2013 Allergy Coding: ICD-10CM Are You Prepared?

Presented by
Teresa Thompson, CPC, CMSCS
TM Consulting, Inc
Teresathom@aol.com

Objectives for Lecture

- Understand the principles of documentation in relationship to ICD-10CM
- Understand the differences between ICD-9 and ICD-10 coding systems
- Identify strategies for implementing ICD-10 in clinical practice
- New CPT Codes for allergists in 2013
Principals of Documentation

- If it is not written, it was not done
- If it is illegible, it was not done
- If it is not signed, it was not done
- For 2014 – specificity for diagnoses documented???

Documentation

- Are skin tests signed or initialed?
- Are PFT's signed or initialed?
- ROS and past family and social history obtained by someone other than the provider?
- EHR’s – if scanned in - initialed first?
- Are there separate reports for challenges, nebulizer treatments, MDI instructions?
- How often are the allergy injection records reviewed and documented as reviewed?
Principles of Documentation

- Chief complaint
- Relevant history
- Physical exam findings
- Diagnostic tests – medical necessity
- Assessment/impression and/or diagnosis
- Plan/recommendation for care
- Time if it is counseling and/or coordination
- Date & verifiable legible identity of provider

Components of the E & M

- History
- Exam
- Medical decision making
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>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HISTORY</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</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>
<tr>
<td>REVIEW OF</td>
<td>Problem</td>
<td>Extended</td>
<td>Complete</td>
<td>Complete</td>
<td>Complete</td>
</tr>
<tr>
<td>SYSTEMS</td>
<td>Pertinent(1)</td>
<td>(2-9 System)</td>
<td>(10+ system)</td>
<td>(10+ system)</td>
<td></td>
</tr>
<tr>
<td>PAST HX</td>
<td>Pertinent-1</td>
<td>Complete-1ea</td>
<td>Complete-1ea</td>
<td>Complete-1ea</td>
<td>Complete-1ea</td>
</tr>
<tr>
<td>FAMILY HX</td>
<td>Pertinent-1</td>
<td>Complete-1ea</td>
<td>Complete-1ea</td>
<td>Complete-1ea</td>
<td>Complete-1ea</td>
</tr>
<tr>
<td>SOCIAL HX</td>
<td>Pertinent-1</td>
<td>Complete-1ea</td>
<td>Complete-1ea</td>
<td>Complete-1ea</td>
<td>Complete-1ea</td>
</tr>
<tr>
<td>EXAM</td>
<td>Perform</td>
<td>Perform</td>
<td>Perform</td>
<td>Perform</td>
<td>Perform</td>
</tr>
<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</td>
<td>organs</td>
<td>Organ systems</td>
<td>systems</td>
<td>systems</td>
<td></td>
</tr>
<tr>
<td>MED. DEC MAKING</td>
<td>(2 of the 3 must be met or exceeded)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<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>
## Difference Between 99204 and a 99205

<table>
<thead>
<tr>
<th>99204</th>
<th>99205</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Comprehensive Hx</td>
<td>• Comprehensive Hx</td>
</tr>
<tr>
<td>• Comprehensive Ex</td>
<td>• Comprehensive Ex</td>
</tr>
<tr>
<td>• Moderate MDM decision making</td>
<td>• High medical decision making</td>
</tr>
</tbody>
</table>

## Moderate Medical Decision Making (need two at same level or higher)

- **Number of Diagnosis:** 3 est pblms
doing well, 1 or 2 new problems
- **Amount of Data:** 3 or more
  - Lab
  - Radiographs
  - Medical records
  - Medicine tests not billed
- **Risk**
  - Moderate: Prescription drug management, undiagnosed new problem, one or more chronic conditions with mild exacerbation, progression or side effects of treatment
**High Medical Decision Making**  
*(need two at the same level or higher)*

