

== P hysician

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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

FIGURE 3–4a. 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 (Children 0–4 years of age)			
		Intermittent	Persistent		
			Mild	Moderate	Severe
Impairment	Symptoms	≤2 days/week	>2 days/week but not daily	Daily	Throughout the day
	Nighttime awakenings	0	1–2x/month	3–4x/month	>1x/week
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week but not daily	Daily	Several times per day
	Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited
Risk	Exacerbations requiring oral systemic corticosteroids	0–1/year	≥2 exacerbations in 6 months requiring oral steroids, or ≥4 wheezing episodes/1 year lasting >1 day AND risk factors for persistent asthma		
		← Consider severity and interval since last exacerbation. Frequency and severity may fluctuate over time. →			
		Exacerbations of any severity may occur in patients in any severity category			

- 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.***

Lowest level of treatment required to maintain control (See figure 4–1a for treatment steps.)	Classification of Asthma Severity			
	Intermittent	Persistent		
	Step 1	Mild	Moderate	Severe
		Step 2	Step 3 or 4	Step 5 or 6

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.

FIGURE 3–4b. CLASSIFYING ASTHMA SEVERITY IN CHILDREN 5–11 YEARS OF AGE

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

Components of Severity		Classification of Asthma Severity (Children 5–11 years of age)			
		Intermittent	Persistent		
			Mild	Moderate	Severe
Impairment	Symptoms	≤2 days/week	>2 days/week but not daily	Daily	Throughout the day
	Nighttime awakenings	≤2x/month	3–4x/month	>1x/week but not nightly	Often 7x/week
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week but not daily	Daily	Several times per day
	Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited
	Lung function	<ul style="list-style-type: none"> • Normal FEV₁ between exacerbations • FEV₁ >80% predicted • FEV₁/FVC >85% 	<ul style="list-style-type: none"> • FEV₁ = >80% predicted • FEV₁/FVC >80% 	<ul style="list-style-type: none"> • FEV₁ = 60–80% predicted • FEV₁/FVC = 75–80% 	<ul style="list-style-type: none"> • FEV₁ <60% predicted • FEV₁/FVC <75%
Risk	Exacerbations requiring oral systemic corticosteroids	0–1/year (see note)	≥2 in 1 year (see note) →		
		← Consider severity and interval since last exacerbation. Frequency and severity may fluctuate over time for patients in any severity category. →			
		Relative annual risk of exacerbations may be related to FEV ₁			

- 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.***

Lowest level of treatment required to maintain control (See figure 4–1b for treatment steps.)	Classification of Asthma Severity			
	Intermittent	Persistent		
		Mild	Moderate	Severe
	Step 1	Step 2	Step 3 or 4	Step 5 or 6

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.

FIGURE 3–4c. CLASSIFYING ASTHMA SEVERITY IN YOUTHS ≥12 YEARS OF AGE AND ADULTS

■ **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)			
		Intermittent	Persistent		
			Mild	Moderate	Severe
Impairment	Symptoms	≤2 days/week	>2 days/week but not daily	Daily	Throughout the day
	Nighttime awakenings	≤2x/month	3–4x/month	>1x/week but not nightly	Often 7x/week
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week but not >1x/day	Daily	Several times per day
	Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited
	Lung function	<ul style="list-style-type: none"> • Normal FEV₁ between exacerbations • FEV₁ >80% predicted • FEV₁/FVC normal 	<ul style="list-style-type: none"> • FEV₁ ≥80% predicted • FEV₁/FVC normal 	<ul style="list-style-type: none"> • FEV₁ >60% but <80% predicted • FEV₁/FVC reduced 5% 	<ul style="list-style-type: none"> • FEV₁ <60% predicted • FEV₁/FVC reduced >5%
Risk	Exacerbations requiring oral systemic corticosteroids	0–1/year (see note)	≥2/year (see note) →		
		← Consider severity and interval since last exacerbation. Frequency and severity may fluctuate over time for patients in any severity category. →			
		Relative annual risk of exacerbations may be related to FEV ₁			

