Advanced Coding Principles for the Allergy Practice

Presented by
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Learning Objectives

• Describe details of coding for patients’ allergy testing and immunotherapy
• Discuss the use of codes pertinent to A/I practice
<table>
<thead>
<tr>
<th>Improving Your Bottom Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Coding conservatively – is it an issue?</td>
</tr>
<tr>
<td>• Co-pays – are they collected</td>
</tr>
<tr>
<td>• Fees that are not current – review</td>
</tr>
<tr>
<td>• Diagnosis not appropriate to encounter</td>
</tr>
<tr>
<td>• Not coding all services – hospital consults, subsequent care, procedures</td>
</tr>
<tr>
<td>• Timeliness of submission</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Improving Your Bottom Line</th>
</tr>
</thead>
<tbody>
<tr>
<td>• New providers and no provider #</td>
</tr>
<tr>
<td>– Only 30 days to prior to NPI with CMS</td>
</tr>
<tr>
<td>• Scheduling of patients – charging for n/s?</td>
</tr>
<tr>
<td>• Staff overload – overtime?</td>
</tr>
<tr>
<td>• Lack of research for best price - antigens</td>
</tr>
<tr>
<td>• New procedures and equipment not recognized as payable by carriers</td>
</tr>
<tr>
<td>– 95012- Nitric oxide expired gas determination</td>
</tr>
</tbody>
</table>
Fee Schedules

• Read your contracts thoroughly before signing
• Know your reimbursement rates
• Ask if the carrier follows CMS guidelines
  – What about mid level providers????
• What bundling program is used – are they available on the carrier website
• Preventive a covered benefit?

Fee Schedules

• What is the “legal” payment time for your state
• Does the carrier change your codes?
• When should you contact your insurance commissioner or medical society?
• What is proper for appealing claims?
Maximizing for a Greater Profit

- Review, posting & processing of EOB to patient account – payment correct
- Following guidelines published per carrier
- Regular auditing & monitoring of all phases
- Are all charges being collected
- What is percentage of uncollected charges
- Continual education and training of all staff

Results?

- Profitable practice
- Patient satisfaction
- Staff accountability, pride and support
Claims Submission

- What is covered and what is non-covered?
- What is legal payment time for carrier?
- Down coding – is it happening?

Claims Submission

- Appeals – What is the appropriate procedure for your major insurance companies?
- What is required? Telephone or paper appeal?
Claims Submission

- What is your basis for appealing?
- Are the modifiers being recognized?
- Contract policies – do you have a copy?

DOCUMENTATION AND TOOLS
Documentation

• Translate medical record into codes
  – ICD-9 codes and CPT codes
• Electronic health record versus paper chart

Most Common Errors

• Diagnoses do not match documentation
• Physician codes rule out possible, probable, as definitive diagnosis
• Co-morbidities are coded with no documentation in note to support coding
• Lack of specificity in documentation and coding
CPT Modifiers

E/M Modifiers

• 25 -- Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service
25 Modifier Tips

- Chief complaint must be appropriately documented to support an E/M plus allergy test, PFT or shots.
- By CPT and CMS guidelines, 25 modifier is required for E/M, allergy testing, allergy injection and/or pulmonary function test performed on the same day.

26 Professional Component

- The interpretation component of a code which has both a professional and technical component.
- Example – PFT read in hospital.
- 26 is the professional component only.
59 Distinct Procedure

- Example:
  - 94060 with 94664
    - Included in the pre and post when the instruction is done to teach patient how to use MDI to accomplish the pre and post
    - 9466459 when the instruction is done for the patient’s knowledge to use a device after the encounter

76 Repeat Procedure By Same Physician

- Example:
  - 94640
  - 9464076
  - When more than one nebulizer treatment is administer to a patient on one day
HCPCS MODIFIERS

