Participant Materials

Based on National Asthma Education and Prevention Program (NAEPP) Guidelines including the NAEPP’s Guidelines Implementation Panel (GIP) Priority Messages. Funded in part by the National Asthma Control Initiative of the National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health (NIH).
PACE Participant’s Binder Contents

This document contains most of the materials that we recommend be copied and contained in a tabbed binder for each participant:

Classification, Assessment, Therapy
- Classification, assessment, and therapy charts, ages 0-4, 5-11, and ≥12

Sample Action Plans
- Sample asthma action plans
- Sample long-term plan

Communication Strategies
- Communication strategies
- Key asthma messages for the patient and family
- Review of concepts
- Physician’s record and self-rating

Documentation and Coding
- Reimbursement Hints Q&A
- How to Use Modifiers Effectively
- CPT Codes for Other Asthma Services
- Coding Based on Complexity: New vs. Established Patients
- CPT Codes for New Patients’ Office Visits
- CPT Codes for Established Patients’ Office Visits
- Example – Level 4 (99214) Established Patient Office Visit Based on Complexity
- Documentation, Coding, and Reimbursement Tools

Priority Messages and Patient Education
- Guidelines Implementation Panel (GIP) Priority Messages
- Patient Education Material

Master Trainers

PACE References

In addition to the above materials, we recommend that handouts of all the presentation slides be included in the binder: 3 per page, with space for notes. Please see the PACE website for a downloadable PDF of the handouts.

Articles are not included in this document due to copyright restrictions. In addition to the bibliography, we recommend that you obtain and include in the References section of the binder four key articles pertaining to PACE:
Classification, Assessment, Therapy
**CLASSIFYING ASTHMA SEVERITY IN CHILDREN 0–4 YEARS OF AGE**

- Classifying severity in children who are not currently taking long-term control medication.

| Components of Severity | Classification of Asthma Severity  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Children 0–4 years of age)</td>
</tr>
<tr>
<td></td>
<td><strong>Intermittent</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Mild</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Moderate</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Severe</strong></td>
</tr>
<tr>
<td><strong>Symptoms</strong></td>
<td>≤2 days/week</td>
</tr>
<tr>
<td></td>
<td>&gt;2 days/week but not daily</td>
</tr>
<tr>
<td><strong>Nighttime awakenings</strong></td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>1–2x/month</td>
</tr>
<tr>
<td></td>
<td>3–4x/month</td>
</tr>
<tr>
<td><strong>Risk</strong></td>
<td>≥2 exacerbations in 6 months requiring oral steroids, or ≥4 wheezing episodes/1 year lasting &gt;1 day AND risk factors for persistent asthma</td>
</tr>
</tbody>
</table>

- Level of severity is determined by both impairment and risk. Assess impairment domain by caregiver’s recall of previous 2–4 weeks. Assign severity to the most severe category in which any feature occurs.

- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma severity. For treatment purposes, patients who had ≥2 exacerbations requiring oral corticosteroids in the past 6 months, or ≥4 wheezing episodes in the past year, and who have risk factors for persistent asthma may be considered the same as patients who have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.

- Classifying severity in patients after asthma becomes well controlled, by lowest level of treatment required to maintain control.*

| Classification of Asthma Severity  
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(See figure 4–1a for treatment steps.)</td>
</tr>
<tr>
<td><strong>Intermittent</strong></td>
</tr>
<tr>
<td><strong>Mild</strong></td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
</tr>
<tr>
<td><strong>Severe</strong></td>
</tr>
<tr>
<td><strong>Step 1</strong></td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
</tr>
<tr>
<td><strong>Step 3 or 4</strong></td>
</tr>
<tr>
<td><strong>Step 5 or 6</strong></td>
</tr>
</tbody>
</table>

Key: EIB, exercise-induced bronchospasm

*Notes:
- For population-based evaluations, clinical research, or characterization of a patient’s overall asthma severity after control is achieved.
- For clinical management, the focus is on monitoring the level of control (See figure 3–5a.), not the level of severity, once treatment is established.
- See figure 3–5a for definition of asthma control.
### Classifying severity in children who are not currently taking long-term control medication.

#### Components of Severity

<table>
<thead>
<tr>
<th>Classification of Asthma Severity (Children 5–11 years of age)</th>
<th>Intermittent</th>
<th>Persistent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate</td>
<td>&lt;2 days/week</td>
<td>&gt;2 days/week but not daily</td>
</tr>
<tr>
<td>Severe</td>
<td>&gt;2 days/week but not daily</td>
<td>Daily</td>
</tr>
<tr>
<td>Impairment</td>
<td>3–4x/month</td>
<td>&gt;1x/week but not nightly</td>
</tr>
<tr>
<td>Interference with normal activity</td>
<td>None</td>
<td>Minor limitation</td>
</tr>
<tr>
<td>Lung function</td>
<td>Normal FEV₁ between exacerbations</td>
<td>FEV₁ &gt;80% predicted</td>
</tr>
<tr>
<td></td>
<td>FEV₁/FVC &lt;75%</td>
<td>FEV₁/FVC = 75–80% predicted</td>
</tr>
<tr>
<td></td>
<td>FEV₁/FVC &gt;85%</td>
<td>FEV₁/FVC &gt;80%</td>
</tr>
</tbody>
</table>

#### Risk

- Exacerbations requiring oral systemic corticosteroids
  - 0–1/year (see note)
  - ≥2 in 1 year (see note)

### Level of severity is determined by both impairment and risk. Assess impairment domain by patient’s/caregiver’s recall of the previous 2–4 weeks and spirometry. Assign severity to the most severe category in which any feature occurs.

### At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma severity. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate greater underlying disease severity. For treatment purposes, patients who had ≥2 exacerbations requiring oral systemic corticosteroids in the past year may be considered the same as patients who have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.

### Classifying severity in patients after asthma becomes well controlled, by lowest level of treatment required to maintain control.*

#### Classification of Asthma Severity

<table>
<thead>
<tr>
<th>Lowest level of treatment required to maintain control (See figure 4–1b for treatment steps.)</th>
<th>Intermittent</th>
<th>Persistent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mild</td>
<td>Moderate</td>
</tr>
<tr>
<td>Step 1</td>
<td>Step 2</td>
<td>Step 3 or 4</td>
</tr>
</tbody>
</table>

Key: EIB, exercise-induced bronchospasm; FEV₁, forced expiratory volume in second; FVC, forced vital capacity; ICU, intensive care unit

*Notes:
- For population-based evaluations, clinical research, or characterization of a patient’s overall asthma severity after control is achieved.
- For clinical management, the focus is on monitoring the level of control (See figure 3–5b.), not the level of severity, once treatment is established.
- See figure 3–5b for definition of asthma control.
Classifying severity for patients who are not currently taking long-term control medications.

