

Introduction to Coding and Billing

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Coding

- I have nothing to disclose

Background

- The desire to develop a consistent “language” to describe standard physician/patient interactions led to the current coding system we now have
- Two types of codes: HCPC Codes (procedure codes) & ICD codes (diagnostic codes)

Coding Systems

- Purpose: To provide a uniform language that will accurately describe the medical, surgical, and diagnostic services, and will thereby provide an effective means for reliable nationwide communication among physicians, patients and third parties
- Use for gathering population statistics and used for reports, outcome studies and cost analysis for covering patient populations in US and rest of the world

Background – HCPCS Codes

- AMA has standing committee that evaluates and adjusts the existence of the codes (Gary Gross and Dr. James Sublett are the allergy representatives)
- Just because a code exists and is used properly does not mean the involved third party payer accepts the code. (We are required to diligently monitor “explanation of benefits” or “EOBs”)

Procedure Coding Systems

- Health care provided to patients
- Health care services paid for by third party payers – Medicare, BC, UHC, Aetna, etc.
- Computer systems
- Communication between parties

Procedure Coding Systems

- Health Care Procedural Coding System (HCPCS):
 - First used in 1966
 - Definition: A listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians

Procedure and Diagnosis Coding Systems

- In 2000, the Department of Health and Human Services was designated as the national coding standard for physician and other health care professional services and procedures under the Health Insurance Portability and Accountability Act (HIPAA)

Healthcare Common Procedure Coding System (HCPCS)




- Codes that describe the patient interactions, from visits to testing procedures or treatment procedures. Fees are set for each “current procedural terminology” (CPT) code for your practice. Reimbursements are based on contract.
- Recent reviews now have established a relative value unit (RVU) for each code to try to create consistency based on work, malpractice, and overhead expense for each procedure

CPT Code Book

- Modifiers
- Introduction
- Place of Service codes
- Evaluation and Management Services
- Anesthesia
- Surgical Procedures
- Radiology Procedures
- Lab and Pathology Procedures
- Medicine Guidelines
- Category II Guidelines
- Category III Guidelines
- Appendix A-P
- Index

CPT Code Book

- Symbols

-  Revised code
-  New Code
-  New or Revised text
- + Add on Code
- # Out of numerical sequence code
- * Telemedicine

CPT Code Book

- Modifiers
- 22 – Increased procedural services
- 25 – Significant, separately identifiable E/M by the same physician or qualified health care professional on the same day of a procedure or other service.
- 26 - Professional component
- 32 – Mandated Service
- 52 – Reduced Services
- 76 – Repeat procedure or service by same physician or other qualified health care professional
- 95 – Telehealth services

CPT Code Book

- Place of Services –
- 02 – Telehealth
- 03 – School
- 11 – Office
- 12 – Home
- 19 – Off campus outpatient hospital
- 20 – Urgent care
- 21 - Hospital
- 22 – On campus outpatient hospital
- 23 – Emergency room – hospital
- 31 – Skilled nursing facility

HCPCS Level II Book

- Services not covered with a HCPCS Level I code
 - Example – cosmetic procedure
- Ambulance Procedures
- Dental Procedures
- Supplies and Durable Medical goods
- Medications
- Medicare specific Codes – Services, supplies, MIPS< Macra Codes
- Blue Cross specific codes

Documentation

Documentation – the beginning
for all coding

Document, Document, Document!!!!

- If it's not recorded, it did not happen!
- If it is illegible – it did not happen!
- If it is not specific, it may not be reimbursed
- If it is “cloned” it doesn't count

Documentation

- HIPAA:

- Documentation had to reflect the codes submitted for payment
- Law created for Health Care Fraud & Abuse Control through the HHS & OIG
- Covers Medicare, Medicaid and private health care industry

Documentation

- HIPAA - Penalties

- \$2,000-\$10,000 per incident & limit increased to not more than three times the amount
- Presenting a claim for an item or service based on a code that a person knows or should know will result in greater payment than appropriate
- Third party payers are doing a percentage error rate and then multiplying it times the universe of payments

Documentation

- Penalties
 - A person submits a claim that they know or should know is for a medical item or service not medically necessary
 - Criminal penalties for “knowingly and willingly” attempting to defraud