- GA  Waiver of liability on file
- GY  Non-covered service by Medicare

Allergy Procedures and Services
Aerosol Demo/Eval pt utiliz 94664
Bronchodilation responsiveness 94060
Bronchospasm Eval - Prolonged 94070
Laryngoscopy - flexible, dx 31575
Nasal endoscopy 31231
Nasopharyngoscopy 92511
Non pressured Inhalation trmt less than 1 hour 94640
Continuous inhalation tx with RX> 1hr 94644
Continuous inhalation tx with Rx ea add'l 1hr 94645
Oximetry, single 94760
Oximetry, multiple 94761
Pulmonary Stress Test, Simple 94620
Respiratory Flow Volume Loop 94375
Spirometry, base 94010
Vital Capacity, total (separate P.) 94150
Nitric oxide expired gas determination 95012

**Allergy**

- Testing and ordering of immunotherapy needs to be done based on orders from the physician
- Testing is either percutaneous, intradermal per antigen, or intradermal sequential & incremental
- Not all carriers recognize testing code 95027
- RAST testing may be performed – check for coverage per patient
- Interpretation and report included in code for test
- Interpretation & report by physician is part of test
### ALLERGY TESTING

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Puncture/Prick allergenic extract</td>
<td>95004</td>
</tr>
<tr>
<td>Intradermals allergenic extract</td>
<td>95024</td>
</tr>
<tr>
<td>Allergy test Prick and ID - venoms</td>
<td>95017</td>
</tr>
<tr>
<td>Allergy test Prick &amp; ID biologicals &amp; drugs</td>
<td>95018</td>
</tr>
<tr>
<td>Skin end point titration</td>
<td>95027</td>
</tr>
<tr>
<td>Delayed ID testing</td>
<td>95028</td>
</tr>
<tr>
<td>Patch Test</td>
<td>95044</td>
</tr>
<tr>
<td>Inhalation bronchial challenge with antigens</td>
<td>95070</td>
</tr>
<tr>
<td>Ingestion challenge test initial 120 minutes</td>
<td>95076</td>
</tr>
<tr>
<td>Ingestion challenge test: ea additional 60 min</td>
<td>95079</td>
</tr>
</tbody>
</table>

### ALLERGEN IMMUNOTHERAPY

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergen-Mult. Dose #Doses</td>
<td>95165</td>
</tr>
<tr>
<td>Allergen - Single Dose #</td>
<td>95144</td>
</tr>
<tr>
<td>Venom Antigen - 1 single stinging</td>
<td>95145</td>
</tr>
<tr>
<td>Venom Antigen - 2 single stinging</td>
<td>95146</td>
</tr>
<tr>
<td>Venom Antigen - 3 single stinging</td>
<td>95147</td>
</tr>
<tr>
<td>Venom Antigen - 4 single stinging</td>
<td>95148</td>
</tr>
<tr>
<td>Venom Antigen - 5 single stinging</td>
<td>95149</td>
</tr>
<tr>
<td>Whole Body - biting insect</td>
<td>95170</td>
</tr>
<tr>
<td>Rapid Desensitization #Hr</td>
<td>95180</td>
</tr>
</tbody>
</table>
Allergy Immunotherapy

- Watch!!!
- Third party payers implementing the definition of a dose the same as Medicare
- Third party payers not allowing “off the board treatment”
- Limits on the number of doses allowed per the carrier guidelines per year or per date
- SLIT – Correct code is 95199

Allergy

- 95165 – two definitions
  - Medicare – per cc of the concentrated solution
  - CPT – A dose is the amount of antigen(s) administered in a single injection from a multiple dose vial
  - Check coverage for patient’s – may be pharmaceutical benefit rather than a professional benefit
Immunotherapy

- 95170  Whole body biting insect fire ants
- 95180  Rapid desensitization
- Charge by time – time must be documented
- Only time of desensitization test, not time in office
- Doses given for desensitization may also be charged

95165 Examples

- Patient is beginning immunotherapy for trees and molds. Because of patient’s sensitivity, patient’s antigens are separated. Patient has four vials of both the molds and trees. There are ten medical doses in each of the vials. The vials are 5 cc vials
95165 Coding

• CPT coding would be 95165 with ?? units

• CMS coding would be 95165 for ?? units since the build up vials are not billable to CMS

• The anticipated number of units the patient will get determines the units for the dilution vials

95165 – Maintenance Vials

• Pt needs a refill for both trees and molds. The vials are 5 cc vials and the patient is on .5 cc for a dose.