- Number of diagnosis: 4 or more est pblms doing well; new pblms with additional workup
- Amount of data: 4 or more studies
- Risk
  - High:
    - Drug therapy requiring intensive monitoring for toxicity
    - One or more chronic illness with severe exacerbation, progression or side effects of treatment
    - Acute or chronic illness or injuries that pose a threat to life or bodily function

### ESTABLISH PT

<table>
<thead>
<tr>
<th>2 OF 3</th>
<th>99211</th>
<th>99212</th>
<th>99213</th>
<th>99214</th>
<th>99215</th>
</tr>
</thead>
<tbody>
<tr>
<td>HISTORY</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHEF COMPLAINT</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>HX PRESENT ILL</td>
<td>Brief</td>
<td>Brief</td>
<td>Extended</td>
<td>Extended</td>
<td></td>
</tr>
<tr>
<td>SYSTEM REVIEW</td>
<td>Prob, Pertinent</td>
<td>Extended</td>
<td>Complete</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAST HISTORY</td>
<td>Pertinent-1</td>
<td>Complete</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FAMILY HISTORY</td>
<td>Pertinent-1</td>
<td>Choice of 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOCIAL HISTORY</td>
<td>Pertinent-1</td>
<td>incl PFS Hx.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EXAM</th>
<th>document</th>
<th>document</th>
<th>document</th>
<th>document</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3 systems</td>
<td>4-6 systems</td>
<td>5-7 systems</td>
<td>8 systems</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### MED. DEC MAKING

<table>
<thead>
<tr>
<th>MGMT/OPTION DX</th>
<th>Minimal (1)</th>
<th>Limited (2)</th>
<th>Multiple (3)</th>
<th>Extensive (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMT DATA/COMPLEX</td>
<td>Minimal (1)</td>
<td>Limited (2)</td>
<td>Moderate (3)</td>
<td>Extensive (4)</td>
</tr>
</tbody>
</table>

- RISK OF COMPLICAT.
  - Minimal
  - Low
  - Moderate
  - High
Electronic Health Records

- Positive points
  - Guidance to the provider as to what is needed for appropriate levels of service
  - Templates may be created to either cover components or disease states
  - Data collection on patient population
  - ICD-10CM diagnoses may be loaded with PQRS measures easier to track

- Negative points
  - Components may not match one another
  - Coding components may lead the provider to coding higher than what is appropriate to medical decision making level

Documentation

- Translate medical record into codes = ICD-9 Codes and CPT Codes
- ICD-9 Coding
  - Review the rules for using ICD-9 codes
- ICD-10 CM Coding
  - Rules for using ICD-10CM diagnosis codes
Guidelines for Diagnosis Coding

• Always code the reason the patient sought medical advice as primary diagnosis
• Do not code probable, possible, rule/out
• Code to the highest degree of specificity documented
  – Statistic – 65% of all providers documentation lacks the degree of specificity required for ICD-10CM
• V codes can be used as primary or secondary diagnosis

Guidelines for Diagnosis Coding

• Chronic diseases can be coded multiple times, but acute diagnosis preceed chronic
  – ICD-10cm You may need to code both the chronic as well as the acute diagnosis if there is not a comprehensive code which covers both
• Nasal endoscopies, laryngoscopies, biopsies, allergy testing should be coded with findings
• E codes are supplemental and not used as primary diagnosis codes
• Multiple diagnosis may be used on one encounter but may need to link to separate services
Most Common Errors with ICD-9 Coding

• 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

ICD-10 CM Diagnosis Coding
**Information**

- Know where to access the latest information for implementation of ICD-10. Updates are still happening. [www.cms.hhs.gov](http://www.cms.hhs.gov)
- Within your practice you should be discussing the change and what will be required
- Create a timeline and flowchart for assignment of duties for everyone involved in diagnosis coding – may be more efficient to work from deadline backward

**Why?**

- ICD-10 will be more detailed moving from 14,000 code for ICD-9 to 70,000 or more codes for ICD-10
- Capacity to measure the quality, safety and efficacy of care
- Reduces the need for attachments to explain the patient’s condition
- Claims **should** be processed quicker
Why the Change to Transaction Code Sets – 5010