### Components of Severity

**Classification of Asthma Severity (Youths ≥12 years of age and adults)**

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Intermittent</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤2 days/week</td>
<td>&gt;2 days/week but not daily</td>
<td>Daily</td>
<td>Throughout the day</td>
<td></td>
</tr>
<tr>
<td>≥2 exacerbations</td>
<td>≤2 days/week but not nightly</td>
<td>Daily</td>
<td>Several times per day</td>
<td></td>
</tr>
<tr>
<td>Nighttime awakenings</td>
<td>≥2x/month</td>
<td>3-4x/month</td>
<td>&gt;1x/week but not nightly</td>
<td>Often 7x/week</td>
</tr>
<tr>
<td>Short-acting beta-agonist use for symptom control (not prevention of EIB)</td>
<td>≤2 days/week</td>
<td>&gt;2 days/week but not &gt;1x/day</td>
<td>Daily</td>
<td>Several times per day</td>
</tr>
<tr>
<td>Interference with normal activity</td>
<td>None</td>
<td>Minor limitation</td>
<td>Some limitation</td>
<td>Extremely limited</td>
</tr>
</tbody>
</table>

**Lung function**

- Normal FEV₁ between exacerbations
- FEV₁ >80% predicted
- FEV₁/FVC normal
- FEV₁/FVC reduced 5%
- FEV₁/FVC reduced >5%
- FEV₁ <60% predicted

**Exacerbations requiring oral systemic corticosteroids**

- 0–1 year (see note)
- 2+year (see note)

**Risk**

- Consider severity and interval since last exacerbation. Frequency and severity may fluctuate over time for patients in any severity category.

### Level of severity

- Determined by assessment of both impairment and risk. Assess impairment domain by patient’s/caregiver’s recall of previous 2–4 weeks and spirometry. Assign severity to the most severe category in which any feature occurs.

- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma severity. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate greater underlying disease severity. For treatment purposes, patients who had ≥2 exacerbations requiring oral systemic corticosteroids in the past year may be considered the same as patients who have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.

### Classifying severity in patients after asthma becomes well controlled, by lowest level of treatment required to maintain control.*

**Classification of Asthma Severity**

<table>
<thead>
<tr>
<th>Lowest level of treatment required to maintain control (See figure 4–5 for treatment steps.)</th>
<th>Classification of Asthma Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>Mild, Moderate, Severe</td>
</tr>
<tr>
<td>Step 2</td>
<td>Step 3 or 4</td>
</tr>
<tr>
<td>Step 5 or 6</td>
<td>Step 5 or 6</td>
</tr>
</tbody>
</table>

Key: EIB, exercise-induced bronchospasm; FEV₁, forced expiratory volume in 1 second; FVC, forced vital capacity; ICU, intensive care unit

*Notes:

- For population-based evaluations, clinical research, or characterization of a patient’s overall asthma severity after control is achieved. For clinical management, the focus is on monitoring the level of control (See figure 3–5c.), not the level of severity, once treatment is established.

- See figure 3–5c for definition of asthma control.
**Figure 3–5a. Assessing Asthma Control in Children 0–4 Years of Age**

<table>
<thead>
<tr>
<th>Components of Control</th>
<th>Classification of Asthma Control (Children 0–4 years of age)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Well Controlled</td>
</tr>
<tr>
<td><strong>Impairment</strong></td>
<td></td>
</tr>
<tr>
<td>Symptoms</td>
<td>≤2 days/week</td>
</tr>
<tr>
<td>Nighttime awakenings</td>
<td>≤1x/month</td>
</tr>
<tr>
<td>Interference with</td>
<td>None</td>
</tr>
<tr>
<td>normal activity</td>
<td></td>
</tr>
<tr>
<td>Short-acting beta2-</td>
<td>≤2 days/week</td>
</tr>
<tr>
<td>agonist use for</td>
<td></td>
</tr>
<tr>
<td>symptom control</td>
<td></td>
</tr>
<tr>
<td>(not prevention of</td>
<td></td>
</tr>
<tr>
<td>EIB)</td>
<td></td>
</tr>
<tr>
<td><strong>Risk</strong></td>
<td></td>
</tr>
<tr>
<td>Exacerbations</td>
<td>0–1/year</td>
</tr>
<tr>
<td>requiring oral systemic corticosteroids</td>
<td></td>
</tr>
<tr>
<td>Treatment-related</td>
<td>Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.</td>
</tr>
<tr>
<td>adverse effects</td>
<td></td>
</tr>
</tbody>
</table>

Key: EIB, exercise-induced bronchospasm; ICU, intensive care unit

Notes:

- The level of control is based on the most severe impairment or risk category. Assess impairment domain by caregiver’s recall of previous 2–4 weeks. Symptom assessment for longer periods should reflect a global assessment, such as inquiring whether the patient’s asthma is better or worse since the last visit.

- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma control. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate poorer disease control. For treatment purposes, patients who had ≥2 exacerbations requiring oral systemic corticosteroids in the past year may be considered the same as patients who have not-well-controlled asthma, even in the absence of impairment levels consistent with persistent asthma.
**Figure 3–5b. Assessing Asthma Control in Children 5–11 Years of Age**

<table>
<thead>
<tr>
<th>Components of Control</th>
<th>Classification of Asthma Control (Children 5–11 years of age)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Well Controlled</td>
</tr>
<tr>
<td><strong>Impairment</strong></td>
<td></td>
</tr>
<tr>
<td>Symptoms</td>
<td>≤2 days/week but not more than once on each day</td>
</tr>
<tr>
<td>Nighttime awakenings</td>
<td>≤1x/month</td>
</tr>
<tr>
<td>Interference</td>
<td>None</td>
</tr>
<tr>
<td>with normal activity</td>
<td></td>
</tr>
<tr>
<td>Short-acting beta2-agonist use for symptom control (not prevention of EIB)</td>
<td>≤2 days/week</td>
</tr>
<tr>
<td>Lung function</td>
<td></td>
</tr>
<tr>
<td>▪ FEV&lt;sub&gt;1&lt;/sub&gt; or peak flow</td>
<td>&gt;80% predicted/ personal best</td>
</tr>
<tr>
<td>▪ FEV&lt;sub&gt;1&lt;/sub&gt;/FVC</td>
<td>&gt;80%</td>
</tr>
<tr>
<td><strong>Risk</strong></td>
<td></td>
</tr>
<tr>
<td>Exacerbations requiring oral systemic corticosteroids</td>
<td>0–1/year</td>
</tr>
<tr>
<td>Reduction in lung growth</td>
<td>Evaluation requires long-term followup.</td>
</tr>
<tr>
<td>Treatment-related adverse effects</td>
<td>Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.</td>
</tr>
</tbody>
</table>

Key: EIB, exercise-induced bronchospasm; FEV<sub>1</sub>, forced expiratory volume in 1 second; FVC, forced vital capacity; ICU, intensive care unit

Notes:

- The level of control is based on the most severe impairment or risk category. Assess impairment domain by patient’s/caregiver’s recall of previous 2–4 weeks and by spirometry/or peak flow measures. Symptom assessment for longer periods should reflect a global assessment, such as inquiring whether the patient’s asthma is better or worse since the last visit.

- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma control. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate poorer disease control. For treatment purposes, patients who had ≥2 exacerbations requiring oral systemic corticosteroids in the past year may be considered the same as patients who have not-well-controlled asthma, even in the absence of impairment levels consistent with not-well-controlled asthma.
### FIGURE 3–5c. ASSESSING ASTHMA CONTROL IN YOUTHS ≥12 YEARS OF AGE AND ADULTS

<table>
<thead>
<tr>
<th>Components of Control</th>
<th>Classification of Asthma Control (Youths ≥12 years of age and adults)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Well-Controlled</td>
</tr>
<tr>
<td>Symptoms</td>
<td>≤2 days/week</td>
</tr>
<tr>
<td>Nighttime awakening</td>
<td>≤2x/month</td>
</tr>
<tr>
<td>Interference with normal activity</td>
<td>None</td>
</tr>
<tr>
<td>Short-acting beta2-agonist use for symptom control (not prevention of EIB)</td>
<td>≤2 days/week</td>
</tr>
<tr>
<td>FEV1 or peak flow</td>
<td>&gt;80% predicted/ personal best</td>
</tr>
<tr>
<td>Validated Questionnaires</td>
<td><em><strong>ATAQ</strong></em>&lt;br&gt;<em><strong>ACQ</strong></em>&lt;br&gt;<em><strong>ACT</strong></em></td>
</tr>
<tr>
<td></td>
<td>0&lt;br&gt;≤0.75*&lt;br&gt;≥20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk</th>
<th>Exacerbations</th>
<th>≥2/year (see note)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Consider severity and interval since last exacerbation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Evaluation requires long-term followup care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Treatment-related adverse effects</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.</td>
<td></td>
</tr>
</tbody>
</table>

*ACQ values of 0.76–1.4 are indeterminate regarding well-controlled asthma.

Key: EIB, exercise-induced bronchospasm; FEV1, forced expiratory volume in 1 second. See figure 3–8 for full name and source of ATAQ, ACQ, ACT.

**Notes:**

- The level of control is based on the most severe impairment or risk category. Assess impairment domain by patient’s recall of previous 2–4 weeks and by spirometry/or peak flow measures. Symptom assessment for longer periods should reflect a global assessment, such as inquiring whether the patient’s asthma is better or worse since the last visit.

- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma control. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate poorer disease control. For treatment purposes, patients who had ≥2 exacerbations requiring oral systemic corticosteroids in the past year may be considered the same as patients who have not-well-controlled asthma, even in the absence of impairment levels consistent with not-well-controlled asthma.
Sample Action Plans
## Asthma Action Plan

The colors of the traffic light will help you use your asthma medicines.
- **Green** means Go Zone! Use preventive medicine.
- **Yellow** means Caution Zone! Add prescribed yellow zone medicine.
- **Red** means Danger Zone! Get help from a doctor.

### Personal Information
- **Name:** Katie Miller
- **Date of Birth:** 10 yrs
- **Effective Date:**
- **Doctor:**
  - **Parent/Guardian:**
- **Doctor's Office Phone Number:**
- **Parent's Phone:**
- **Emergency Contact After Parent:**
  - **Contact Phone:**

### Go (Green)
- You have all of these:
  - Breathing is good
  - No cough or wheeze
  - Sleep through the night
  - Can work and play

#### Personal Best Peak Flow

### Caution (Yellow)
- You have any of these:
  - First sign of cold
  - Exposure to known trigger
  - Cough
  - Mild wheeze
  - Tight chest
  - Coughing at night

#### Peak flow from ___ to ___

### Danger (Red)
- Your asthma is getting worse fast:
  - Medicine is not helping
  - Breathing is hard and fast
  - Nose opens wide
  - Ribs show
  - Lips blue
  - Fingernails blue
  - Trouble walking and talking

#### Peak flow from ___ to ___

### Use these medicines every day

<table>
<thead>
<tr>
<th>MEDICINE/DOSAGE</th>
<th>HOW MUCH TO TAKE</th>
<th>WHEN TO TAKE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Qvar 40</strong></td>
<td>2 Puffs</td>
<td><strong>Morning and Night</strong></td>
</tr>
</tbody>
</table>

**COMMENTS:** Don’t forget to use your spacer!

For asthma with exercise, take:
- **Albuterol** 2 Puffs 30 minutes before exercise

### Continue with green zone medicines and ADD:

<table>
<thead>
<tr>
<th>MEDICINE/DOSAGE</th>
<th>HOW MUCH TO TAKE</th>
<th>WHEN TO TAKE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Qvar 40</strong></td>
<td>2 Puffs</td>
<td><strong>Morning and Night</strong></td>
</tr>
<tr>
<td><strong>Albuterol</strong></td>
<td>2 Puffs</td>
<td>Every 4-6 hours as needed</td>
</tr>
</tbody>
</table>

**COMMENTS:**

IF QUICK RELIEVER/YELLOW ZONE MEDICINE IS NEEDED MORE THAN 2-3 TIMES A WEEK THEN CALL YOUR DOCTOR.

### Take these medicines and call your doctor

<table>
<thead>
<tr>
<th>MEDICINE/DOSAGE</th>
<th>HOW MUCH TO TAKE</th>
<th>WHEN TO TAKE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Orapect</strong></td>
<td>2 tsp</td>
<td><strong>Morning and Night</strong> for five days only</td>
</tr>
<tr>
<td><strong>Albuterol</strong></td>
<td>2 Puffs</td>
<td><strong>Every 3-4 hours</strong> as needed</td>
</tr>
</tbody>
</table>

**COMMENTS:** Use Orapect only if OK by office.

### Get help from a doctor now! It’s important!

Asthma is a potentially life threatening illness. If you cannot contact your doctor, go directly to the emergency room. **DO NOT WAIT.** Make an appointment with your primary care provider within two days of an ER visit or hospitalization.

---

This student is capable and has been instructed in the proper method of self-administering the medications named above (or attached prescription).

☐ This student is not approved to self-medicate.

Check asthma severity:

- □ Mild Intermittent
- □ Mild Persistent
- √ Moderate Persistent
- □ Severe Persistent

**PHYSICIAN SIGNATURE:**

**PHYSICIAN STAMP:**

---

**WHITE - School/Child Care Copy**

**Pink - Family Copy**

**Yellow - Doctor Copy**

---

Produced by the Iowa Department of Public Health
Adapted from the NYC Childhood Asthma Initiative
Adapted from NIH

Funding provided through a cooperative agreement with the Centers for Disease Control and Prevention

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Other Things That Can Make Asthma Worse

- If your child gets a cold, they may have more trouble breathing.
- Other infections, such as bronchitis, can make asthma worse.
- Cold or flu can trigger asthma attacks.
- Allergies, such as those caused by pollen or dust, can trigger asthma attacks.
- Stress and anxiety can also make asthma worse.

Smoke, Cigarettes and Other Smoke

- Smoking or being around smoke can make asthma worse.
- Secondhand smoke can trigger asthma attacks.
- Even if you don't smoke, other people's smoke can make your asthma worse.