- Level of severity is 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.***

Lowest level of treatment required to maintain control (See figure 4–5 for treatment steps.)	Classification of Asthma Severity			
	Intermittent	Persistent		
	Step 1	Mild	Moderate	Severe
		Step 2	Step 3 or 4	Step 5 or 6

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

Components of Control		Classification of Asthma Control (Children 0–4 years of age)		
		Well Controlled	Not Well Controlled	Very Poorly Controlled
Impairment	Symptoms	≤2 days/week	>2 days/week	Throughout the day
	Nighttime awakenings	≤1x/month	>1x/month	>1x/week
	Interference with normal activity	None	Some limitation	Extremely limited
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week	Several times per day
Risk	Exacerbations requiring oral systemic corticosteroids	0–1/year	2–3/year	>3/year
	Treatment-related adverse effects	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.		

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

Components of Control		Classification of Asthma Control (Children 5–11 years of age)		
		Well Controlled	Not Well Controlled	Very Poorly Controlled
Impairment	Symptoms	≤2 days/week but not more than once on each day	>2 days/week or multiple times on ≤2 days/week	Throughout the day
	Nighttime awakenings	≤1x/month	≥2x/month	≥2x/week
	Interference with normal activity	None	Some limitation	Extremely limited
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week	Several times per day
	Lung function ▪ FEV ₁ or peak flow ▪ FEV ₁ /FVC	>80% predicted/ personal best >80%	60–80% predicted/ personal best 75–80%	<60% predicted/ personal best <75%
Risk	Exacerbations requiring oral systemic corticosteroids	0–1/year	≥2/year (see note)	
	Reduction in lung growth	Consider severity and interval since last exacerbation		
	Treatment-related adverse effects	Evaluation requires long-term followup.		
		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.		

Key: EIB, exercise-induced bronchospasm; FEV₁, 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

Components of Control		Classification of Asthma Control (Youths ≥12 years of age and adults)		
		Well-Controlled	Not Well-Controlled	Very Poorly Controlled
Impairment	Symptoms	≤2 days/week	>2 days/week	Throughout the day
	Nighttime awakening	≤2x/month	1–3x/week	≥4x/week
	Interference with normal activity	None	Some limitation	Extremely limited
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week	Several times per day
	FEV ₁ or peak flow	>80% predicted/ personal best	60–80% predicted/ personal best	<60% predicted/ personal best
	Validated Questionnaires			
	ATAQ ACQ ACT	0 ≤0.75* ≥20	1–2 ≥1.5 16–19	3–4 N/A ≤15
Risk	Exacerbations	0–1/year	≥2/year (see note)	
		Consider severity and interval since last exacerbation		
	Progressive loss of lung function	Evaluation requires long-term followup care		
	Treatment-related adverse effects	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.		

*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

www.idph.state.ia.us

(Press Firmly)

The colors of the traffic light will help you use your asthma medicines.

Name <i>Katie Miller</i>	Date of Birth <i>10 yrs</i>	Effective Date / / to / /
Doctor		Parent/Guardian
Doctor's Office Phone Number		Parent's Phone
Emergency Contact After Parent		Contact Phone



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.

Pay Attention to Symptoms.

GO (Green)

You have **all** of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work and play

Peak flow from _____
to _____

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

MEDICINE/DOSAGE	HOW MUCH TO TAKE	WHEN TO TAKE IT
<i>Qvar 40</i>	<i>2 Puffs</i>	<i>Morning and Night</i>
COMMENTS: <i>Don't forget to use your spacer!</i>		

For asthma with exercise, take:

<i>Albuterol</i>	<i>2 Puffs</i>	<i>30 minutes before exercise</i>
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Continue with green zone medicine and ADD:

MEDICINE/DOSAGE	HOW MUCH TO TAKE	WHEN TO TAKE IT
<i>Qvar 40</i>	<i>2 Puffs</i>	<i>Morning and Night</i>
<i>Albuterol</i>	<i>2 Puffs</i>	<i>Every 4-6 hours as needed</i>
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

EMERGENCY MEDICINE/DOSAGE	HOW MUCH TO TAKE	WHEN TO TAKE IT
<i>Orapred</i>	<i>2 tsp</i>	<i>Morning and Night for five days only</i>
<i>Albuterol</i>	<i>2 Puffs</i>	<i>Every 3-4 hours as needed</i>
COMMENTS: <i>Use Orapred only if OK by office</i>		

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.