• CPT coding – 95165 ?? units

• CMS coding – 95165 ?? units

• The CMS coding would be 10 units since there are 2 vials of 5 ml each
Venom Immunotherapy

- The code that is used is determined by the sum of all venoms that will be provided at a single visit
- If a patient gets honey bee and mixed vespid, the code would be 95148 for 4 venoms
- Patient has mixed honey and wasp ????

Immunotherapy

- 95170 Whole body biting insect fire ants
- 95180 Rapid desensitization
- Charge by time – time must be documented
- Only time of desensitization test, not time in office
- Doses given for desensitization may also be charged
### INJECTIONS

<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Injection - 1</td>
<td>95115</td>
</tr>
<tr>
<td>Allergy Injections - 2+</td>
<td>95117</td>
</tr>
<tr>
<td>Allergy Inj + Antigen</td>
<td>95120</td>
</tr>
<tr>
<td>Allergy Inj + Antigen 2+</td>
<td>95125</td>
</tr>
<tr>
<td>Xolair Injection</td>
<td>96372</td>
</tr>
<tr>
<td>Other Injections</td>
<td></td>
</tr>
<tr>
<td>Antibiotic Inj (#)</td>
<td>96372</td>
</tr>
<tr>
<td>Immun. admin. Single with counseling</td>
<td>90460</td>
</tr>
<tr>
<td>Immun. admin. ea add'l with counseling</td>
<td>90472</td>
</tr>
<tr>
<td>Flu Vac under 3yr pre free</td>
<td>90655</td>
</tr>
<tr>
<td>Flu Vac under 3yr</td>
<td>90657</td>
</tr>
<tr>
<td>Flu Vac 3yr +, split virus</td>
<td>90658</td>
</tr>
<tr>
<td>Flu Vac intranasal</td>
<td>90660</td>
</tr>
<tr>
<td>IV Med Admin push</td>
<td>96374</td>
</tr>
<tr>
<td>Infusion Therapy 1st hr</td>
<td>96365</td>
</tr>
<tr>
<td>ea. add’tl hr.</td>
<td>96366</td>
</tr>
<tr>
<td>Pneumovax</td>
<td>90732</td>
</tr>
<tr>
<td>Therapeutic Inj</td>
<td>96372</td>
</tr>
</tbody>
</table>

### SUPPLIES/ MISCELLANEOUS

<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab Handling</td>
<td>99000</td>
</tr>
<tr>
<td>Nasal Smears</td>
<td>89190</td>
</tr>
<tr>
<td>Solumedrol</td>
<td>J2930</td>
</tr>
<tr>
<td>Syringes</td>
<td>A4206</td>
</tr>
<tr>
<td>Special Reports</td>
<td>99080</td>
</tr>
<tr>
<td>Triamcinolone</td>
<td>J3301</td>
</tr>
<tr>
<td>Xolair</td>
<td>J2357</td>
</tr>
<tr>
<td>Portable peak flow meter (A4614)</td>
<td>S8096</td>
</tr>
<tr>
<td>Peak flow expir. flow physician service</td>
<td>S8110</td>
</tr>
<tr>
<td>Nebulizer &amp; supplies</td>
<td>A7003</td>
</tr>
<tr>
<td>through</td>
<td>A7017</td>
</tr>
</tbody>
</table>
Asthma Education

- S Code for BC/BS and Health Insurance Association of America
- S9441 – asthma education non-physician provider per session
- 98960 – education – for non-physician per patient – not specific to asthma
- Requires standardized curriculum

Peak Flow Reading

- For Medicare/Medicaid it is included in the E/M
- S code for third party payers
- S8110 – Peak expiratory flow rate (physician services)
Chart Auditing

• What do you when a letter arrives asking for multiple chart notes?
• Who is your lead for release of records?
• Do you know your risk?
• Monitoring your most frequent codes is maintaining a healthy practice
• How often do you run a utilization for your practice?

