#### Coding for the Allergist

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• I have nothing to disclose





#### 2021 – Changes in health care

- · COVID has continued
- · CPT Coding for evaluation and management services
- · Medicare has changed requirements for telehealth
- CPT Coding for telemedicine
  - · Synchronous and asynchronous
- · Diagnosis coding guidelines
- · Payer Reimbursements and challenges

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# Evaluation and Management coding changes: Outpatient Codes 99202-99215





#### 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.

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# 2021 Evaluation and Management Code Selection Revisions

Time
OR
Medical Decision Making





#### Time Revisions

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

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#### Time Includes the following:

- · Preparing to see the patient (review of tests)
- Obtaining and/or reviewing 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 not separately reported
- · Documenting clinical information in EHR or other health record
- Independently interpreting results if not separately reported
- · Communicating results to the patient/family/caregiver
- Coordinating care (not separately reported)





#### What doesn't count toward total time?

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The performance of other services reported separately.

Traval

Teaching that is general and not limited to discussion that is required for the management of a specific patient

Tests that are results only and are analyzed as part of the MDM do count toward MDM and can be used for time or MDM.

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#### 2021 Revised E/M Coding Guidelines: 99202-99215



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In an effort to reduce burden and improve payment for cognitive care, the American Medical Association along with the Centers for Medicare and Medicaid Services (CMS) have implemented key changes to office and outpatient evaluation and management (E/M) services starting on January 1, 2021.

Use this reference sheet as a guide for your consideration when choosing the appropriate code for your new and established patients. Please send any comments or questions you have to coding@aaaal.org.

applicable

#### **Coding Based on Time**

New Patients		Establ	ished Patients	Document time in the medical record when used for the basis for the code.
99202	15-29 minutes	99211	No time reference	
99203	30-44 minutes	99212	10-19 minutes	Use time for coding whether or not counseling and/or coordination of care dominates the service.
99204	45-59 minutes	99213	20-29 minutes	Reimbursed procedures are excluded from
99205	60-74 minutes	99214	30-39 minutes	total time.
+99417*	75 minutes and beyond for each			Count the total time on the date of services: 99202-99215.
	15 minutes of time	+99417*	55 minutes and beyond for each 15 minutes of time	To count physician or another qualified health care professional's time spent in the supervision of clinical staff who perform
and lasted fo	tient/physician interaction or or a total of 105 minutes, the ts to equal the 105 minutes.	correct coding		the face-to-face services of the encounter, use 99211.  1/2 American Academy of Allergy Asthma & Immun

Prolong Services in 2021

- CPT 99417 for each additional 15 minutes on and beyond the highest level of E/M (99205, 99215).
- G2212 for each additional 15 minutes on and beyond the highest level of E/M (99205, 99215)
  - · For Medicare only.
- CPT 99354, 99355 Prolong services with face to face provider time. May be added to other CPT codes (99202-99204, 99212-99214). Requires more than 30 minutes.
- CPT 99358, 99359 Prolong services without face to face provider time. May be charged as stand alone codes for more than 30 minutes
- · Payers vary on reimbursing prolong services codes

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#### Definition for Medical Decision Making

- Problem/problems Addressed
- Data Reviewed
- Risk(s) Assessed

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# Definitions for Medical Decision Making Problem(s)

- 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

- Minimal Problem may not require the presence of the provider but the service is provided under the providers direct supervision. (CPT 99211)
- 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 CPT definition is defined by the specific treatment goals for an individual patient.
  - · Patient not at their specific treatment goals is not stable.
    - Condition may not have changed there may be not threat to life or function.
  - Chronicity stage of severity does not affect definition of chronic.

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#### Definitions for Medical Decision Making

- Acute uncomplicated illness or injury:
  - Short term problem with low risk of morbidity which treatment is considered.
  - There is little to no risk of mortality with treatment and full recovery without functional impairment is expected.
  - A self-limited problem which is not responding to a definite and prescribed course of treatment is an acute uncomplicated illness.
  - 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 or requiring attention to treatment for side effects but that does not require consideration of hospital level of 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

- 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.

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#### Definitions for Medical Decision Making

- 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.