Check all items that trigger your asthma and things that could make your asthma worse:

- Chalk Dust
- Cigarette smoke & second hand smoke
- Colds/Flu
- Dust mites, dust, stuffed animals, carpet
- Exercise
- Mold
- Ozone alert days
- Pests - rodents & cockroaches
- Pets - animal dander
- Plants, flowers, cut grass, pollen
- Strong odors, perfumes, cleaning products, scented products
- Sudden temperature change
- Wood smoke
- Foods:
- Other:

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

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

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

Printed 2003

WHITE - School/Child Care Copy

Pink - Family Copy

Yellow - Doctor Copy

Permission to Reproduce Blank Form

Asthma Action Plan

For: Scott Smith Doctor: _____ Date: _____
Doctor's Phone Number _____ Hospital/Emergency Department Phone Number _____

GREEN ZONE

Doing Well

- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

And, if a peak flow meter is used,

Peak flow: more than _____ (80 percent or more of my best peak flow)

My best peak flow is: _____

Before exercise

Albuterol _____ 2 or 4 puffs _____ 5 to 60 minutes before exercise

Asthma Is Getting Worse

- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

-Or-

Peak flow: _____ to _____ (50 to 79 percent of my best peak flow)



Add: quick-relief medicine—and keep taking your GREEN ZONE medicine.

Albuterol _____ 2 or 4 puffs, every 20 minutes for up to 1 hour
(short-acting beta₂-agonist) Nebulizer, once



If your symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment:
 Continue monitoring to be sure you stay in the green zone.

-Or-

If your symptoms (and peak flow, if used) do not return to GREEN ZONE after 1 hour of above treatment:

Take: Albuterol _____ 2 or 4 puffs or Nebulizer

Add: Prednisone 60 (short-acting beta₂-agonist) _____ mg per day For 5 ~~10~~ days

Call the doctor before/ ~~after~~ after taking the oral steroid.

RED ZONE

Medical Alert!

- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone

-Or-

Peak flow: less than _____ (50 percent of my best peak flow)

Take this medicine:

Albuterol _____ 4 or 6 puffs or Nebulizer
(short-acting beta₂-agonist)

Prednisone _____ 60 mg
(oral steroid)

Then call your doctor NOW. Go to the hospital or call an ambulance if:

- You are still in the red zone after 15 minutes AND
- You have not reached your doctor.

DANGER SIGNS ■ Trouble walking and talking due to shortness of breath

- Lips or fingernails are blue

Take 4 or 6 puffs of your quick-relief medicine AND

Go to the hospital or call for an ambulance _____ NOW!
(phone)

See the reverse side for things you can do to avoid your asthma triggers.

How To Control Things That Make Your Asthma Worse

This guide suggests things you can do to avoid your asthma triggers. Put a check next to the triggers that you know make your asthma worse and ask your doctor to help you find out if you have other triggers as well. Then decide with your doctor what steps you will take.

Allergens

Animal Dander

Some people are allergic to the flakes of skin or dried saliva from animals with fur or feathers.

The best thing to do:

- Keep furred or feathered pets out of your home.
- If you can't keep the pet outdoors, then:
 - Keep the pet out of your bedroom and other sleeping areas at all times, and keep the door closed.
 - Remove carpets and furniture covered with cloth from your home. If that is not possible, keep the pet away from fabric-covered furniture and carpets.