Other Things That Can Make Your Asthma Worse

- Exposure to outdoor air pollution, such as pollution from factories or cars, can make asthma worse.
- Exposure to indoor air pollution, such as dust or mold, can make asthma worse.
- Exposure to certain chemicals, such as those found in some cleaning products, can make asthma worse.
- Exposure to temperature extremes, such as extreme heat or cold, can make asthma worse.

Other Things That Can Make Your Asthma Better

- Eating a healthy, balanced diet can help keep your asthma under control.
- Getting regular exercise, such as walking or swimming, can help improve your breathing.
- Taking medicines prescribed by your doctor, such as inhalers or oral steroids, can help control your asthma.
- Avoiding triggers, such as those listed above, can also help keep your asthma under control.

Other Things That Can Make Your Asthma Worse

- Exposure to outdoor air pollution, such as pollution from factories or cars, can make asthma worse.
- Exposure to indoor air pollution, such as dust or mold, can make asthma worse.
- Exposure to certain chemicals, such as those found in some cleaning products, can make asthma worse.
- Exposure to temperature extremes, such as extreme heat or cold, can make asthma worse.

Other Things That Can Make Your Asthma Better

- Eating a healthy, balanced diet can help keep your asthma under control.
- Getting regular exercise, such as walking or swimming, can help improve your breathing.
- Taking medicines prescribed by your doctor, such as inhalers or oral steroids, can help control your asthma.
- Avoiding triggers, such as those listed above, can also help keep your asthma under control.
<table>
<thead>
<tr>
<th>CLINICAL CONDITION</th>
<th>Baseline Plan &amp; When asthma is under control</th>
<th>At the FIRST sign of a cold or mild asthma attack</th>
<th>For rapidly worsening asthma (severe attack)</th>
<th>When there is no cough or wheeze for 3 months</th>
<th>For cough or wheeze with exercise</th>
</tr>
</thead>
<tbody>
<tr>
<td>SYMPTOMS</td>
<td>• Breathing is good with no daily or nighttime symptoms</td>
<td>• Breathing problems and symptoms present or waking up from sleep</td>
<td>• Breathing is hard and fast</td>
<td>• Breathing is good with no daily or nighttime symptoms</td>
<td>2 puffs 5-10 minutes before exercise</td>
</tr>
<tr>
<td></td>
<td>• Able to do usual activities</td>
<td>• Can do some but not all usual activities</td>
<td>• Rescue medicines have not helped</td>
<td>• Cannot do usual activities</td>
<td></td>
</tr>
<tr>
<td>PEAK FLOW (LPM)</td>
<td>200-230</td>
<td>180-200</td>
<td>&lt;180</td>
<td>200-230</td>
<td></td>
</tr>
<tr>
<td>MEDICATION</td>
<td>Reliever: Albuterol</td>
<td>2 puffs every 4 hr</td>
<td>2-6 puffs every 20 minutes for 3 doses then 2-4 puffs every 4 hr</td>
<td>2 puffs as needed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 puffs as needed</td>
<td>2 puffs every 4 hr</td>
<td>2-6 puffs every 20 minutes for 3 doses then 2-4 puffs every 4 hr</td>
<td>2 puffs as needed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Controller: 1) Beclomethasone (ICS), 40 mcg</td>
<td>1-2 puffs 2x/day</td>
<td>1-2 puffs 2x/day</td>
<td>0-1 puffs 2x/day</td>
<td></td>
</tr>
<tr>
<td>Corticosteroid Tablet or Syrup</td>
<td>0</td>
<td>0</td>
<td>Begin with 1-2 mg/kg/day NOTIFY MD</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

* If patients develops symptoms when corticosteroid discontinued, either resume corticosteroids or try leukotriene modifier
Communication Strategies

**Nonverbal attentiveness**  
Sit at the same level as patient and family. Avoid having a barrier, such as a desk between you. Make eye contact when listening and speaking. Lean forward slightly.

**Eliciting underlying fears**  
Ask open-ended questions such as:  
- "What is your greatest worry about asthma?"  
- "What concerns do you have about the medicine?"  
- "What things would you like to do that your asthma makes it hard to do?"

**Addressing immediate concerns**  
Patient or family concerns should be addressed right away, even if a complete answer isn't possible at the time. The purpose is to reassure the family by being responsive to the issues that matter to them.

**Reassuring messages**  
Unrealistic fears (of medicines or possible fatality) can block compliance. By conveying accurate information about risks and stressing that following your recommendations will increase the child's safety, the family will be reassured and more likely to follow your advice.

**Interactive conversation**  
Ask open-ended questions that can't be answered "yes" or "no" to encourage the family to convey information about beliefs, concerns, and how they manage asthma at home. Use simple, clear language and avoid medical jargon. Use analogies to ensure that the family grasps new ideas.

**Tailoring the regimen**  
Assess the family's daily routine to learn the best times and places for giving medicines during the day. Reach agreement on a daily plan for taking the medicine, making sure they are willing and able to follow it.

**Planning for decision-making**  
Help the family plan for decision-making by encouraging them to keep a diary and/or develop strategies for handling potential problems or choices that may occur, such as emergencies at school or participation in sports at school or summer camp. Reviewing the written treatment plan with the family helps them know how to decide when medicines should be adjusted to control symptoms, and when the child needs immediate medical attention.

**Setting short-term goals for treatment**  
Should be decided with the family, and tied to the patient's own goals to increase motivation to follow the treatment plan. Provides a benchmark for the family to judge progress.

**Setting goals with the long-term treatment plan**  
Having a long-term treatment plan helps the family know what to expect and what they may be able to achieve through preventive care.

**Nonverbal encouragement and verbal praise**  
Reinforce positive steps the family has taken to control asthma. Use these strategies to increase their confidence that they can manage asthma successfully following your plan.
Key Asthma Messages for the Patient and Family

1. What happens in an asthma attack
In an asthma attack you have trouble breathing because:
   - The airway lining swells and produces too much mucus (inflammation)
   - The muscles around the airways squeeze them partly shut (bronchospasm)

2. How medicines work
Anti-inflammatories don't give an immediate feeling of relief, but are crucial to reducing inflammation and preventing its return. Bronchodilators relax the muscles that have tightened around the airways.

Call me if either of the following happen, because it means the medicines need to be adjusted:
   - If bronchodilators are needed more than 4 times a day, we need to increase the amount of anti-inflammatory medicine.
   - If there is jitteriness or anxiety, we will need to reduce the amount of bronchodilator.

3. Responding to changes in asthma severity

   GiP Message: All people who have asthma should receive a written asthma action plan to guide their self-management efforts.

   When symptoms change, use the long term plan to adjust the medicines.

   If symptoms worsen rapidly, follow the emergency plan I've given you.

   Come immediately for treatment to my office or the hospital if any of the following happens:
   - No improvement after following the emergency plan
   - So breathless you can't talk or walk
   - Blue fingernails or lips

4. How to take medicines
Demonstrate for me how to use the metered dose inhaler and spacer.

Show me how to use the peak flow meter.