Diagnosis Coding

(The medical necessity
for the encounter)

Diagnosis Codes

- Created by the Centers for Disease Control and Center for Medicare and Medicaid services (CMS)
- Revised yearly
- Committees meet during the year and take recommendations from societies regarding changes, additions and deletions should be made to the code.
- ICD-11 is currently in review from the WHO for use
- Purposed change from ICD-10 to ICD-11

Diagnosis Codes

- Various publications available – in hard back form
- EHR - should be updated yearly with new codes
- “Favorites” list should be reviewed yearly to edit for deletions, corrections and additions
- One hard bound copy should be in your office

Diagnosis Codes

- Coding from a book
 - Code from the tabular section
 - Read the subsection heading guidelines
- Coding from an electronic device
 - Read subsection guidelines for code
 - Code to the specificity known at the time of coding

Diagnosis Codes

- All active diagnoses should be used in any patient interaction. Level of importance for that diagnosis should be documented
- Important to support complexity of visits later on and link each diagnosis to procedure

Diagnosis Codes

- Must link the diagnosis code with each procedure code used for billing purposes
- With ICD-10CM codes, you may use up to 12 diagnosis codes for each claim

Basics of Diagnosis Coding

- Select the code which corresponds to a diagnosis or reason for visit documented in the medical record.
- Diagnosis codes are reported at the highest level of specificity documented
- Codes that describe symptoms and signs as opposed to diagnoses are acceptable for reporting purposes when a related definitive diagnosis has not been established by the provider.
- Signs and symptoms that may not be associated routinely with a disease process should be coded separately.
- Acute and chronic may be reported if separate subentries exist. The acute code is sequenced first.

Basics of Diagnosis Coding

- Chapter J guidelines
 - When a respiratory condition is described as occurring in more than one site and is not specifically indexed, it should be classified to the lower anatomical site.
 - Use additional code where applicable 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)
 - Tobacco dependence (F17.---)
 - Tobacco use NOS (Z72.0)

Basics of Diagnosis Coding

- Excludes 1 – two codes may not be coded together on the same claim
 - J30 subsection
 - Excludes J45.909 – unspecified asthma
 - Excludes – J31.10 – rhinitis NOS
 - L50 – Urticaria
 - Excludes T78.3 – angioneurotic edema
 - Excludes L23. -- contact dermatitis
- Excludes 2 – two codes are usually not coded together but in some circumstances may be allowed
 - T78.05 anaphylactic reaction due to tree nuts and seeds
 - Excludes T78.01X- Anaphylactic reaction due to peanuts

Basics of Diagnosis Coding

- Chapter 19 – Injuries, poisoning and certain other consequences of external causes requires the 7th character
 - A – Initial encounter while the patient is receiving active treatment for the condition. Examples of active treatment – emergency department encounter and evaluation and continuing treatment by the same or a different physician
 - B – 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 - medication adjustment, other aftercare and follow up visits following treatment of the injury or condition
 - S – residual effects (condition produced) after the acute phase of an illness has terminated.

There is no time limit. Sequela coding generally requires two codes sequenced in the following order: The condition or nature of the sequela is sequenced first. The sequela code is sequenced second.

Basics of Diagnosis Coding

- Chapter 19 – Subsection guidelines for poisoning, adverse effects of, under-dosing of drugs, medicaments, and biological substances (T36-T50)
 - Includes adverse effect of correct substance properly administered
 - Poisoning by wrong substance given or taken in error
 - Poisoning by overdose of substance
 - Under-dosing by (inadvertently)(deliberately) taking less substance than prescribed or instructed
- Code first, for adverse effects, the nature of the adverse effect (examples)
 - Dermatitis due to substances taken internally
 - Urticaria
 - Pruritus
 - Erythema
- Codes from the T36-T50 will be sequenced second

Basics of Diagnosis Coding

- Status – Indicates that a patient is either a carrier of a disease or has the sequelae or residual of a past disease or condition
 - The status code is informative, because the status may affect the course of treatment and outcome
- History – Indicates that the patient no longer has the condition
- Do not use the status code with a diagnosis code from one of the body system chapters if the diagnosis code includes the information provided by the status code.
- Alphabetical index list food and bee Z codes under “history – personal – allergy”