Chart Auditing

• EHR and incentives need to be monitored
• Watch “canned” statements and repetitions
• Have an outside “look” for compliance
• Know the key components required to support your coding
Allergist Coding Curve

<table>
<thead>
<tr>
<th>National</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>.47 %</td>
</tr>
<tr>
<td>99202</td>
<td>5.00 %</td>
</tr>
<tr>
<td>99203</td>
<td>30.15%</td>
</tr>
<tr>
<td>99204</td>
<td>51.32%</td>
</tr>
<tr>
<td>99205</td>
<td>13.06%</td>
</tr>
<tr>
<td>99241</td>
<td>.52 %</td>
</tr>
<tr>
<td>99242</td>
<td>3.48 %</td>
</tr>
<tr>
<td>99243</td>
<td>30.42%</td>
</tr>
<tr>
<td>99244</td>
<td>54.02%</td>
</tr>
<tr>
<td>99245</td>
<td>11.56%</td>
</tr>
</tbody>
</table>

Allergist Coding Curve

National

| 99211    | 3.98 %   |
| 99212    | 6.77%    |
| 99213    | 55.25%   |
| 99214    | 31.09%   |
| 99215    | 2.91 %   |
Components of Evaluation and Management Codes

Components of the E & M

- History
- Exam
- Medical Decision Making
- Time is ONLY important when more than 50% of the encounter is counseling and coordination of care
Requirement for New/Consult Patient vs. Established Patient

- History, Exam & Medical Decision Making need to be at the same level or higher to support the level of care
- Two of the three of the components at the same level or higher to support the level of care
- The history and exam must be appropriate to the patient’s presenting problem

<table>
<thead>
<tr>
<th>CONSULT-HOSPITAL</th>
<th>99251</th>
<th>99252</th>
<th>99253</th>
<th>99254</th>
<th>99255</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONSULT-3 of 3</td>
<td>99241</td>
<td>99242</td>
<td>99243</td>
<td>99244</td>
<td>99245</td>
</tr>
<tr>
<td>NEW PT-3 of 3</td>
<td>99201</td>
<td>99202</td>
<td>99203</td>
<td>99204</td>
<td>99205</td>
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</table>

<table>
<thead>
<tr>
<th>HISTORY</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>CHIEF COMPLAINT</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>HX of PRESENT ILL</td>
<td>Brief(1-3)</td>
<td>Brief(1-3)</td>
<td>Extended(4+)</td>
<td>Extended(4+)</td>
<td>Extended(4+)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REVIEW OF</th>
<th>Problem</th>
<th>Extended</th>
<th>Complete</th>
<th>Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>SYSTEMS</td>
<td>Pertinent (1)</td>
<td>(2-9 System)</td>
<td>(10+ system)</td>
<td>(10+ system)</td>
</tr>
<tr>
<td>PAST HX</td>
<td>Pertinent-1</td>
<td>Complete-1</td>
<td>Complete-1</td>
<td>Complete-1</td>
</tr>
<tr>
<td>FAMILY HX</td>
<td>Pertinent-1</td>
<td>Complete-1</td>
<td>Complete-1</td>
<td>Complete-1</td>
</tr>
<tr>
<td>SOCIAL HX</td>
<td>Pertinent-1</td>
<td>Complete-1</td>
<td>Complete-1</td>
<td>Complete-1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EXAM</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 organ</td>
<td>2-4</td>
<td>5-7</td>
<td>8 organ</td>
<td>8 organ</td>
<td></td>
</tr>
<tr>
<td>system organs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MED. DEC MAKING</th>
<th>(2 of the 3 must be met or exceeded)</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MGMT OPT. &amp; DX</td>
<td>Minimal (1)</td>
<td>Minimal (1)</td>
<td>Limited (2)</td>
<td>Multiple (3)</td>
<td>Extensive(4)</td>
</tr>
<tr>
<td>AMT DATA &amp; COMPLEX</td>
<td>Minimal(1)</td>
<td>Minimal (1)</td>
<td>Limited (2)</td>
<td>Moderate (3)</td>
<td>Extensive(4)</td>
</tr>
<tr>
<td>RISK OF COMPLICAT.</td>
<td>Minimal</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
</tbody>
</table>
### History Audit Sheet