Dust Mites

Many people with asthma are allergic to dust mites. Dust mites are tiny bugs that are found in every home—in mattresses, pillows, carpets, upholstered furniture, bedcovers, clothes, stuffed toys, and fabric or other fabric-covered items.

Things that can help:

- Encase your mattress in a special dust-proof cover.
- Encase your pillow in a special dust-proof cover or wash the pillow each week in hot water. Water must be hotter than 130° F to kill the mites. Cold or warm water used with detergent and bleach can also be effective.
- Wash the sheets and blankets on your bed each week in hot water.
- Reduce indoor humidity to below 60 percent (ideally between 30—50 percent). Dehumidifiers or central air conditioners can do this.
- Try not to sleep or lie on cloth-covered cushions.
- Remove carpets from your bedroom and those laid on concrete, if you can.
- Keep stuffed toys out of the bed or wash the toys weekly in hot water or cooler water with detergent and bleach.

Cockroaches

Many people with asthma are allergic to the dried droppings and remains of cockroaches.

The best thing to do:

- Keep food and garbage in closed containers. Never leave food out.
- Use poison baits, powders, gels, or paste (for example, boric acid). You can also use traps.
- If a spray is used to kill roaches, stay out of the room until the odor goes away.

Indoor Mold

- Fix leaky faucets, pipes, or other sources of water that have mold around them.
- Clean moldy surfaces with a cleaner that has bleach in it.

Pollen and Outdoor Mold

What to do during your allergy season (when pollen or mold spore counts are high):

- Try to keep your windows closed.
- Stay indoors with windows closed from late morning to afternoon, if you can. Pollen and some mold spore counts are highest at that time.
- Ask your doctor whether you need to take or increase anti-inflammatory medicine before your allergy season starts.

Irritants

Tobacco Smoke

If you smoke, ask your doctor for ways to help you quit. Ask family members to quit smoking, too.

- Do not allow smoking in your home or car.

Smoke, Strong Odors, and Sprays

- If possible, do not use a wood-burning stove, kerosene heater, or fireplace.
- Try to stay away from strong odors and sprays, such as perfume, talcum powder, hair spray, and paints.

Other things that bring on asthma symptoms in some people include:

Vacuum Cleaning

- Try to get someone else to vacuum for you once or twice a week, if you can. Stay out of rooms while they are being vacuumed and for a short while afterward.
- If you vacuum, use a dust mask (from a hardware store), a double-layered or microfilter vacuum cleaner bag, or a vacuum cleaner with a HEPA filter.

Other Things That Can Make Asthma Worse

- Sulfites in foods and beverages: Do not drink beer or wine or eat dried fruit, processed potatoes, or shrimp if they cause asthma symptoms.
- Cold air: Cover your nose and mouth with a scarf on cold or windy days.
- Other medicines: Tell your doctor about all the medicines you take. Include cold medicines, aspirin, vitamins and other supplements, and nonselective beta-blockers (including those in eye drops).



U.S. Department of Health and Human Services
National Institutes of Health



For More Information, go to: www.nhlbi.nih.gov
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SAMPLE LONG TERM TREATMENT PLAN

Name: Daryll Ward

Age: 8 years old

Weight: 60 lbs

Moderate persistent asthma currently on long-term medication

CLINICAL CONDITION	Baseline Plan & When asthma is under control	At the FIRST sign of a cold or mild asthma attack	For rapidly worsening asthma (severe attack)	When there is no cough or wheeze for 3 months	For cough or wheeze with exercise
SYMPTOMS	<ul style="list-style-type: none"> Breathing is good with no daily or nighttime symptoms Able to do usual activities 	<ul style="list-style-type: none"> Breathing problems and symptoms present or waking up from sleep Can do some but not all usual activities 	<ul style="list-style-type: none"> Breathing is hard and fast Rescue medicines have not helped Cannot do usual activities 	<ul style="list-style-type: none"> Breathing is good with no daily or nighttime symptoms Able to do usual activities 	2 puffs 5-10 minutes before exercise
PEAK FLOW (LPM)	200-230	180-200	<180	200-230	
MEDICATION <i>Reliever:</i> Albuterol	2 puffs as needed	2 puffs every 4 hr	2-6 puffs every 20 minutes for 3 doses then 2-4 puffs every 4 hr	2 puffs as needed	
<i>Controller:</i> 1) Beclomethasone (ICS), 40 mcg	1-2 puffs 2x/day	1-2 puffs 2x/day	1-2 puffs 2x/day	0-1 puffs 2x/day	
Corticosteroid Tablet or Syrup	0	0	Begin with 1-2 mg/kg/day NOTIFY MD	0	