- Maximum number of diagnosis codes increased
- 5010 format accommodates 12 diagnosis codes per claim
- 5010 accommodates both ICD-9 and ICD-10 codes – very important looking ahead

Timelines

- ICD-10 CM will be required October 1, 2014
- Will be used by all providers in every health care setting
- No delays – no grace period - ??
Timelines

• ICD-9 CM diagnosis codes will not be accepted for services provided on or after October 1, 2014
• For inpatient scenarios use the date of discharge. If after October 1, 2014 use ICD-10CM diagnosis codes.

Responsibility

• Select a team to implement the changes in your office
• Each department should have a representative involved in the process – small office or large
• Determine what should be outsourced and what may be handled internally
Plan

- Budget – funds to operate practice if payments for services rendered are interrupted
- Manpower requirements – is the staff prepared and knowledgeable?
- Staff training – providers as well as support staff; who is the physician “champion”?
- Vendor contracts – what is it going to cost additionally?
- Office policy and procedures and impact on their documentation and structure

ICD-9 CM Versus ICD-10CM

**ICD-9-CM**
- 3-5 characters
- First character is numeric or alpha (E or V)
- Characters 2-5 are numeric
- Always at least 3 characters
- Use of decimal after 3 characters

**ICD-10-CM**
- 3 - 7 characters
- Character 1 is alpha (all letters except U are used)
- Character 2 is numeric
- Characters 3 -7 are alpha or numeric
- Use of decimal after 3 characters
- Use of dummy placeholder “x”
- Alpha characters are not case-sensitive
ICD-10 CM Character Layout

• 1ˢᵗ Character – name of section
• 2ⁿᵈ Character – body system
• 3ʳᵈ Character – etiology
• 4ᵗʰ Character – anatomical site
• 5ᵗʰ Character – severity
• 6ᵗʰ Character – device
• 7ᵗʰ Character- qualifier (extension) only used in some sections of the system

ICD-10CM Coding Guidelines

• Locate the term in the alphabetic index
• Verify the code in the tabular list
• Read instructional notations that appear in both alphabetic Index and tabular index
• A dash (-) at the end of an alphabetic index indicates that additional characters are required
ICD-10CM Coding Guidelines

• Codes are composed of codes with 3-7 characters
• Codes will be from A00.0 through T88.9, Z00-Z99.8
• Codes describing signs and symptoms are acceptable for reporting when a related definitive diagnosis has not been confirmed by the provider
• Chapter 18 - R00.0-R99 contain most of the signs, symptoms and abnormal clinical and lab finding codes

ICD-10CM Coding Guidelines

• Conditions that are an integral part of the disease process that are associated routinely with a disease process should not be assigned as additional codes; unless otherwise instructed
• Conditions that are not an integral part should be coded when present
ICD-10CM Coding Guidelines

• A combination code is a single code used to classify:
• Two diagnoses, or
  – A diagnosis with an associated secondary process (manifestation)
  – A diagnosis with an associated complication

ICD-10CM Coding Guidelines

• Coding for BMI
  – Code assignment may be based on medical record documentation from clinicians who are not the patient’s provider since this information is typically documented by other clinicians
  – Associated diagnosis such as overweight, obesity should be documented by provider and coded by provider
Examples of ICD-10CM

J30 Vasomotor and allergic rhinitis
- Includes: spasmodic rhinorrhea
- Excludes: allergic rhinitis with asthma (bronchial) (J45.909)
- rhinitis NOS (J31.0)
- J30.0 Vasomotor rhinitis
- J30.1 Allergic rhinitis due to pollen
  - Allergy NOS due to pollen
  - Hay fever Pollinosis