Basics of Diagnosis Coding

- Z codes
 - Z codes may be listed as a primary codes
 - Z23 – is for encounters for vaccinations
 - The procedure code required will identify the actual administration of the injection and the types of immunizations given
 - Z01.82 – Encounter for allergy testing without complaint, suspected or reported diagnosis
 - Z88- - Allergy status to drugs, medications and biological substances
 - Z20.828 – Exposure to a person with confirmed COVID-19
 - Z03.818 – Possible exposure to COVID19 – Rule out
 - Z09 - Patient seen in follow-up during COVID19 treatment
 - Z86.19 – Personal history of COVID19 after COVID has resolved

Other New Diagnosis Codes for 2021

- U07.1 COVID-19
 - Use only if the patient has confirmed COVID19 infection
 - This may be by test results or documentation from provider
 - If there are respiratory manifestations, code U07.1 first followed by codes for the manifestations
 - Examples – COVID19 patient with acute bronchitis confirmed as due to COVID19 assign codes U07.1 and J20.8
- D84.81 – Immunodeficiency due to conditions classified elsewhere
 - Excludes 1 – certain disorders involving the immune mechanisms
 - (D80-D83, D84.0, D84.1, D84.9)
- D84.82 – Immunodeficiency due to drugs and external causes
 - D84.821 – Immunodeficiency due to drugs – code the appropriate T code for the drug as an additional code
 - D84.822 – Immunodeficiency due to external causes
 - D84.89 – Other immunodeficiency
- D89.83X- Cytokine release syndrome Grade 1 through 5 and unspecified

Other New Diagnosis Codes for 2021

- J82.83 – Eosinophilic Asthma
 - Code first asthma by type such as mild, moderate or severe
- J82.89 – Other pulmonary eosinophilia, not elsewhere classified includes allergic pneumonia
- R51.9 – Headache, unspecified includes facial pain NOS

Evaluation and Management Coding

AMA and CMS Changes

- Revisions only apply to CPT 99201-99215
 - Elimination of history and physical as elements for code selection
 - Providers may choose whether to use MDM (Medical decision making) or total time
 - Modifications to criteria for medical decision making
 - Deletion of CPT code 99201

Evaluation and Management Changes (99202-99215 only)

- Burden reduction
 - Reduce note “bloat” and documentation for coding, without impeding good patient care
 - Only document relevant history and perform relevant exam when appropriate for you patient.
 - Simplify code selection criteria making it more clinically relevant
 - Consistency across payers by adding details to guidelines

History and Exam Changes

- Medically appropriate history and/or exam should be performed.
- Nature and extent of the history and/or exam is determined by the treating provider.
- Care team may collect information and the patient or caregiver may supply information (portal or questionnaire) that is reviewed by the reporting provider.
- History and exam are not elements in selection of appropriate code.

Time Revisions

- Time is the total time on the date of the encounter.
- Includes both face-to-face and non face-to-face time personally spent by the provider on the day of the encounter
- Does not include activities normally performed by clinical staff

Time Includes the Following

- Preparing to see the patient (review of tests)
- Obtaining and/or review separately obtained history
- Performing a medically appropriate exam
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals
- Documenting clinical information in EHR or other health record
- Independently interpreting results & communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

Separately Reported Services

- Performance and/or interpretation of diagnostic tests during a patient encounter are not included in determining the level of E/M when separately reported.
- Diagnostic tests with specific CPT codes may be reported separately in addition to the appropriate E/M code.
- Diagnostic tests which are not reported separately may be included as part of the medical decision making

Definitions for Medical Decision Making

- Problem - a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter with or without a diagnosis being established at the time of the encounter
- Problem addressed – When it is evaluated or treated at the encounter by the provider reporting the service
 - Testing or treatment is considered but may not be elected
 - Notation another professional is managing the problem without additional assessment does not qualify as addressed.
 - Referral without evaluation does not qualify

Definitions for Medical Decision Making – Number & Complexity of Problems Addressed

