent asthma with (acute) exacerbation

J45.32 Mild persistent asthma with status asthmaticus

J45.40 Moderate persistent asthma, uncomplicated (NOS)

J45.41 Moderate persistent asthma with (acute) exacerbation

J45.42 Moderate persistent asthma with status asthmaticus

J45.50 Severe persistent asthma, uncomplicated (NOS)

J45.51 Severe persistent asthma with (acute) exacerbation

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J45.52 Severe persistent asthma with status asthmaticus
J45.901 Unspecified asthma with (acute) exacerbation
J45.902 Unspecified asthma with status asthmaticus
J45.909 Unspecified asthma, uncomplicated (NOS)
J45.990 Exercise induced bronchospasm
J45.991 Cough variant asthma
J45.998 Other asthma

R06.02 Shortness of breath

R06.2 Wheezing

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