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

Communication Strategies

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

- Clark NM, Gong M, Schork MA, Evans D, Roloff D, Hurwitz M, Maiman L, Mellins RB. Impact of education for physicians on patient outcomes. *Pediatrics* 1998;101:831-36.
- Clark NM, Gong M, Schork MA, Kaciroti N, Evans D, Roloff D, Hurwitz M, Maiman LA, Mellins RB. Long-term effects of asthma education for physicians on patient satisfaction and use of health services. *Eur Respir J* 2000;16:15-21.
- NHLBI (2007). Expert Panel Report 3—Guidelines for the Diagnosis and Management of Asthma, <http://www.nhlbi.nih.gov/guidelines/asthma/index.htm>
- NHLBI (2008). Guidelines Implementation Panel Report: Partners Putting Guidelines into Action, http://www.nhlbi.nih.gov/guidelines/asthma/gip_rpt.htm

Review of Concepts - Management & Treatment

Message		What the Message Addresses
Airway lining swells and mucous forms Muscles tighten around airways		Asthma diagnosis (bad news)
Anti-inflammatories reduce inflammation Quick-relief medicines (short-acting β_2 -agonists) relax muscles		Benefits of medicine (good news)
Quick-relief medicine not to be used more than two days a week Watch for jitteriness and anxiety		Side effects can be limited
Follow the written asthma action plan		Shows that medicines are adjusted according to the level of control a patient can achieve Shows the benefits of using medicines can outweigh costs
Demonstrate use of asthma medicines and devices Use instructions in written asthma action plan		Builds self confidence and level of skills
Need daily anti-inflammatories		Reducing susceptibility to asthma episodes
Long-term goal to control asthma with as little medicine as necessary		Shows how benefits of following regimen over time outweigh costs
Medicines safe when used as instructed Inhaled corticosteroids safe in low doses Corticosteroids differ from anabolic		Builds confidence in the regimen Reduces fear associated with use of medicine
Expect to exercise without symptoms Expect to sleep through the night		Shows benefits of therapy
Plan can be fine-tuned if problems arise		Shows that ongoing partnership with clinician is needed

Be physically active Sports champs have asthma in control		Shows benefits of therapy Builds self-confidence
School personnel need to be informed about triggers, medications, physical exercise, emergencies		Need for support in the social environment
Triggers can be identified		Increases feelings of control Reduces susceptibility to episodes
Use medicines preventively when your child may be exposed to triggers		Shows benefits of therapy Increases feeling of control
The goal is to be symptom-free		Shows benefits of staying with therapy
Take part in additional asthma education		Builds self-confidence

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:

1. Use appropriate non-verbal attentiveness (e.g. eye contact, closing social distance, etc.)?

1 2 3 4 5

2. Elicit the parents' and child's underlying concern about the child's asthma?

1 2 3 4 5

3. Construct reassuring messages regarding the parents' and child's fears?

1 2 3 4 5

4. Address immediately the concerns the family expressed?

1 2 3 4 5

5. Engage the family in interactive conversation (e.g. used open-ended questions, simple language, analogies, etc.)?

1 2 3 4 5

6. Tailor the regimen by eliciting and addressing potential problems in the timing, dosage, or side effects of the medicines recommended?