Use the step by step instructions at home.

5. Safety of medicines
The medicines I've prescribed are safe when used in the doses I've recommended.

   Low doses of inhaled corticosteroids are safe and do not cause serious side effects.

   Corticosteroids are not the same as the muscle-building steroids some athletes use.

6. Goals of therapy
Your child should be symptom free.
This control should be achieved with as little medicine as possible. The long-term plan can get us to the point of decreasing or stopping the medicines.

Some people with asthma have been sports champions and Olympic gold medalists.

### 7. Criteria of successful treatment

Your child should sleep through the night, have no wheeze or cough even during exercise or colds, and be fully active.

If you continue to have symptoms, call me and we'll fine tune the plan.

If your child has asthma symptoms more than once every two months, daily medicines will be needed until there are no symptoms for 3 or 4 months even during exercise or colds.

### 8. Managing asthma at school

Key school personnel need to be informed about the child's asthma.

Important points to inform the school about are:
- How to minimize exposure to triggers
- When to use medicine at school
- Encouraging participation in physical activities
- What to do in an emergency

Only keep your child home if the wheezing is bad or she has a fever or sore throat.

### 9. Identifying and avoiding triggers

GIP Message: Clinicians should review each patient’s exposure to allergens and irritants and provide a multipronged strategy to reduce exposure to those allergens and irritants to which a patient is sensitive and exposed.

Sometimes triggers to symptoms can be identified, so see if you can discover what yours are.

Triggers may include respiratory infections, allergens (dust, roach, and animal dander), irritants (smoke), and exercise.

Use bronchodilator and cromolyn preventively when you may be exposed to a trigger.

### 10. Referral to further education and review of goals

Take part in a comprehensive asthma self-management program. Remember our goal for your child is to be symptom free and fully active.

**REFERENCES**


### Review of Concepts - Management & Treatment

<table>
<thead>
<tr>
<th>Message</th>
<th>What the Message Addresses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airway lining swells and mucous forms</td>
<td>Asthma diagnosis (bad news)</td>
</tr>
<tr>
<td>Muscles tighten around airways</td>
<td></td>
</tr>
<tr>
<td>Anti-inflammatories reduce inflammation</td>
<td>Benefits of medicine (good news)</td>
</tr>
<tr>
<td>Quick-relief medicines (short-acting $\beta_2$-agonists) relax muscles</td>
<td></td>
</tr>
<tr>
<td>Quick-relief medicine not to be used more than two days a week</td>
<td>Side effects can be limited</td>
</tr>
<tr>
<td>Watch for jitteriness and anxiety</td>
<td></td>
</tr>
<tr>
<td>Follow the written asthma action plan</td>
<td>Shows that medicines are adjusted according to the level of control a patient can achieve Shows the benefits of using medicines can outweigh costs</td>
</tr>
<tr>
<td>Demonstrate use of asthma medicines and devices</td>
<td>Builds self confidence and level of skills</td>
</tr>
<tr>
<td>Use instructions in written asthma action plan</td>
<td></td>
</tr>
<tr>
<td>Need daily anti-inflammatories</td>
<td>Reducing susceptibility to asthma episodes</td>
</tr>
<tr>
<td>Long-term goal to control asthma with as little medicine as necessary</td>
<td>Shows how benefits of following regimen over time outweigh costs</td>
</tr>
<tr>
<td>Medicines safe when used as instructed</td>
<td>Builds confidence in the regimen</td>
</tr>
<tr>
<td>Inhaled corticosteroids safe in low doses</td>
<td>Reduces fear associated with use of medicine</td>
</tr>
<tr>
<td>Corticosteroids differ from anabolic</td>
<td></td>
</tr>
<tr>
<td>Expect to exercise without symptoms</td>
<td>Shows benefits of therapy</td>
</tr>
<tr>
<td>Expect to sleep through the night</td>
<td></td>
</tr>
<tr>
<td>Plan can be fine-tuned if problems arise</td>
<td>Shows that ongoing partnership with clinician is needed</td>
</tr>
<tr>
<td>Activity/Condition</td>
<td>Benefit</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Be physically active</td>
<td>Shows benefits of therapy</td>
</tr>
<tr>
<td>Sports champs have asthma in control</td>
<td>Builds self-confidence</td>
</tr>
<tr>
<td>School personnel need to be informed about triggers, medications, physical</td>
<td>Need for support in the social</td>
</tr>
<tr>
<td>exercise, emergencies</td>
<td>environment</td>
</tr>
<tr>
<td>Triggers can be identified</td>
<td>Increases feelings of control</td>
</tr>
<tr>
<td></td>
<td>Reduces susceptibility to episodes</td>
</tr>
<tr>
<td>Use medicines preventively when your child may be exposed to triggers</td>
<td>Shows benefits of therapy</td>
</tr>
<tr>
<td></td>
<td>Increases feeling of control</td>
</tr>
<tr>
<td>The goal is to be symptom-free</td>
<td>Shows benefits of staying with therapy</td>
</tr>
<tr>
<td>Take part in additional asthma education</td>
<td>Builds self-confidence</td>
</tr>
</tbody>
</table>
Physician’s Record: Categories of Asthma Messages Provided

Patient’s Name: ____________________________________________

Check if topic covered.

VISIT ONE
- □ What happens to the airways in an asthma attack?
- □ How medicines work (rescue/control)?
- □ Responding at home to changes in asthma severity (long-term plan and emergency plan)
- □ How to take medicines (child/parent demonstrate)

VISIT TWO
- □ Safety of medicines when used as directed
- □ Goals of therapy (no symptoms with as little medicine as necessary)
- □ Criteria of successful treatment (sleep through the night, no asthma symptoms even with exercise or colds)

VISIT THREE
- □ Managing asthma at school
- □ Identifying triggers
- □ Referral to additional asthma education
- □ Review of goals of therapy
Physician’s Self-Rating Scale on Interactions with the Family

Patient’s Name: __________________________              Date:___________________

**PHYSICIAN GOALS FOR THE INTERACTION:**

- Have parent and child specify his/her concerns and get questions onto the table.
- Reach agreement on being partners.
- Ensure that in achieving a short-term treatment goal, parents see the necessity of a long-term treatment plan.
- Agree on the steps of self-management at home.

