Basic Coding for the Allergist

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• I have nothing to disclose

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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)

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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

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Background – HCPCS Codes

- AMA has standing committee that evaluates and adjusts the existence of the codes (Gary Gross is the allergy representative)

- 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")

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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

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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

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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)

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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

CMS - RVU

- Values for RVUs are modified on a yearly basis
- Three components – work RVU, overhead RVU, malpractice RVU
- Conversion factor is determined by Congress and CMS based on economic index factor

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

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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

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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

- Payment = (work x GPCI +PE x GPCI +MP x GPCI) x CF

RVUs CMS Fee Schedule

- Headings
- Columns
- Values
- (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 – 0.13 – 2017 .17
- Fac PE – 0.13 – 2017 .17
- Mal Prac – 0.01
- Total non Fac – 0.15
- Total Fac – 0.15
- Conversion factor - $35.9996
- GPCI for local area for MAC to apply
- Physician supervision - 02 (direct)

Diagnosis Codes

- Created by the Center of Disease Control and Center of Medicare and Medicaid services
- 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
- Proposed change from ICD-10 to ICD-11 – 2019???

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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

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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

Evaluation and Management Review

- In a study report, the Office of the Inspector General (OIG) noted that 42 percent of claims for Evaluation and Management (E/M) services in 2010 were incorrectly coded, which included both up-coding and down-coding (i.e., billing at levels higher and lower than warranted), and 19 percent were lacking documentation

- A number of physicians increased their billing of higher level, more complex and expensive E/M codes

- Many providers submitted claims coded at a higher or lower level than the medical record documentation supports

Coding for Evaluation and Management Services

CPT 99201-99215

Codes Based on Complexity of Visit

Three key components:

- History
- Examination
- Medical decision making
- Time - only if 50% or more of the encounter is counseling and coordination of care

General Principles of Documentation

- Complete & legible
- Each encounter should include:
  - Chief complaint
  - Relevant history
  - Physical exam findings
  - Prior diagnostic tests
  - Assess/impression/diagnosis
  - Plan for care
  - Date & verifiable legible identity of the provider

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Chief Complaint

- Chief Complaint can be part of the HPI or separate
  - Chief complaint is to be in the patient's own words or summary of the reason why the patient is seeking medical care
  - If chief complaint is for a "procedure or diagnostic test" third party payers will consider the E/M "incidental" to the procedure or diagnostic test and will not reimburse for the E/M

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Relevant History

- The billing provider is responsible for obtaining and documenting the history of present illness. The review of systems, past, family and social history may be obtained by the staff, but it needs to be reviewed by the provider.

History Levels

- Patient history taking can range from brief (chief complaint only) to very detailed and extensive including complete review of systems, past history & social history

- MUST DOCUMENT IF CLAIMING TO BE DONE!!!

HPI: History of Present Illness

- 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.

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HPI: History of Present Illness

- Context - how complaint occurred
- Modifying factor- what has alleviated symptoms
- Signs and symptoms – additional information from patient

- **HPI elements must be obtained by the physician/NPP**

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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

Review of Systems

- Can be documented by staff
- Must be reviewed by physician
- Can be separate or part of the HPI
- Cannot use one statement in both categories

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

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Physical Exam

- Pertinent positives and negatives need to be documented to count toward the appropriate level of E/M
- Document what you find and what you exam even if it is negative.
- Remember if it isn't documented ……

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Exam

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

Physical Examination

- **Problem Focused** – one body area or organ system; Level 1
- **Expanded Problem Focused** – 2-4 body areas or organ systems; Level 2-3 – established pt.
- **Detailed** – 5-7 body areas or organ systems; Level 4 – established pt
- **Comprehensive** – 8 or more body areas or organ systems; Level 5 – established pt

Diagnostic Tests

- The medical decision to order tests, review tests or perform diagnostic testing needs to be indicated in the body of the E/M
- CMS indicated several years ago the lack of medical necessity in allergy for performing allergy testing and desensitization was found in many cases reviewed

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Assessment, Impression

- If diagnoses are documented as "rule out possible, probable, I think it is consistent with, etc" the correct diagnoses to code on the billing are the presenting signs and symptoms for the patient
- If a definitive diagnosis is documented, the definitive diagnosis is the appropriate diagnosis to use on the billing

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Documentation Principles

- If not specifically documented, the rationale for ordering diagnostic test and other ancillary services should be able to be easily inferred

- Past & present diagnosis and conditions should be accessible to the treating and/or consulting provider, but not coded unless they are addressed today

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Allergy Testing and Immunotherapy Documentation

- Document the medical necessity of testing based on hx, ex 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

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Documentation Principles

- Appropriate risk factors should be identified
- Progress, response, changes in treatment, planned follow-up care and instructions, and diagnosis
- CPT **& ICD10-CM codes** should be the same on the billing form as in the chart

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Plan/Recommendation

- This information is necessary to indicate how the patient is going to be cared for currently and for future services
- Signature of the provider indicates that the provider is attesting to the validity of the encounter and the encounter supports the charges presented to either the patient or the insurance carrier
- Attesting provider is accountable for any other person's documentation in the patients' chart