- **HPI:** Chief Complaint – Reason for encounter
  - Location – specific to area of the body
  - Quality – describe the pain – dull, sharp, wound jagged, dirty or clean
  - Severity – measure on a scale
  - Duration – how long, since when, etc
  - Context – how complaint occurred
  - Modifying factor – what has alleviated symptoms
  - Signs and symptoms – additional information from patient
History Audit Sheet

• Review of Systems:
  – Ten are required for a complete ROS
  – Pertinent positives and negatives must be documented
  – A notation of negative for the remaining review of systems may be documented for the remaining systems
  – Can be documented by staff patient
  – Must be reviewed by physician
  – Can be separate or part of the HPI
  – Cannot use one statement in both categories

History Audit Sheet

• Past, Family and Social History:
  – Past – Events in the patient’s past medical/surgery history
  – Family – Diseases that impact patient’s health
  – Social - Factors which are age appropriate that impact from an environmental and social pattern
Exam Audit Sheet

- The 1995 guidelines or the 1997 guidelines can be used for documentation
- Allergy has a specific exam for the specialty
- Abnormal findings must be described
- Normal findings can be indicated by negative
1995 Exam Components

- Problem focused: one organ system
- Expanded problem focused: two or more organ systems (2-4)
- Detailed: two or more with detailed information (5-7)
- Comprehensive: eight or more organ systems

Medical Decision Making

- Number of diagnosis and treatment options
- Amount of data and complexity of data
- Risk
Number of Diagnosis & Treatment Options

- New problem
- Established problem stable
- Established problem worsening
- Established problem, improved
- Workup planned
- No workup planned

Amount & Complexity of Data

- Review/order lab tests
- Review/order routine x-rays
- Review/order medicine tests
- Discussion of tests results with performing physician
- Decision to obtain old records & document
- Direct visualization & independent interpretation documented
Risk

- Presenting problem
- Diagnostic procedure
- Management options

Presenting Problem

- Minimal:
  - One self limited or minor problem
- Low:
  - Two or more self-limited or minor problems
  - One stable chronic illness
  - Acute uncomplicated illness/injury
Presenting problem, con’t

• Moderate:
  – One or more chronic illness with mild exacerbation
  – Two or more stable chronic illnesses
  – Undiagnosed new problem with uncertain prognosis
  – Acute illness with systemic symptoms
  – Acute complicated injury

Presenting Problem, con’t

• High:
  – Chronic illness with severe exacerbation
  – Acute or chronic illness/injury that may pose a threat to life or bodily function
Diagnostic Procedures Ordered

• Minimal:
  – Lab tests requiring veni-puncture
  – X-rays
  – Ultrasounds

• Low:
  – Superficial needle biopsies
  – Skin biopsies
  – Pulmonary function tests

Diagnostic Procedures, con’t

• Moderate:
  – Diagnostic endoscopy
  – Deep needle or incisional biopsy

• High:
  Diagnostic endoscopy with risk factors
Management Options

- Minimal:
  - Rest
  - Gargles
  - Elastic/superficial dressings

- Low:
  - Over the counter drugs – saline washes
  - Minor surgery – ear piercing
  - Physical Therapy

Management Options, con’t

- Moderate:
  - Minor surgery with risk
  - Elective major surgery
  - Prescription drug management
  - Closed treatment of fracture w/o manipulation
Management Options, con’t

- High:
  - Elective major surgery with risk
  - Emergency major surgery
  - Decision not to resuscitate or de-escalate care because of poor prognosis
  - Drug therapy requiring intensive monitoring for toxicity.
  - High morbidity mortality without treatment
What About Time?