*Rate your behavior in the interaction with the family: 1=low rating, 5=high rating*

**WERE YOU ABLE TO:**

<p>| | | | | | |</p>
<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Use appropriate non-verbal attentiveness (e.g. eye contact, closing social distance, etc.)?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Elicit the parents’ and child’s underlying concern about the child’s asthma?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. Construct reassuring messages regarding the parents’ and child’s fears?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Address immediately the concerns the family expressed?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Engage the family in interactive conversation (e.g. used open-ended questions, simple language, analogies, etc.)?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Tailor the regimen by eliciting and addressing potential problems in the timing, dosage, or side effects of the medicines recommended?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Use appropriate non-verbal encouragement and verbal praise when the family reported using correct management strategies?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Elicit the family’s immediate objective related to asthma control and agree on a short-term goal?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. Review the long-term plan?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. Help the family plan for decision-making by encouraging them to keep a diary and/or develop strategies for handling potential problems (e.g. emergencies, participation at school, sports)?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Documentation and Coding
Q. What is the proper way to code when a child comes in for a preventive medicine visit with a problem-oriented visit?
A. You can report a new patient preventive medicine visit and a new patient problem-oriented visit when performed at the same encounter. Make sure that the required key components for a new patient office/outpatient encounter (3 of 3 or time) are met and documented! Do not report a separate problem-oriented evaluation and management (E/M) service with modifier 25 when a problem encountered during a preventive medicine visit is insignificant (e.g., minor diaper rash, stable chronic problem, renewal of prescription medications) or does not require additional work to perform the required key components.

Q. I often hear about the “bell curve” in relation to E/M codes. How do we know if our physicians are under-coding or over-coding their services?
A. Pediatricians frequently under-code their services. This means that their revenue is less than it should be. When general pediatricians analyze how many times they bill 99211, 99212, 99213, 99214, and 99215 in a given year, they should have a bell curve distribution. Pediatricians should be reporting 99213 more than any other code. Specifically, pediatricians should be reporting 99211 5% of the time, 99212 20% of the time, 99213 50% of the time, 99214 20% of the time, and 99215 5% of the time. Not all physicians will follow this bell curve exactly. There are certainly many practices (especially subspecialists) that will have curves skewed either up or down the bell shape depending on their scope of practice. Some pediatricians may see a larger number of children with special needs, justifying a shift in the curve (more 99214 and fewer 99213). This must be supported with ELM documentation and diagnoses to justify higher-level coding.

Q. Can I use time as the key factor in determining the appropriate level of service for all E/M codes (99201–99499)?
A. Time can be used as the key factor in the following CPT codes that include a “typical time” right in the code descriptor: 99201–99215, 99221–99233, 99241–99255, 99341–99350. These codes are considered “time-based” E/M codes and, therefore, time can be used as the key factor for each of them. Time becomes a key factor when counseling and/or coordination of care account for more than 50% of the face-to-face time with the patient. When this situation occurs, it is necessary to enter the total duration of counseling and/or coordination of care into the clinical notes, as well as a description of the care that took place. Level of service is determined by comparing the total time of the visit with the typical time listed in the descriptor (that is, you’d have to have a 25-minute visit where counseling and/or coordination of care is at least 13 minutes to code a 99214. Unless counseling and coordination of care dominate the visit, the history, physical examination, and medical decision making remain the key factors in selecting a code. Face-to-face time is defined as the amount of time the physician spends in the room with the patient. It does not include the nurse time. In hospital encounters, the time listed as floor time is defined as the amount of time the physician spends not only at the patient’s bedside, but also on the unit (communicating with nurses and family members, writing notes, reviewing laboratory tests, and so on).
Q. When can primary care physicians use consultation codes 99241–99245?
A. A consultation is a type of service provided by a physician whose opinion or advice regarding the evaluation or management of a specific problem is requested by another physician or other appropriate source. A consultant may initiate diagnostic and therapeutic services at the same or subsequent visits. The request for the consultation may be made in writing or verbally as long as the request is documented in the record. However, the report to the referral source must be written. The request for the consultation may come from the physician or other appropriate source; therefore, a school psychologist, teacher, or institution such as the health department could be the referral source. Within a group practice, a physician with special expertise (e.g., dermatology), can be consulted and bill as a consultation as long as it is understood that a written report will be transmitted to the referring physician and that the patient will be returned to the referring physician for ongoing care (that is, the patient is not merely switching providers within a practice). Note, as of January 1, 2010, Medicare and Medicaid and some commercial payers no longer accept consultation codes. 1

Q. Should a consultation code be used if the school requests that a child be seen by the pediatrician?
A. Yes, it would be appropriate to use a consultation code if specific criteria are met. A consultation is a type of service provided by a physician at the request of another physician or “other appropriate source” (including schools, juvenile courts, nurse practitioners). In this example, if the school requested the consultation, you should use the office consultation codes (99241–99245). It is important that the referral source be clearly documented and that a report be transmitted back to the referral source. Normally, a note from the teacher, sent home with a child, to alert a parent to an acute medical concern, would not be treated as a consultation. 1

Q. We occasionally have parents who come in to discuss their child's problem with the pediatrician without the patient being present. Can we code for this?
A. Pediatricians spend a great deal of time dealing with families who have children with health risk issues such as obesity, developmental concerns, and children with special health care needs. Many times the parent will come in to discuss these issues without the child being present during the visit. It is appropriate for the pediatrician to report this service. Typically, the history, examination, and medical decision making are the key factors in determining the level of E/M service you choose. However, when counseling and/or coordination of care account for more than 50% of the face-to-face time with the patient and/or family, time becomes the key factor in determining which level of E/M service you choose. In this case, all of the time is spent in counseling with the family. It is important that you document your service and the time spent with the parent. Time indicators are as follows: 99211 (5 minutes), 99212 (10 minutes), 99213 (15 minutes), 99214 (25 minutes), and 99215 (40 minutes). CPT clearly states that the time the physician spends can be with the patient and/or family (including legal guardians, foster parents). Check with payers as their rules regarding patient presence may differ. 1

Q. Is there a CPT code for asthma education?
A. There is not a specific code for asthma education. If the physician provides the counseling, education, or training to an individual, report the appropriate E/M service code. If a physician provides counseling and education in a group setting, report code 99078. These services can be reported the same day as a physician E/M service if it is significant and separately identifiable.
Apply modifier 25 to the E/M visit. When reporting an E/M service based on time, medical record documentation must reflect the total face-to-face time spent, the total time spent in counseling/coordination of care, and a summary of the issues discussed.\(^2\)

**Q.** Parents often bring in forms for the physician to fill out. This is very time consuming, and I was wondering if I could charge for this service.

**A.** Yes, it is appropriate to report this service. The CPT code 99080 is for special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form. As stated in the code descriptor, this code is used for things such as insurance forms (for life insurance or new health insurance). The most common forms physicians have to fill out are sports and camp forms. You can try reporting 99080, but chances are you will not get reimbursed for this. If the carrier says it is not a covered service, this allows you to be able to charge the patient if the patient filled out a waiver agreeing to pay for this non-covered service. However, most physicians consider sports and camp forms “usual medical communications or standard reporting forms.”\(^1\)

**Q.** I noticed the 2008 CPT book published codes for telephone care provided by a "qualified nonphysician health care professional." Our practice uses registered nurses to answer our office and after-hours patient telephone calls. Can we report these codes to charge for our nurse telephone triage? Specifically, can we report the codes when one of our registered nurses returns an advice call about a 4-year-old with fever and cough?\(^1\)

**A.** In 2008, new CPT codes (98966, 98967, 98968) were published that allow for the billing of clinical telephone calls managed by "qualified nonphysician health care professionals." Whether nurses are considered "qualified nonphysician health care professionals" is the issue at hand.