Examples of ICD-10CM

J31.0 Chronic rhinitis
- Atrophic rhinitis (chronic)
- Granulomatous rhinitis (chronic)
- Hypertrophic rhinitis (chronic)
- Obstructive rhinitis (chronic)
- Ozena
- Purulent rhinitis (chronic)
- Rhinitis (chronic) NOS
- Ulcerative rhinitis (chronic)
  - Excludes1: allergic rhinitis (J30.1-J30.9)
- Vasomotor rhinitis (J30.0)
Examples of ICD-10CM

- J30.2 Other seasonal allergic rhinitis
- J30.5 Allergic rhinitis due to food
- J30.8 Other allergic rhinitis
  - J30.81 Allergic rhinitis due to animal (cat) (dog) hair and dander
  - J30.89 Other allergic rhinitis
    - Perennial allergic rhinitis
- J30.9 Allergic rhinitis, unspecified

Breaking Down a Code:
J30.81 – Allergic Rhinitis Due to Animal Danders

- J00-J99 – Diseases of the respiratory system
- 30 – Vasomotor and allergic rhinitis
- .8 – other allergic rhinitis
- .81 animals versus house dust mites .89 – J30.89
Examples of ICD-10CM

J31 Chronic rhinitis, nasopharyngitis and pharyngitis
- J31.1 – Chronic nasopharyngitis
- Use additional code to identify:
  - Exposure to environmental tobacco smoke (Z77.22)
  - Exposure to tobacco smoke in the perinatal period (P96.81)
  - History of tobacco use (Z87.891)
  - Occupational exposure to environmental tobacco smoke (Z57.31)
  - Tobacco dependence (F17.-) tobacco use (Z72.0)

Other Codes

- Z77 - Other contact with and (suspected) exposures hazardous to health
- Z87.0 – Personal history of respiratory diseases
- Z87.8 Personal history of other specified conditions
Includes: Allergic (predominantly) asthma
• Allergic bronchitis NOS
• Allergic rhinitis with asthma
• Atopic asthma
• Extrinsic allergic asthma
• Hay fever with asthma
• Idiosyncratic asthma
• Intrinsic nonallergic asthma
• Nonallergic asthma

Use additional code to identify:
• Exposure to environmental tobacco smoke (Z77.22)
• Exposure to tobacco smoke in the perinatal period (P96.81)
• History of tobacco use (Z87.891)
• Occupational exposure to environmental tobacco smoke (Z57.31)
• Tobacco dependence (F17.-) tobacco use (Z72.0)
• Excludes: detergent asthma (J69.8)
• Eosinophilic asthma (J82)
• Lung diseases due to external agents (J60-J70)
• Miner’s asthma (J60)
• Wheezing NOS (R06.2) wood asthma (J67.8)
ICD-10CM

- **Excludes2**: asthma with chronic obstructive pulmonary disease
- Chronic asthmatic (obstructive) bronchitis
- Chronic obstructive asthma
- J45.2 Mild intermittent asthma
  - J45.20 Mild intermittent asthma, uncomplicated
    - Mild intermittent asthma NOS
  - J45.21 Mild intermittent asthma with (acute) exacerbation
  - J45.22 Mild intermittent asthma with status asthmaticus
- J45.3 Mild persistent asthma

ICD-10 CM

Peanut Anaphylaxis 995.61

- T78.00XA – Anaphylaxis peanut initial encounter
- T78.00XD – Anaphylaxis peanut subsequent encounter
- T78.00XS – Anaphylaxis peanut sequela encounter
• 7th character “A”, initial encounter is used while the patient is receiving active treatment for the condition. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.

• 7th character “D” subsequent encounter is used for encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase. Examples of subsequent care are: cast change or removal, removal of external or internal fixation device, medication adjustment, other aftercare and follow up visits following treatment of the injury or condition.
• 7th character “S”, sequela, is for use for complications or conditions that arise as a direct result of a condition, such as scar formation after a burn. The scars are sequelae of the burn. When using 7th character “S”, it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself. The “S” is added only to the injury code, not the sequela code. The 7th character “S” identifies the injury responsible for the sequela. The specific type of sequela (e.g. scar) is sequenced first, followed by the injury code.