- Minimal problem – may not require the presence of the provider but the service is provided under the provider's direct supervision.
- Self-limited or minor – runs a definite & prescribed course, is transient in nature and is not likely to permanently alter health status (cold)
- Stable chronic illness – expected duration of at least a year or until the death of the patient.
 - Stable – patient is at treatment goals
 - Chronicity – stage of severity does not effect definition of chronic

Definitions for Medical Decision Making – Number & Complexity of Problems Addressed

- Acute uncomplicated illness or injury:
 - *Short term problem with low risk of morbidity which treatment is considered.*
 - *Examples – cystitis, allergic rhinitis or a simple sprain*
- Chronic illness with exacerbation, progression, or side effects of treatment:
 - *Acutely worsening, poorly controlled or progressing with an intent to control progression & requires supportive care*
- Undiagnosed new problem with uncertain prognosis –
 - *A differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment – example lump in breast*

Definitions for Medical Decision Making – Number & Complexity of Problems addressed

- Acute Illness with systemic symptoms –
 - *Has a high risk of morbidity without treatment*
 - *May be single system or multi-system*
 - *Examples – pyelonephritis, pneumonitis, or colitis*
- Acute, complicated injury
 - *An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or treatment options are multiple and/or associated with risk of morbidity.*

Definitions for Medical Decision Making – Number & Complexity of Problems Addressed

- Chronic illness with severe exacerbation, progression, or side effects of treatment –
 - *The illness or severe side effects of treatment have significant risk of morbidity and may require hospital level of care*
- Acute or chronic illness or injury that poses a threat to life or bodily function
 - *---poses a threat to life or bodily function in the near term without treatment. Examples – MI, pulmonary embolus, severe respiratory distress*

Medical Decision Making –Amount &/or Complexity of Data

- Tests: imaging, laboratory, psychometric or physiologic data.
- External: communications and/or test results are from an external provider facility or healthcare organization
- External provider: An external provider is an individual who is not in the same group practice or is a different specialty or subspecialty.
- Independent historian: An individual (parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history or a confirmatory history is judged to be necessary.

Medical Decision Making –Amount &/or complexity of Data

- Independent Interpretation: Interpretation of a test which has a CPT code and an interpretation is customary
- Appropriate source: Includes professionals who are not health care professional but may be involved in the management of the patient. Does not include discussion with family or informal caregivers

Medical Decision making – Risk of complications, morbidity, mortality of patient management

- Risk: - level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization.
- Morbidity – A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.
- Social determinants of health – Economic and social conditions that influence that health of people and communities – food or housing insecurity

Medical Decision making – Risk of complications, morbidity, mortality of patient management

- Drug therapy requiring intensive monitoring for toxicity:
 - *Therapeutic agent that has the potential to cause serious morbidity or death*
 - *Assessment is performed for adverse effects*
 - *According to Medical standards*
 - *Monitoring may be by lab, a physiologic test or imaging.*
 - *History and exam does not constitute monitoring*

Medical decision making 99202/99212 Level – straightforward 2 out of 3 must at same level or higher

- Number and complexity of problems addressed:
 - 1 self-limited or minor problem
- Amount and/or complexity of data to be reviewed and analyzed:
 - Minimal or none
- Risk of complications and/or morbidity or mortality of pt mgmt.
 - Minimal risk or morbidity from additional diagnostic testing or treatment

Medical decision making 99203/99213 Level – Low 2 out of 3 must at same level or higher

- Number & complexity of problems addressed:
 - Low – 2 or more self limited or minor problem, or 1 stable chronic illness; or 1 acute, uncomplicated illness
- Amount and/or complexity of data to be reviewed and analyzed
 - Limited – (must meet the requirements of at least 1 or 2 categories
 - Category 1: Test and documents (any combination of 2 from the following:
 - Review of prior external note(s) from each unique source
 - Review of the result(s) of each unique test
 - Ordering of each unique test
 - **OR**
 - Category 2: assessment requiring and independent historian(s)
- Risk – low risk of morbidity from additional diagnostic testing or treatment