If a nurse performs duties within the scope of his or her state’s nurse practice act by performing a patient assessment over the phone, and then follows pre-approved standing orders (approved telephone triage guidelines), then it has been determined that the nurse meets the criteria of a "qualified nonphysician health care professional."

Most state nurse practice acts do not allow registered nurses (RNs) to develop a care plan after performing an assessment. However, RNs are allowed to implement plans created or ordered by a physician. Therefore, as long as the RN follows physician-approved telephone triage guidelines while developing a plan (advice) for the caller, then he/she meets the criteria of a "qualified nonphysician health care professional."

Note the importance of proper documentation that the RN performs an assessment and utilizes an approved telephone triage guideline during the telephone call. The nurse’s calls should be archived and undergo physician review and quality assurance.

The table in this manual shows the proper codes, qualifications, rules and descriptors to be used with RN telephone calls. The call must not pertain to an office visit in the preceding seven days involving the same or similar problem, nor lead to an office visit within the next 24 hours or next available appointment. These types of calls are considered part of the "global period" related to an office visit. Payment for telephone services within this global period are bundled into the office visit payment.\(^1\)
Q. Can CPT codes 98966–98968 be used when one of our medical assistant staff returns an advice call about a child with an asthma exacerbation?

A. A medical assistant, as well as any other nonclinical staff, does not meet the criteria of a "qualified nonphysician health care professional." Therefore, a fee cannot be submitted for triage and advice calls performed by these individuals.¹

Q. When to use Level II codes:¹

A. Most pediatricians and pediatric coders are familiar with the many Current Procedural Terminology Level I modifiers, such as modifier 25 or modifier 59. However, pediatric practices may not be as familiar with Level II (HCPCS/National) modifiers because they may consider them Medicare modifiers and may not see the benefit of their use.

It is important to recognize that Level II modifiers are not limited to Medicare patients. In fact, many state Medicaid plans and private payers require the use of Level II modifiers. Pediatricians should be aware of some Level II modifiers that may be required by the insurance carriers they bill, including Medicaid.

Many are aware of modifier QW, which is used to indicate that a Clinical Laboratory Improvement Amendments (CLIA) waived test was performed in a CLIA waived facility. Some of the less familiar Level II modifiers that may be of importance to pediatric offices are as follows:

- GD – Units of service exceed medically unlikely edit value and represents reasonable and necessary services
- HS – Family/couple without client present
- Q5 – Service furnished by a substitute physician under a reciprocal billing arrangement
- SC – Medically necessary service or supply
- SK* – Member of a high-risk population
- SL – State-supplied vaccine
- SY* – Persons who are in close contact with member of a high-risk population
- TL – Early intervention/individual family service plan
- TM – Individualized education program (IEP)
- TR – School-based IEP services provided outside the public school district responsible for the student
- TU – Special payment rate, overtime
- TV – Special payment rate, holiday/weekends
- UH – Services provided in the evening
- UJ – Services provided at night
* Use only with immunization codes

Q. Modifier 25 vs. modifier 59: which to choose?

A. There has been much confusion over the difference between and use of modifiers 25 and 59. There was so much uncertainty, in fact, that in 2008, the description for modifier 59 was edited in the Current Procedural Terminology (CPT) manual to clarify the distinction between the two.

It is important to understand the use of these modifiers since they probably are the top two
modifiers you will use in your practice when billing for multiple services on the same date. The modifiers are described as follows:

**Modifier 25** is used to indicate a significant and separately identifiable evaluation and management (E/M) service by the same physician on the same day another procedure or service was performed. It may be necessary to indicate to a payer that on the day a procedure or service was performed, the patient’s condition required a significant and separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. Modifier 25 may be appended only to a code found in the E/M section of the CPT manual.

**Modifier 59** is used to indicate a distinct procedural service. Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is the modifier of last resort, meaning it should be used only when no other established modifiers are more appropriate. You should never append modifier 59 to a code found in the E/M section of the CPT manual.¹

Q. A 3-year-old patient presents to the office for a sick visit. The pediatrician performs a full E/M service (99214) and determines that a nebulizer treatment (94640) is needed. She also decides to order a nebulizer machine for the patient’s home. She asks her nurse to demonstrate to the mom how to use, clean and operate the nebulizer machine (94664). How should the pediatrician report all services in order to be paid?

A. The physician would report 99214–25** (Office or other outpatient E/M visit – Level 4), 94640 (Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes) and 94664–59 (Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered-dose inhaler or IPPB device).

Since the physician is reporting two non-E/M services (94640 and 94664) and she is trying to relay to the payer that they are two distinct procedural services, the 59 modifier would be used. You should always place the 59 modifier on the "lesser" of the two procedures or the one that would be considered inclusive of the other procedure. In some cases, the 25 modifier will be required on the E/M service (see above). Since the physician is indicating that an E/M service was significant and separate from a procedure or procedure(s) (94640 and 94664), the 25 modifier could be reported on the E/M service (99214).¹

Sources:
How to Use Modifiers Effectively

Attach these modifiers to CPT codes when two or more services are provided for the same patient on the same date by the same provider.

25- Attach to an E/M code when reporting other services provided on the same day (e.g., E/M service plus spirometry).

76- Attach to procedure codes when the same service is performed multiple times on the same date (e.g., multiple nebulizer treatments).

59- Attach to procedures that should be billed separately from the office visit and other procedures (e.g., nebulizer treatment and nebulizer teaching same day).

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CPT Codes for Other Asthma Services

Pulse Oximetry (94760)

Spirometry (94010)

Nebulizer Treatment (94640)

Teaching: Nebulizer, Metered-Dose Inhaler, etc. (94664)

Flu Vaccine (90655 through 90668)

Prolonged Physician Services (99354, 99355)

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Coding Based on Complexity

New vs. Established Patients

**New patients**
For a new patient, all 3 components (history, examination, and medical decision making) must be documented at the selected level. A *new* patient is one who has received no face-to-face services by the physicians of a like specialty in the same group for the past three years.

