American Academy of Pediatrics

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Asthma Coding Fact Sheet for Primary Care Pediatricians

CPT Codes

Initial assessment usually involves a lot of time determining the differential diagnosis, a diagnostic plan, and potential treatment options. Therefore, most pediatricians will report either an office/outpatient evaluation and management (E/M) code using time as the key factor (when greater than 50% of the total face-to-face time spent in counseling and/or coordination of care) or a consultation code for the initial assessment:

Office or Other Outpatient E/M Codes

99201/99202/99203/99204/99205: Use for new* patients only; require 3 of 3 key components or greater than 50 percent of the visit spent in counseling or coordinating care.
99212/99213/99214/99215: Use for established patients; require 2 of 3 key components or greater than 50 percent of the visit spent in counseling or coordinating care.

Prolonged Services

+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.
- + Codes are "add-on" codes, meaning they are reported separately in addition to the appropriate code for the service provided (eg, office or other outpatient E/M codes, 99201-99215).
- Prolonged service of less than 15 minutes beyond the first hour or less then 15 minutes beyond the final 30 minutes is not reported separately.
- Time spent does not have to be continuous.
- If the physician spends at least 30 and no more than 74 minutes over the typical time associated with the reported E/M code, he/she can report 99354 (for face-to-face contact). Code 99355 (each additional 30 minutes of face-to-face prolonged service) is used to report each additional 30 minutes of service beyond the first 74 minutes.
- Prolonged service of less than 15 minutes beyond the first hour or less then 15 minutes beyond the final 30 minutes is not reported separately.

99358 Prolonged physician services without direct patient contact; first hour NOTE: This code is no longer an "add-on" service and can be reported alone.
+99359 each additional 30 min. *(+ designated add-on code, use in conjunction with 99358*)

- Time spent does not have to be continuous, but must occur on a single calendar day.
- Prolonged service of less than 15 minutes beyond the first hour or less then 15 minutes beyond the final 30 minutes is not reported separately.
- If the physician spends at least 30 and no more than 74 minutes on a single calendar date performing non-face-to-face services, he/she can report 99358. Code 99359 (each additional 30 minutes of non-face-to-face prolonged service) are used to report each additional 30 minutes of service beyond the first 74 minutes.
- Prolonged service of less than 15 minutes beyond the first hour or less then 15 minutes beyond the final 30 minutes is not reported separately.

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)

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

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.

Non-Physician Services:

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

Health Risk Assessment – Asthma Control Test

99420 Administration and interpretation of health risk assessment instrument

Care Plan Oversight Codes

99339/99440 Use these codes to report care plan oversight done over the course of a calendar month for a patient who is not under the care of a home health agency and who requires complex and multidisciplinary care modalities involving regular physician development and/or revisions of care plans. The minimal time spent in a calendar month must be 15 minutes. Only one code can be reported once per calendar month.

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

Special Services

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

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)

ICD-9-CM (Diagnosis) 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 that does not directly contribute to the primary diagnosis.
• Counseling diagnosis codes can be used when patient is present or when counseling the parent/guardian(s) when the patient is not physically present.

493.00 Extrinsic asthma; unspecified

493.01 Extrinsic asthma; with status asthmaticus

493.02 Extrinsic asthma; with (acute) exacerbation

493.10 Intrinsic asthma; unspecified

493.11 Intrinsic asthma; with status asthmaticus

493.12 Intrinsic asthma; with (acute) exacerbation

493.20 Chronic obstructive asthma; unspecified

493.21 Chronic obstructive asthma; with status asthmaticus

493.22 Chronic obstructive asthma; with (acute) exacerbation

493.81 Exercise induced bronchospasm

493.82 Cough variant asthma

493.90 Asthma, unspecified (Bronchitis: allergic, asthmatic); unspecified

493.91 Asthma, unspecified (Bronchitis: allergic, asthmatic); with status asthmaticus

493.92 Asthma, unspecified (Bronchitis: allergic, asthmatic); with (acute) exacerbation

786.05 Shortness of breath

786.07 Wheezing