Medical decision making 99204/99214 Level - moderate

- Number & complexity of problems addressed:
 - 1 or more chronic illness with exacerbation, progression, or side effects of treatment Or 2 or more stable chronic illness; or 1 undiagnosed new pbm with uncertain prognosis or 1 acute illness with systemic symptoms
- Amount & complexity of data to be reviewed and analyzed: (must meet at least 1 out of the 3 categories)
 - Category 1 – any combination of 3 from the following: Review of prior external note(s) from each unique source; review of the result(s); order each unique test; assessment requiring an independent historian(s)
 - Category 2 – Independent interpretation of tests performed by another physician
 - Category 3 – Discussion of management or test interpretation with external physician/other qualified health care provider not separately reported
- Risk – Prescription drug mgmt., diagnosis or tx significantly limited by social determinants of health.

Medical decision making 99205/99215 Level - high

- Number & complexity of problems addressed:
 - 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment Or 1 acute or chronic illness posing a threat to life or bodily function
- Amount& complexity of data to be reviewed and analyzed: (must meet at least 2 out of the 3 categories)
 - Same categories as level 4 except it requires two instead of one categories to be met.
- Risk – examples only
 - drug therapy requiring intensive monitoring for toxicity
 - Decision regarding elective major surgery with identified patient or procedure risk factors
 - Decision regarding emergency major surgery
 - Decision regarding hospitalization
 - Decision not to resuscitate or to de-escalate care because of poor prognosis

Time

- Time may be used for level of code whether or not counseling and/or coordination of care dominates the service.
- Time is the total time on the date of services
- Time may only be used for selecting the level of other E/M services when counseling and/or coordination of care dominates the service
- If physician or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211
- When prolonged time occurs, the appropriate add-on code may be reported. The time should be documented in the medical record when it is used for the basis for the code.

Time Guidelines for E/M

- | | |
|---|---------------------------|
| • 99202 – 15-29 Min | 99211 – no time reference |
| • 99203 – 30-44 Min | 99212 – 10-19 Min |
| • 99204 – 45- 59 Min | 99213 – 20 -29 Min |
| • 99205 – 60-74 Min | 99214 – 30-39 Min |
| • 99XXX - 75 min & up | 99215 – 40-54 Min |
| • 99XXX - 55 min or longer | |
| • ***99417 – for each additional 15 minutes on and beyond the time for 99205 or 99215 only. | |

Prolong time codes for 2021

- CPT 99354, 99355 – will continue to require face to face time by the provider.
- New Code 99XXX – will only be used when time has been the determinant for level of base E/M – Per 15 minutes
 - May only be used on 99205, 99215
 - Must have at least 15 minutes on and beyond 99205, 99215
- **99415 – Prolong staff time with face to face patient time
 - Changed from 45 minutes required to 30 minutes required prior to reporting first hour. Bill in addition to provider E/M

Services reported separately

- The performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when reported separately. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately in addition to the appropriate E/M code.

Allergy Testing and Immunotherapy Documentation

- Document the medical necessity of testing based on hx, ex , MDM for the patient
- Document the results of the allergy testing together with the actual test
- Document the need for immunotherapy versus other pharmaceutical options
- Document the recipe
- Document the number of anticipated doses the patient will receive when preparing the doses
- Document review and orders for reviews for immunotherapy

New Patients versus Consults

- Consultations require history, exam and medical decision making based on either 1995 or 1997 guidelines
- Inpatient services are also still requiring documentation based on 1995 or 1997 guidelines
- Consultation requires a request from another provider for your opinion and advise
- Your opinion must be rendered back to the requesting provider
- There cannot be a transfer of care prior to seeing the patient.
- Many payers are not covering consultation codes since CMS has stopped recognizing the 99241-99245 as payable codes

Additional Documentation Requirements for Consultations

- Note must state that the patient was sent for consultation and state the requesting physician's name as well as the reason for the consult
- Note must state the findings
- Note must indicate that a report was sent to the requesting physician
- Assumption is that patient's follow up care may be provided by requesting physician