**Established patients**
For an *established* patient, only 2 of the 3 components must be at the selected level.
# CPT Codes for New Patients’ Office Visits

<table>
<thead>
<tr>
<th>Code:</th>
<th>Level 1 99201</th>
<th>Level 2 99202</th>
<th>Level 3 99203</th>
<th>Level 4 99204</th>
<th>Level 5 99205</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>History:</strong></td>
<td>Problem focused</td>
<td>Expanded problem focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
</tr>
<tr>
<td><strong>Exam:</strong></td>
<td>Problem focused</td>
<td>Expanded problem focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
</tr>
<tr>
<td><strong>Medical Decision Making:</strong></td>
<td>Straight forward</td>
<td>Straight forward</td>
<td>Low complexity</td>
<td>Moderate Complexity</td>
<td>High complexity</td>
</tr>
<tr>
<td><strong>Time:</strong></td>
<td>10 minutes</td>
<td>20 minutes</td>
<td>30 minutes</td>
<td>45 minutes</td>
<td>60 minutes</td>
</tr>
</tbody>
</table>

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# CPT Codes for Established Patients’ Office Visits

<table>
<thead>
<tr>
<th>Code</th>
<th>Level 1 99211</th>
<th>Level 2 99212</th>
<th>Level 3 99213</th>
<th>Level 4 99214</th>
<th>Level 5 99215</th>
</tr>
</thead>
<tbody>
<tr>
<td>History:</td>
<td>Not required</td>
<td>Problem focused</td>
<td>Expanded problem focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Exam:</td>
<td>Not required</td>
<td>Problem focused</td>
<td>Expanded problem focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Medical Decision Making:</td>
<td>Not required</td>
<td>Straight forward</td>
<td>Low complexity</td>
<td>Moderate Complexity</td>
<td>High complexity</td>
</tr>
<tr>
<td>Time:</td>
<td>5 minutes</td>
<td>10 minutes</td>
<td>15 minutes</td>
<td>25 minutes</td>
<td>40 minutes</td>
</tr>
</tbody>
</table>

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Example – Level 4 (99214) Established Patient Office Visit Based on Complexity

History-Detailed
  – HPI with 4 or more elements
  – ROS of 2 to 9 systems
  – Either family, social or past medical history

Exam-Detailed
  – 5 to 7 areas

Medical Decision Making
  – Moderate complexity

**Note that the types of components required to meet the different levels of complexity for a new patient are different from those for an established patient. For example, a level 4 new patient requires a comprehensive history whereas a level 4 established patient only requires a detailed history.

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Documentation, Coding, and Reimbursement Tools

AAP Coding Hotline for Questions- aapcodinghotline@aap.org

AAP News - Coding Corner (monthly)
http://aapnews.aappublications.org/cgi/collection/coding_corner

Coding for Pediatrics, 2011 (AAP)

AAP Pediatric Coding Newsletter Online
http://coding.aap.org/

AAP Section on Administration and Practice Management (SOAPM)
http://www.aap.org/sections/soapm/soapm_home.cfm
Priority Messages and Patient Education
## Summary of Guidelines Implementation Panel (GIP) Priority Messages and the Underlying EPR-3 Recommendations

<table>
<thead>
<tr>
<th>Message: Inhaled Corticosteroids</th>
<th>Message: Asthma Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inhaled corticosteroids are the most effective medications for long-term management of persistent asthma, and should be utilized by patients and clinicians as is recommended in the guidelines for control of asthma.</td>
<td>At planned follow-up visits, asthma patients should review level of control with their health care provider based on multiple measures of current impairment and future risk in order to guide clinician decisions to either maintain or adjust therapy.</td>
</tr>
</tbody>
</table>

**EPR-3 Recommendation:** The Expert Panel recommends that long-term control medications be taken on a long-term basis to achieve and maintain control of persistent asthma, and that inhaled corticosteroids (ICSs) are the most potent and consistently effective long-term control medication for asthma. (Evidence A).

<table>
<thead>
<tr>
<th>Message: Asthma Action Plan</th>
<th>Message: Follow-up Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>All people who have asthma should receive a written asthma action plan to guide their self-management efforts.</td>
<td>Patients who have asthma should be scheduled for planned follow-up visits at periodic intervals in order to assess their asthma control and modify treatment if needed.</td>
</tr>
</tbody>
</table>

**EPR-3 Recommendation:** The Expert Panel recommends that all patients who have asthma be provided a written asthma action plan that includes instructions for: (1) daily treatment (including medications and environmental controls), and (2) how to recognize and handle worsening asthma (Evidence B).

<table>
<thead>
<tr>
<th>Message: Asthma Severity</th>
<th>Message: Allergen and Irritant Exposure Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients should have an initial severity assessment based on measures of current impairment and future risk in order to determine type and level of initial therapy needed.</td>
<td>Clinicians should review each patient’s exposure to allergens and irritants and provide a multipronged strategy to reduce exposure to those allergens and irritants to which a patient is sensitive and exposed, i.e., that make the patient’s asthma worse.</td>
</tr>
</tbody>
</table>

**EPR-3 Recommendation:** The Expert Panel recommends that once a diagnosis of asthma is made, clinicians classify asthma severity using the domains of current impairment (Evidence B) and future risk (Evidence C, and D) for guiding decisions in selecting initial therapy. "Note: While there is not strong evidence from clinical trials for determining therapy based on the domain of future risk, the Expert Panel considers that this is an important domain for clinicians to consider due to the strong association between history of exacerbations and the risk for future exacerbations."

**EPR-3 Recommendation:** The Expert Panel recommends that patients who have asthma at any level of severity be queried about exposure to inhalant allergens, particularly indoor inhalant allergens (Evidence A), tobacco smoke and other irritants (Evidence C), and be advised as to their potential effect on the patient’s asthma. The Expert Panel recommends that allergen avoidance requires a multifaceted, comprehensive approach that focuses on the allergens and irritants to which the patient is sensitive and exposed – individual steps alone are generally ineffective (Evidence A).
6 Steps to Asthma Control

Work with your child’s doctor to help your child breathe easier

1. Describe your child’s asthma to the doctor
Tell your doctor about your child’s asthma and how it affects his or her life. Be sure to tell your doctor if allergens and irritants in your home or outdoors make your child’s asthma worse. Tell your doctor about all symptoms so it can be determined how severe your child’s asthma is and if it is in control. Your child’s doctor will listen carefully to you and ask about your child’s day-to-day management of asthma at home and at school.

2. Listen to and discuss the doctor’s recommendations
Inhaled corticosteroids are “controller” medicines. They are the most helpful medicines for taking care of persistent asthma or asthma that affects your child every day. Work with your doctor to determine which medicines, including “controller” medicines, are right for your child.

3. Create an asthma action plan
Work with your child’s doctor to create an asthma action plan (also called a treatment plan). The asthma action plan will lay out the treatment recommendations and tell you how to take care of your child’s asthma on a day-to-day basis. Your child’s doctor will write down an asthma action plan for you.

4. Follow the doctor’s recommendations at home and at school
The asthma action plan will help you see if your child’s asthma gets worse and will tell you what to do to take care of your child’s asthma. Your child’s doctor will provide you with information so that you can make decisions at home. The doctor will teach you and your child about asthma and discuss the short-term goals of your therapy.

5. Inform your child’s doctor about how the treatment plan is working
Be sure to schedule follow-up appointments with your child’s doctor at regular times. Talk to your child’s doctor about how your child is doing now and how to do better in the future. Discuss any problems your child has with taking his or her medicines and how asthma affects daily activities. Your child’s doctor will update the asthma action plan as needed.

6. Revise your asthma management practices as needed and continue to communicate with your child’s doctor
Talk with your child’s doctor when problems occur so that the asthma action plan can be revised as needed.


Master Trainers
PACE Master Trainers

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