1 2 3 4 5

7. Use appropriate non-verbal encouragement and verbal praise when the family reported using correct management strategies?

1 2 3 4 5

8. Elicit the family's immediate objective related to asthma control and agree on a short-term goal?

1 2 3 4 5

9. Review the long-term plan?

1 2 3 4 5

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)?

1 2 3 4 5

Documentation and Coding

COMMON PEDIATRIC CODING QUESTIONS & ANSWERS

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.²

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.¹

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).¹

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:

1. American Academy of Pediatrics (1999-2010). Coding Corner. *AAP News*, 15(5), 16(3), 18(6), 19(3), 20(2), 20(5), 30(2), 30(7), 31(6). Retrieved from <http://aapnews.aappublications.org/>
2. Committee on Coding and Nomenclature - American Academy of Pediatrics. (2010). *Coding for Pediatrics*. Elk Grove Village: American Academy of Pediatrics.

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).

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

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

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CPT Codes for Established Patients' Office Visits

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

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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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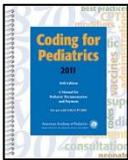
Documentation, Coding, and Reimbursement Tools

AAP Coding Hotline for Questions- aapcodinghotline@aap.org



AAP News - Coding Corner (monthly)

http://aapnews.aapublications.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

<p>Message: Inhaled Corticosteroids 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.</p> <p>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).</p>	<p>Message: Asthma Control 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.</p> <p>EPR-3 Recommendation: The Expert Panel recommends that every patient who has asthma be taught to recognize symptom patterns and/or Peak Expiratory Flow (PEF) measures that indicate inadequate asthma control and the need for additional therapy (Evidence A), and that control be routinely monitored to assess whether the goals of therapy are being met – that is, whether impairment and risk are reduced (Evidence B).</p>
<p>Message: Asthma Action Plan All people who have asthma should receive a written asthma action plan to guide their self-management efforts.</p> <p>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).</p>	<p>Message: Follow-up Visits 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.</p> <p>EPR-3 Recommendation: The Expert Panel recommends that monitoring and follow up is essential (Evidence B), and that the stepwise approach to therapy – in which the dose and number of medications and frequency of administration are increased as necessary (Evidence A) and decreased when possible (Evidence C, D) be used to achieve and maintain asthma control.</p>
<p>Message: Asthma Severity 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.</p> <p>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. <i>*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.</i></p>	<p>Message: Allergen and Irritant Exposure Control 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.</p> <p>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).</p>

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.

National Heart, Lung, and Blood Institute. National Asthma Education and Prevention Program. Guidelines Implementation Panel Report for: Expert Panel Report 3- Guidelines for the Diagnosis and Management of Asthma; December 2008. http://www.nhlbi.nih.gov/guidelines/asthma/gip_rpt.pdf

Clark NM, Cabana MD, Nan B, Gong ZM, Slish KK, Birk NA, Kaciroti N. [The clinician-patient partnership paradigm: outcomes associated with physician communication behavior](#). Clin Pediatr (Phila). 2008 Jan;47(1):49-57.

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PACE References

PACE Program Bibliography

Brown R, Bratton S, Cabana M, Kaciroti N, and Clark NM. "Physician Asthma Education Program Improves Outcomes for Children of Low-Income Families." *CHEST*, 126(2): 369-374, 2004. Also appears at <http://www.chestjournal.org>.

Clark NM, Cabana MD, Nan B, Gong M, Slisk KK, Kaciroti N . "Long Term Change in Patient Outcomes from an Intervention for their Physicians." *Clinical Pediatrics*. 2008 Nov;47(9):883-90. Also appears at <http://cpj.sagepub.com/content/47/9/883.long>.

Clark NM, Cabana MD, Nan B, Gong M, Slisk KK, Birk NA, Kaciroti N. "The Clinician-Patient Partnership Paradigm: Outcomes Associated with Physician Communication Behavior." *Clinical Pediatrics*. 2008 Jan;47(1):49-57. Also appears at <http://cpj.sagepub.com/content/47/1/49.long>.