CONSULT-HOSPITAL	99251	99252	99253	99254	99255
CONSULT-3 of 3	99241	99242	99243	99244	99245
HISTORY					
CHIEF COMPLAINT	Required	Required	Required	Required	Required
HX of PRESENT ILL	Brief(1-3)	Brief(1-3)	Extended(4+)	Extended(4+)	Extended(4+)
REVIEW OF		Problem	Extended	Complete	Complete
SYSTEMS		Pertinent (1)	(2-9 System)	(10 + system)	(10+ system)
PAST HX			Pertinent-1	Complete-1ea	Complete-1ea
FAMILY HX			Pertinent-1	Complete-1ea	Complete-1ea
SOCIAL HX			Pertinent-1	Complete-1ea	Complete-1ea
	Perform/ document	Perform/ document	Perform/ document	Perform/ document	Perform document
EXAM	1 organ sys	2-4 organ sys	5-7 organ sys.	8 organ systems	8 organ systems
MED. DEC MAKING	(2 of the 3 must be met or exceeded)				
MGMT OPT. & DX.	Minimal (1)	Minimal (1)	Limited (2)	Multiple (3)	Extensive(4)
AMT DATA & COMPLEX	Minimal(1)	Minimal (1)	Limited (2)	Moderate (3)	Extensive(4)
RISK OF COMPLICAT.	Minimal	Minimal	Low	Moderate	High

Basic Allergy Procedures

CPT Code addition

- 99072 – additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s) when performed during a public health emergency as defined by law due to respiratory transmitted infectious disease
- 86413 – Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease {COVID-19} antibody, quantitative)

New Code for 2021

- ***94619 – Exercise test for bronchospasm with pre and post spirometry and pulse oximetry without ECG.

Pulmonary Codes

- PFTs:
- 94010 – spirometry
- 94060 – Bronchodilation responsiveness, spirometry as in 94010, pre and post bronchodilator administration
- 94070 – Bronchospasm provocation evaluation, multiple spirometric determinations with administered agents
- 95070 – Inhalation bronchial challenge testing

Allergy Testing Codes

- Skin testing codes:
 - 95004 - Scratch testing
 - 95024 - Intradermal
- Precutaneous/Intradermal:
 - 95017 – venoms
 - 95018 – drugs or biologicals
- 95044 - Patch tests:
- Remember you need to document the results of the tests as part of the testing code

Specific allergy coding

- CPT 96401 – 96372 Biologics administration and reimbursement
 - Prefilled syringes do not meet all of the requirements for use of CPT 96401
 - Payer specific as to which code is allowed for biologics
 - If administering a biologic in office which may be administered by patient, document the medical necessity for the encounter and administration
 - Buy and Bill – make sure you are not losing money due to
 - Lack of support from pharmaceutical
 - Office support staff for verification and pre-authorizations
 - Financial risk for cost of products.
 - CMS will require you to use the smallest size available for your drug.
 - Documentation must contain amount used and amount wasted.

Specific allergy coding

- Drug testing, challenge and desensitization
 - CPT 95018 for percutaneous and intradermal testing
 - Oral challenge – 95076, 95079 if administering sequential and incremental doses
 - Subcutaneous challenge – CPT does not have a code
 - Options: 96372 multiple times or 95199 unlisted procedure with documentation to support the value of the code.

Allergy Codes

Immunotherapy codes:

- 95165 - Professional services for the supervision or preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specific number of doses)
- 95145-8 for venoms
- 95170 – Fire ant extract or other biting insect
- 95115 or 95117 - Extract administration

Payment for services

Payment Methodology

Usual and customary terms:

- RVU – Relative value units
- ACO – Accountable Care Organizations
- MH – Medical home models
- Value based payments for containing cost
- MACRA's MIPS

Medicare Part A vs. Part B – Private Payers

- Part A – hospitals are reimbursed with DRG's
- Part B – physician and non-physician provider reimbursement for fee for service
- Medicare Advantage programs –adopts some of third party payer guidelines but must follow Medicare guidelines for medical necessity
- Other payers may use RVU values and a conversion factor determined by their actuary.