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New Patients versus Consults

- 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

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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

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Follow up visits – 99211-99215

- Follow up office visit codes require a less stringent criteria to establish "complexity" levels
- A patient seen by any provider in your office within the last 3 years is a follow up visit patient
- If the physician changes practices, patient is considered established
- More than 3 years between visits makes the interaction a "new" patient visit

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Medical Decision Making

- Number of diagnosis and treatment options
- Amount of data and complexity of data
- Risk

Number of Diagnosis and Treatment Options

- Established problem stable

- Established problem worsening

- Established problem, improved

- New problem, no workup planned

- New problem, workup planned

Amount and Complexity of Data

- Review/order lab tests
- Review/order routine x-rays
- Review/order medicine tests
- Discussion of tests results with performing physician

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Amount and Complexity of Data

- Decision to obtain old records and document
- Direct visualization and independent interpretation documented

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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

- 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

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Presenting Problem

- High:
  - Chronic illness with severe exacerbation
  - Acute or chronic illness/injury that may pose a threat to life or bodily function

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Diagnostic Procedures Ordered

- Minimal:
  - Lab tests requiring venipuncture
  - X-rays
  - Ultrasounds
- Low:
  - Superficial needle biopsies
  - Skin biopsies
  - Pulmonary function tests

Management Options

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

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

Management Options

- Moderate:
  - Minor surgery with risk
  - Elective major surgery
  - **PRESCRIPTION DRUG MANAGEMENT**
  - Closed treatment of fracture w/o manipulation

Management Options

- 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

Number of Diagnosis or Treatment Options	Number	Points	Results
A	B X	C =	D
Self –limited or minor (stable improved or worsening)	max = 2	1	
Est. pblm (to examiner) stable, improved		1	
Est. pblm (to examiner) worsening		2	
New pblm (to examiner); no additional w/u	max = 1	3	
New pblm (to examiner); add. w/u planned		4	
Total			

Amt/Complex or Data Reviewed	Pts
Review &/or order of clinical lab tests	1
Review &/or order tests in the rad. sect. of CPT	1
Review &/or order tests in the med. sect of CPT	1
Discussion or test results –performing phy.	1
Decision to obtain old records &/or obtain history from someone other than pt.	1
Rev. & summarization of old records &/or obtaining hx from someone other than pt. &/or discussion of case with another physician	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2
Total	

Level of Risk	Presenting Problem (s)	Diagnostic Procedure(s) ordered	Management Options selected
Minimal/ Straight-forward Complexity	>One self limited or minor problem e.g., cold, insect bite, tinea corporis	>Laboratory tests requiring venipuncture >Chest x-rays >EKG/EEG >Urinalysis >Ultrasound;e.g.,echo >KOH prep	>Rest >Gargles >Elastic bandages >Superficial dressings
Low Complexity	>Two or more self-limited or minor pblms. >One stable chronic illness e.g., well controlled hypertension or non insulin dependent diabetes cataract, BPH >Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	>Physiologic tests not under stress, eg. pulmonary function tests >Non-cardiovascular imaging studies with cataract,eg, barium enema >Clinical laboratory tests requiring arterial puncture >Skin biopsies	>Over the counter drugs >Minor surgery with no identified risk factors >Physical therapy >Occupational therapy >IV fluids without additives >Morbidity low/full recovery expected
Moderate Complexity	>One or more chronic illness with mild exacerbation, progression, or side effects of treatment >Two or more stable chronic illnesses undiagnosed new problem with uncertain prognosis, eg, lump in breast >Acute illness with systemic symptoms, eg. pyelonephritis, pneumonitis, colitis >Acute complicated injury, eg, head injury with brief loss of consciousness	>Physiologic tests under stress eg, cardia stress test, fetal contraction stress test >Diagnostic endoscopies with no identified risk facts >Deep needle or incisional biopsy >Cardiovascular imaging studies with contrast and no identified risk factors, eg arteriogram, cardiac catharization	>Minor surgery with identified risk factors >Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors >Prescription drug management >Therapeutic nuclear medicine >Moderate morbidity/mortality without treatment. Prolonged functional impairment possible
High Complexity	>One or more chronic illness with severe exacerbation, progression, or side effects of treatment >Acute or chronic illnesses or injuries that pose a threat to life or bodily function, eg. multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure	>Cardiovascular imaging studies- contrast with identified risk factors >Cardiac electrophysiological tests >Diagnostic Endoscopies with identified risk factors	>Emergency major surgery (open, percutaneous or endoscopic) >Parenteral controlled substances >Drug therapy requiring intensive monitoring for toxicity >Decision not to resuscitate or to de-escalate care because of poor prognosis >High morbidity/mortality without treat-ment. Severe prolonged functional impairment probable.

Final Result for Complexity
Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2nd circle from the left.