ICD10-CM for Bee Sensitivity – 989.5

• T63.441A,D, S, - Toxic effect of venom bees – accidental
• T63.442- – toxic effect bees – intentional
• T63.443- – toxic effect bees – assault
• T63.444- - toxic effect bees - undetermined
ICD-10 Cough 786.2

- R05 (affected) (chronic) (epidemic) (nervous) bronchial, laryngeal spasmodic

Summary

2013
- Budget, plan
- Work on more specific documentation
- Document co-morbidities and the impact as part of the allergy/immunology evaluation
- Begin end to end testing through vendors to payers
Summary

2014

– Complete end to end testing with payers
– Begin to recognize the difference in the verbiage for diagnosis codes in your software
– Learn the general guidelines for choosing the appropriate code(s)
– October 1, 2014 – begin using the ICD-10CM codes
– May need to use both ICD-9 and ICD-10 if payers such as workman’s comp do not change

Resources

• [www.cms.hhs.gov/ICD10cm](http://www.cms.hhs.gov/ICD10cm)
• [www.aapc.com](http://www.aapc.com)
• [www.icddata.com](http://www.icddata.com)
• [www.aaaai.org](http://www.aaaai.org)
• COMPLIANCE

False Claims

• Fail to respond to inquiry
• Fail to adopt compliance plan
• Fail to implement compliance plan
• Advertise compliance violations
• Stand out against peers in utilization
• Fail to change practices after violation
• Correct your records after notice of audit
### Allergist Coding Curve

#### National

<table>
<thead>
<tr>
<th>Code</th>
<th>Percentage</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

<table>
<thead>
<tr>
<th>Code</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>3.98%</td>
</tr>
<tr>
<td>99212</td>
<td>6.77%</td>
</tr>
<tr>
<td>99213</td>
<td>55.25%</td>
</tr>
<tr>
<td>99214</td>
<td>31.09%</td>
</tr>
<tr>
<td>99215</td>
<td>2.91%</td>
</tr>
</tbody>
</table>
False Claims

• Re-bill denied services without checking for documentation
• Fail to read payer bulletins
• Rely on something “Cheryl” at the carrier told you without documenting the guidance received

Incident To Guidelines

• Applicable to ALL government entities – Medicare, Medicaid, Champus, Federal employees
• Incident to - physician has established a plan of care for an employee to follow
  – Physician must be on site when the service is provided
  – NP, PA may not supervise diagnostic test under incident to guidelines and bill the service under the physician
OIG Work plan for 2012-2013

1. Non-compliance with assignment guidelines
2. Incident to services
3. Place of service errors
4. Evaluation and management codes based on 2010 payments
5. E/M with modifiers
6. Claims with G modifiers
7. Payments for physician administered drugs and biologics
8. Medicare as a secondary payer

Medicare - 2013

- Conversion factor for Medicare for 2013 is the same as 2012 – at least for now
- E-Prescribing is required or a 1% deduct on Medicare reimbursement
- PQRS requires starting to report in 2013
- 2015 there will be a deduct for not participating in PQRS
- Phase II of Meaningful Use is implemented
RAC Reviews and Audits

• RAC scope includes pre-payment fraud, waste and abuse efforts not limited to credit balance audits, incorrect billing and processing errors, and lack of medical necessity

• Post payment RAC work includes data mining, medical records review, identifying overpayments

RAC Reviews and Audits – Connelly Consulting

• Incorrect billing of evaluation and management claims

• Physician evaluation and management services during same day global period

• Place of service errors for physician claims for service performed in an ASC or outpatient hospital

• Place of service errors for physician claims for service performed in hospital inpatient setting