Payment Methodology

- Usual and customary was used until 1992 for reimbursement of services provided by physicians and other health care entities
- RVU – Relative value units
 - Based on a scientific basis to determine values of codes: work, practice expense, malpractice
 - Non facility or facility
 - GPCI (Geographic Price Cost Index)

The Value of CPT Codes by CMS

- $\text{Payment} = (\text{work} \times \text{GPCI} + \text{PE} \times \text{GPCI} + \text{MP} \times \text{GPCI}) \times \text{CF}$

RVUs CMS Fee Schedule

- Headings
- Columns
- Values
- (Let's look at some codes)
- www.cms.gov/PhysicianFeeSched/PFSRVF/

The Value of CPT Codes by CMS

- $\text{Payment} = (\text{work} \times \text{GPCI} + \text{PE} \times \text{GPCI} + \text{MP} \times \text{GPCI}) \times \text{CF}$

RVUs CMS Fee Schedule

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- (Let's look at some codes)
- www.cms.gov/PhysicianFeeSched/PFSRVF/

RVU quick look

- Code – 95004
- Description – Percut allergy skin test
- Status code – A – Active
- Work RVU – 0.1
- Non-fac PE – 0.11
- Fac PE – 0.0
- Mal Prac – 0.01
- Total non Fac – 0.13
- Total Fac – 0
- Conversion factor -- \$32.26
- GPCI for local area for MAC to apply
- Physician supervision 02 – (direct)

CPT/ HCPCS	Status	Description	Work RVU's	2020 Non- Facility PE RVU's	2021 Non- Facility PE RVU's	2020 Facility PE RVU's	2021 Facility PE RVU's	2020 Malprac tice RVU's	2021 Malprac tice RVU's	2020 total non- Facility RVU's	2021 Total Non- Facility RVU's	2020 Total Facility RVU's	2021 Total Facility RVU's
95004	A	Percut allergy skin tests	0.01	0.10	0.11	NA	NA	0.01	0.01	0.12	0.13	0.12	NA
95012	A	Exhaled nitric oxide meas	0.00	0.55	0.60	NA	NA	NA	0.01	0.56	0.61	0.56	NA
95017	A	Perq & icut allg test venoms	0.07	0.15	0.19	0.03	0.03	0.01	0.01	0.24	0.27	0.11	0.11
95018	A	Perq&ic allg test drugs/biol	0.14	0.45	0.51	0.05	0.06	0.01	0.01	0.60	0.66	0.2	0.21
95024	A	Icut allergy test drug/bug	0.01	0.21	0.25	0.01	0.01	0.01	0.01	0.23	0.27	0.03	0.03
95027	A	Icut allergy titrate-airborn	0.01	0.12	0.13	NA	NA	0.01	0.01	0.14	0.15	0.14	NA
95028	A	Icut allergy test-delayed	0	0.35	0.40	NA	NA	0.01	0.01	0.36	0.41	0.36	NA
95044	A	Allergy patch tests	0	0.14	0.15	NA	NA	0.01	0.01	0.15	0.16	0.15	NA
95052	A	Photo patch test	0	0.17	0.19	NA	NA	0.01	0.01	0.18	0.20	0.18	NA
95056	A	Photosensitivity tests	0	1.30	1.43	NA	NA	0.01	0.01	1.31	1.44	1.31	NA
95060	A	Eye allergy tests	0	0.98	1.07	NA	NA	0.01	0.01	0.99	1.08	0.99	NA
95065	A	Nose allergy test	0	0.71	0.84	NA	NA	0.01	0.01	0.73	0.85	0.73	NA
95070	A	Bronchial allergy tests	0	0.90	1.05	NA	NA	0.02	0.02	0.93	1.07	0.93	NA
95076	A	Ingest challenge ini 120 min	1.5	1.80	2.04	0.57	0.64	0.06	0.07	3.37	3.61	2.13	2.21
95079	A	Ingest challenge addl 60 min	1.38	0.97	1.09	0.53	0.58	0.06	0.06	2.40	2.52	1.96	2.02
95115	A	Immunotherapy one injection	0	0.24	0.26	NA	NA	0.01	0.01	0.26	0.28	0.26	NA

Billing

- Credentials with payers
- Contracts with payers
 - Allowed amounts known and keyed into practice management system
 - Denials are identified and worked prior to any write offs
 - Appeals
 - Timeliness for payment

Questions???

- Thank you for attending.