Final Result for Complexity					
A	Number diagnoses or treatment options	< 1 Minimal	2 Limited	3 Multiple	> 4 Extensive
B	Amount & complexity of data	< 1 Minimal	2 Limited	3 Multiple	> 4 Extensive
C	Highest Risk	Minimal	Low	Moderate	High
Type of Decision Making		STRAIGHT	LOW	MODERATE	HIGH

TIME
If the physician documents total time and suggests that conseling or coordinating c than 50%) the encounter, time may determine level of service. Documentation ma differential diagnosis, risks, benefits of treatment, instructions, compliance, risk red another health care provider.

Does documentation reveal total time? Face to face -outpt.; floor - inpt.	☐
Does documentation describe the content of counseling or coordinating of care?	☐
Does documentation reveal that more than half of the time was counseling or coordinating of care?	☐
If all answers are "yes" select level based on time	

Key Components: Medical Decision Making

- Straightforward   Level 1 & 2

- Low   Level 3

- Moderate   Level 4

- High   Level 5

- Medical decision making remains the same for new patients, established patients, inpatient and outpatient consultations

Calculation of Level of Complexity

- For new patients the level is based on the lowest level of the three key components
- For established patients based on the lowest level of 2 out of 3 components
- Medical decision making must always be one of the two components for an established patient encounter
- Medical necessity is the over arching criteria

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CONSULT-HOSPITAL	99251	99252	99253	99254	99255
CONSULT-3 of 3	99241	99242	99243	99244	99245
NEW PT- 3 of 3	99201	99202	99203	99204	99205
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/	Perform/	Perform/	Perform/	Perform
EXAM	document	document	document	document	document
	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

ESTABLISH PT	Level 1	Level 2	Level 3	Level 4	Level 5
2 OF 3	**99211**	**99212**	**99213**	**99214**	**99215**
HISTORY					
CHIEF COMPLAINT	Required	Required	Required	Required	Required
HX PRESENT ILL.		Brief	Brief	Extended	Extended
SYSTEM REVIEW			Prob. Pertinent	Extended	Complete
PAST HISTORY				Pertinent-1	Complete:
FAMILY HISTORY				Pertinent-1	Choice of 2
SOCIAL HISTORY				Pertinent-1	ele PFS Hx.
		Perform/	Perform/	Perform/	Perform/
EXAM		document	document	document	document
		1-3 systems	4-6 systems	5-7 systems	8 systems
MED. DEC MAKING					
MGMT/OPTION DX		Minimal (1)	Limited (2)	Multiple (3)	Extensive(4)
AMT DATA/COMPLEX		Minimal(1)	Limited(2)	Moderate(3)	Extensive(4)
RISK OF COMPLICAT.		Minimal	Low	Moderate	High

Time Based Coding

- When counseling and coordination of care are greater than 50% of the service, code by time
- Must have total face to face time
- Total time spent in counseling or coordination
- Details of the discussion

Time vs. Coding by Key Components

- Code either by **time** or **key component** – you do not code by both
- Time is not a consideration when coding by key component

Time Tables – New Patient

Code	Time
99201	10 minutes
99202	15 minutes
99203	30 minutes
99204	45 minutes
99205	60 minutes

Time Tables – Established Patient

Code	Time
99211	5 minutes
99212	10 minutes
99213	15 minutes
99214	25 minutes
99215	40 minutes

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Diagnosis Coding

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Diagnosis Codes

- International Classification of Diseases (9th edition), Clinical Modification or "ICD-10CM" is the code system currently used

- Multiple sources and software to find the right numerical "code" to every diagnosis

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-10 CM codes, you may use up to 12 diagnosis codes for each claim

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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.

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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 (Z72.0) Basics of Diagnosis Coding

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Basics of Diagnosis Coding

- Use additional codes to identify infectious agents for tonsillitis, sinusitis, etc – if you know
- J30 – subsection
  - Excludes J45.909 - unspecified asthma
  - Excludes – rhinitis NOS (J31.l0)
- L50 – Urticaria
  - Excludes angioneurotic edema (T78.3)
  - Excludes contact dermatitis (L23.-)

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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

  - 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 medication adjustment, other aftercare and follow up visits following treatment of the injury or condition.

  - S – The residual effect (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.

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Basics of Diagnosis Coding

- Chapter 19 - Subsection guidelines for Poisoning by, adverse effects of and 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 effects
  - Dermatitis due to substances taken internally
  - Urticaria
  - Pruritus
  - Erythema
- Codes from the T36-T50 will be sequenced second

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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 its 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"

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Basics of Diagnosis Coding

- Z codes
  - Z codes may be listed as the primary diagnosis code
  - Z23 is for encounters for vaccinations. The procedure code required will identify the actual administration of the injection and the type(s) of immunizations given.
  - Z01.82 – "Encounter for allergy testing without complaint, suspected or reported diagnosis"
  - Z88 - Allergy status to drugs, medications and biological substances

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Diagnosis Coding Guidelines

- Code for why the patient sought medical advice
- Do not code probable, possible, or rule out diagnosis
- Code to the highest level of ICD-10CM code that is available

Diagnosis Coding Guidelines

- When other conditions exist, these conditions should be coded additionally
- The co-morbidities must be addressed in the note as to the impact on the allergy/asthma diagnoses
- Chronic diseases may be coded as often as necessary

Basic Allergy Procedures

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

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

Questions???

- Thank you for attending.

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