- Time is only used if more than 50% of the encounter is counseling and co-ordination of care. You must document:
  1. Total face to face time
  2. The amount which was counseling
  3. The counseling and coordination of care discussion

Case #1 - History

- CC: Rash. Pt has experienced symptoms since 6 months of age. She has had frequent rashes on her trunk and extremities. Her skin gets dry with red patches. Rash is perennial, no seasonal changes so far. She has had distatin and topical Benadryl.
Case # 1 - History

• Past history – birth wt 6 lbs, neonatal jaundice
• Medication allergies: NKDA
• Family hx: Hay fever, migraine – mother
• ROS: Constipation and bloating. All remaining 14 systems are negative

Case #1 - Exam

• Gen: ht 35 1/2 ″, Wt- 24#, Pulse 118, RR 24 WN – thin
• Skin – normal    Nose - normal
• Head – normal    Mouth - normal
• Eyes – normal    Neck - normal
• Ears – normal    Resp - normal
• Ears – normal    Heart – normal
• Extrem – normal  Neuro - normal
Case #1 – A/P

- Lab data – negative CBC & IG
- Prick testing for peanut, egg, cows milk, wheat, walnut, fish, soy shrimp and corn are negative
- Inhalants are negative for trees and grasses

Case #1 A-P

- Chronic atopic dermatitis, in remission today
- Role for IgE-mediated food allergy appears unlikely, food intolerance remains possible
Case #2

- CC: watery eyes, nasal congestion-chronic. Pt has had increasing rhinoconjunctivitis symptoms over the past year. She was tested for allergy when she was living in another state many years ago and found to be allergic to dust mite and animal dander. She is concerned about allergies as a trigger for her symptoms. She also has a history of asthma.

Case #2

- Past medical history – negative
- Family history – brothers have hay fever and asthma
- Social history – not a smoker, enjoys outdoor activities and has a dog for a pet
- ROS – GI, Endocrine, Resp are positive the remaining 14 systems are negative
Case #2

- Gen – BP 118/70, Ht 5’10”, Wt 150, Pulse 82, RR 12, healthy in NAD
- Skin – normal
- Eyes – normal
- Nose – pale boggy mucosa, edema of turbinates, discharge watery clear, no polyps
- Mouth – normal
- Resp – normal
- Abd – normal
- Neuro – normal

A/P

- Seasonal and perennial allergic rhinoconjunctivitis that has worsened over the past year
- Mild persistent asthma with allergic trigger
- Rec: nasal irrigations
- Environmental controls
- Decongestants with antihistamine
- Nasal spray, RX for eyedrops, allergy immunotherapy recommended, Rx for asthma
Case #3

- CC: evaluation of allergies – R/O VCD vs asthma, cough - review meds. Cough is worse at night but not waking up. Vomiting, thick mucus associated with cough. Headache over the past 3-4 days. Sinus pressure for three days also.
- No change in environmental hx, ROS not updated.

Case #3

- Exam:
  - General – normal
  - Skin – normal
  - Sinus tender both left and right
  - Eyes – normal
  - Lungs - normal
  - Ears – normal
  - Heart - normal
  - Nose – septum normal, mucus watery and clear with edema
  - Oropharynx – normal
  - Neck - normal
Case #3

- A/P
- Dx: Seasonal, perennial allergic rhinitis which is worse; asthma which is not well controlled – cough, PND
- RX – trial of bronchodilator, consider CT if cough persist, check for GERD

- Questions????
- Thank you for coming