- Presenting symptoms that are likely to represent a highly morbid condition may "drive" MDM even when the ultimate diagnosis is not highly morbid.
- The evaluation and/or treatment should be consistent with the likely nature of the condition.
- Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.
- The term "risk" as used in these definitions relates to risk from the condition.
- While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.

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	Straightforward 99202/ 99212	Low 99203/ 99213	Moderate 99204/ 99214	High 99205/ 99215
Problem	1 self-limited or minor problem	2 or more self-limited or minor problems, OR     1 stable chronic illness, OR     1 acute, uncomplicated illness	1 or more chronic illness with exacerbation, progression, or side effects for treatment, OR     2 or more stable chronic illnesses, OR     1 undiagnosed new problem with uncertain prognosis, OR     1 acute illness with systemic symptoms	1 or more chronic illness with severe exacerbation, progression, or side effects of treatment, OR     1 acute or chronic illness posing a threat to life or bodily function
Data	Minimal or none	Limited: Must meet the requirement of at least 1 of 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 Category 2: Assessment requiring an independent historian(s)	Must meet at least 1 of 3 categories: Category 1: Any combination 3 of 4 below:  Review of prior external note(s) from each unique source Review of the result(s) of each unique test 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	Must meet at least 2 of 3 categories: Category 1: Any combination 3 of 4 below:  Review of prior external note( from each unique source Review of the result(s) of each unique test Order each unique test Assessment requiring an independent historian(s) Category 2: Independent interpretatio of tests performed by another physicic Category 3: Discussion of managemen or test interpretation with external physician/other qualified health care provider not separately reported
Risk	Minimal risk of morbidity from additional diagnostic testing or treatment	Low risk of morbidity from additional diagnostic testing or treatment	Prescription drug management; diagnosis or treatment significantly limited by social determinants of health	Drug therapy requiring intensive monitoring for toxicity     Decision regarding not to resuscitate or de-escalate care due to poor prognosis

## Definitions for Medical Decision Making Data Reviewed

- Tests ordered are presumed to be analyzed when the results are reported.
- When they are ordered during an encounter, they are counted in that encounter.
- Tests that are ordered outside of an encounter may be counted in the encounter in which they are analyzed.
- In the case of a recurring order, each new result may be counted in the encounter in which it is analyzed. Example: that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed.
- Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter.
- Any service for which the professional component is separately reported by the physician or other qualified health care professional reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

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#### Definitions for Medical Decision Making Data Reviewed

- 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.
- This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.

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## Definitions for Medical Decision Making Data Reviewed

 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.

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#### Definitions for Medical Decision Making

- 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.
- The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.





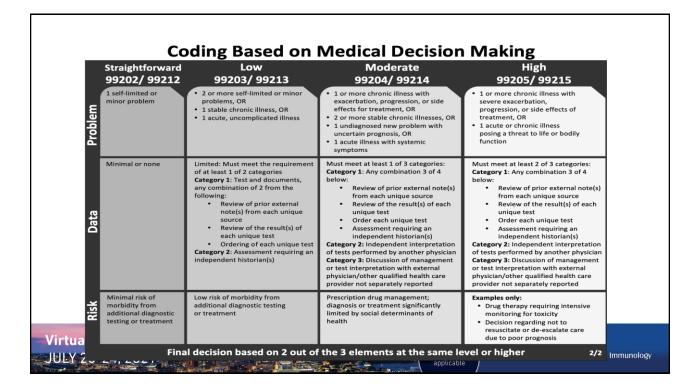
Discussion is defined as:

Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (eg, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter, but it is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (ie, does not need to be in person), but it must be initiated and completed within a short time period (e.g., within a day or two).

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# Definitions for Medical Decision Making Risk(s) Assessed

- 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.