• Duplicate claims - physician (carrier) CMS

• Modifier 59 – know when you can use it appropriately

• Excessive units - untimed codes
RAC and Other Payer Audits

- Focusing on allergy doses and testing
- E/M on the same date as testing
- Some allergists have been reviewed back for three years from Medicaid or Medicare
- Blue Cross in NJ has reviewed most allergists for E/M on the same day
- United is not paying in some states for E/M and testing on the same date unless notes are submitted

RAC Contractors

- Connelly Consulting
  - Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, North Carolina, New Mexico, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia, Puerto Rico and the U.S. Virgin Islands

- Health DataInsights
  - Alaska, Arizona, California, South Dakota, North Dakota, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, Oregon, Utah, Washington and Wyoming

- Diversified Collection Services
  - Vermont, New Hampshire, Maine, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, Delaware, Maryland, Washington DC, Pennsylvania

- CGI Technologies
  - Minnesota, Wisconsin, Michigan, Ohio, Indiana, Illinois, Kentucky
RAC Contractors

• Some of the services reviewed:
  – Modifier 59 – Know when you can use it appropriately
  – Modifier 25
  – Once in a lifetime
  – Excessive Units - untimed codes
  – Excessive Units - blood transfusions
  – Excessive Units - bronchoscopy
  – Excessive Units - IV Hydration
    1. IV Hydration should be billed with a maximum number of units (1) per patient per date of service

RAC Contractors

• Services Reviewed
  • Global vs TC/PC
  • Duplicate claims
  • Evaluation and management service
  • Not a new patient
  • Medically unlikely edits
  • Part B duplicates - automated review
Compliance Mistakes

- Collect dust on compliance plan
- Disciplinary procedures?
- Claim denials?
- Not following up on complaints
- No training for staff or physicians
- No auditing for errors
- Lack of attention toward credit balances
- Add-on codes paid without required primary code for professional services

Allergy CPT Changes for 2013

Allergy Procedures and Services
2013 CPT Changes

- Allergy testing code changes
- For administration of medications (eg, epinephrine, steroidal agents, antihistamines) for therapy for severe or intractable allergic reactions, use 96372
- 95004 – Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests (deleted “by a physician”)

2013 CPT Changes

- 95010 and 95015 – deleted
- 95017 – Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal) sequential and incremental, with venoms, immediate type reaction, including test interpretation and report. Specify number of tests
- RVU value 0.26
2013 CPT Changes

- 95018  Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal) sequential and incremental with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of test.
- RVU value 0.64

2013 CPT Changes

- 95024, 95027 – Deleted the wording “by a physician.”
- New subsection – Ingestion Challenge Testing
New Subsection – Ingestion Challenge Testing

- Codes 95076 and 95079 are used to report ingestion challenge testing. Report 95076 for initial 120 minutes of testing time (ie, not physician face to face time). Report 95079 for each additional 60 minutes of testing time.

- For total time less than 61 minutes (eg positive challenge resulting in cessation of testing). Report an evaluation and management service if appropriate.

Ingestion Challenge Testing

- Patient assessment/monitoring activities for allergic reaction are not separately reported
- Intervention therapy (eg injection of steroid or epinephrine) may be reported separately as appropriate
- For purposes of reporting testing times, if an E/M service is required, then testing time ends
2013 CPT Changes

- 95076 – Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance); initial 120 minutes – RVU value 3.42
- +95079 – each additional 60 minutes of testing RVU value 2.41
- Time will need to be documented in the testing document to support the coding

2013 CPT Changes

- 95120 – 95134 – added “in the office or institution of the prescribing physician or other qualified health care professional” including allergenic extract
2013 CPT Changes

- Pulmonary coding changes
- Subsection instruction changes – same as allergy section for definition for E/M billing in addition to pulmonary billing
  - 94014, 94016 added “physician or other qualified health care professional” to the code description

2013 CPT Changes

- Miscellaneous code changes
- 99000, 99001 – handling and/or conveyance of specimen for transfer from the office to a laboratory……delete “physician”
Summary

• Questions???
• Thank you