Cabana MD, Slisk KK, Evans D, Mellins RB, Brown R, Lin X, Kaciroti N and Clark NM. "Impact of Physician Asthma Care Education on Patient Outcomes." *Pediatrics*, 117(6): 2149-57, 2006. Also appears at <http://pediatrics.aappublications.org>.

Cabana MD, Bradley J, Meurer JR, Holle D, Santiago C and Clark NM. "Coding for asthma patient education in the primary care setting." *Journal of Medical Practice Management*, 21(2): 115-9, 2005. Also appears at <http://www.mpmnetwork.com/index.cfm>.

Cabana MD, Slisk KK, Nan B, Lin X and Clark NM. "Asking the Correct Questions to Assess Asthma Symptoms." *Clinical Pediatrics*, 44: 319-325, 2005. Also appears at <http://cpj.sagepub.com>.

Cabana MD, Slisk KK, Brown R and Clark NM. "Pediatrician attitudes and practices regarding collaborative asthma education." *Clinical Pediatrics*, 43: 269-274, 2004. Also appears at <http://cpj.sagepub.com>.

Cabana MD, Brown R, Clark NM, White DF, Lyons J, Wanner-Lang S and Bratton SL. "Improving physician attendance at educational seminars sponsored by managed care organizations." *Managed Care*, 13: 49-57, 2004. Also appears at <http://www.managedcaremag.com>.

Cabana MD, Slisk KK, Lewis TC, Brown R, Nan B, Lin X and Clark NM. "Parent management of asthma triggers within a child's environment." *Journal of Allergy and Clinical Immunology*, 114: 352-357, 2004. Also appears at <http://journals.elsevierhealth.com/periodicals/ymai>.

Cabana MD, Slisk KK, Nan B and Clark NM. "Limits of the HEDIS criteria in determining asthma severity in children." *Pediatrics*, 114: 1049-55, 2004. Also appears at <http://pediatrics.aappublications.org>.

Cabana MD, Bruckman D, Meister K, Bradley J and Clark NM. "Documentation of asthma severity in pediatric outpatient clinics." *Clinical Pediatrics*, 42(2): 121-5, 2003. Also appears at <http://cpj.sagepub.com>.

Cabana MD and Clark NM. "Challenges in evaluating methods to improve physician practice." *Pediatrics*, 143: 413-414, 2003. Also appears at <http://pediatrics.aappublications.org>.

Clark NM, Gong M, Schork MA, Kaciroti N, Evans D, Roloff D, Hurwitz M, Maiman LA and Mellins RB. "Long-term effects of asthma education for physicians on patient satisfaction and use of health services." *European Respiratory Journal*, 16(1): 15-21, 2000. Also appears at <http://erj.ersjournals.com>.

Clark NM, Gong M, Schork MA, Evans D, Roloff D, Hurwitz M, Maiman L and Mellins RB. "Impact of education for physicians on patient outcomes." *Pediatrics*, 101(5): 831-6, 1998. Also appears at <http://pediatrics.aappublications.org>.

Clark NM., Gong M, Schork MA, Maiman LA, Evans D, Hurwitz ME, Roloff D and Mellins RB. "A scale for Assessing Health Care Providers' Teaching and Communication Behavior regarding asthma." *Health Education & Behavior*, 24(2): 245-56, 1997. Also appears at <http://heb.sagepub.com>.

Clark NM, Nothwehr F, Gong M, Evans D, Maiman LA, Hurwitz ME, Roloff D and Mellins RB. "Physician-patient partnership in managing chronic illness." *Academic Medicine*, 70(11):957-9, 1995. Also appears at www.academicmedicine.org.

Mellins RB, Evans D, Clark NM, Zimmerman B and Wiesemann S. "Developing and communicating a long-term treatment plan for asthma." *American Family Physician*, 61(8): 2419-28, 2000. Also appears at <http://www.aafp.org/online/en/home/publications/journals/afp.html>.