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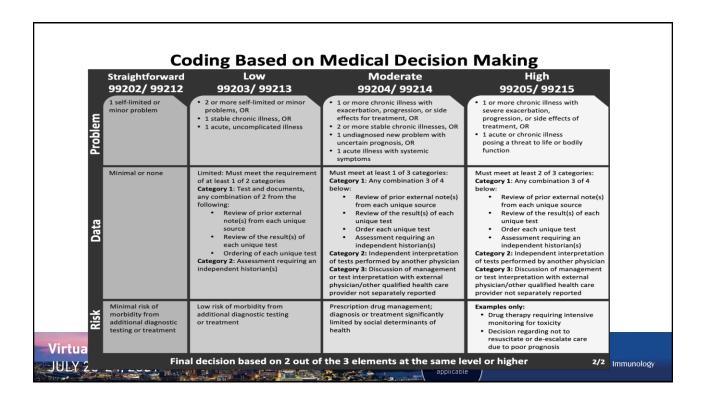


#### Definitions for Medical Decision Making

- · 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.









#### Telemedicine Types

#### Asynchronous – Stored and Forwarded

- · Medical data, images
- Not in real time at physician convenience

- Telephone call, video conference,
- Both parties are present at the same time
- Facilitated
  - · Real time two way video conferencing
- Scheduled visits with a facilitator at the originating site
- Insurance is billable
- Non-facilitated
  - · Generally initiated on demand by the patient
  - · Audio only encounters
  - May not involve a physical exam
  - · Direct payment insurance not involved

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#### Telemedicine

- Telehealth Private Payers Reimbursement: There is no federal mandate requiring private payers to reimburse for telehealth services, but several states have enacted telehealth parity laws. Parity laws compel payers to cover the same types of services provided through telehealth as those that are provided face-to-face. They also require payers to reimburse telehealth services at the same payment rate as in-clinic services.
- If CVS's merger with Aetna is finalized, increased competition may motivate other payers to find ways to offer telehealth

services and, by extension, levels of reimbursement.
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#### Telemedicine

- · Telehealth and the Future of Healthcare
- Despite the current reimbursement challenges, there are numerous benefits to increasing
  the use of telehealth to meet the nation's demand for health care. Convenience of care,
  increased access, improved worker productivity from not having to take time off and travel
  to appointments, decreased costs, and clinician time savings are a few. For these
  reasons, providers, payers, and employers alike are moving forward with more and more
  telehealth solutions.
- · States are enacting laws regarding parity
- Considering laws regarding across state line coverage

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#### CMS considerations and concerns

- Extending coverage for a 1,2 years
- Gather more information
- Pay physicians at the facility rate
  - Collect data on cost of providing services
- Physician would be required to collect co-pays and deductibles for encounters.
- Medicare and Medicaid are two largest insurers





- Fraud
  - Easier for providers to commit fraud on large scale basis
  - \$4.5 million in allegedly false and fraudulent claims in last year
  - 86 criminal defendants related to telemedicine
  - 256 medical professional revoked billing privileges

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#### Telemedicine

- Two guidelines CMS and private payers
  - CMS restrictions have been lifted regarding place of service for the patient and for the provider.
  - Telehealth is currently defined as any device having audio and video capabilities that are used for two-way, real-time interactive communication.
  - Definition for telehealth applies to any services historically covered by Medicare, which are listed by CMS.
  - Appendix P of the CPT 2020 book also has a list of approved telehealth codes
  - Patient permission for telehealth should be documented.
  - Document time if using time to support level of service.





#### Telemedicine

#### **Private Payers**

Following CMS Guidelines

Have their own sets of codes that are payable

Some had waived the co-pays for telehealth for a period of time

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#### Telemedicine

- · Place of Services
  - CMS place of service is the same as if the patient was seen in person (11 for clinic)
  - Private payers 11 or 02 depending on the payer. Most payers are asking for 02 to indicate it
    is a telehealth encounter
  - State guidelines have been relaxed but every state may not follow CMS guidelines
  - State and federal guidelines may change after the end of the year of the pandemic





#### Telemedicine

- Telehealth has become a standard method for evaluation of patients
- · Coding for encounters for most payers are covered as if it were a face- to face encounter
- CPT 99202-99215 are covered for telehealth for audio and video telehealth visits.
- New patient encounters are an exception for the pandemic
  - CMS indicates by waiver 1135 that there should be an established relationship with the patient to
    provide telehealth services
  - HHS will not be conducting audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.

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#### Telemedicine

- Face to face encounters
- Telehealth Visits
- Online digital evaluation and management services
- Telephone Calls





• What is appropriate if the patient begins as an audio video encounter and it drops to audio before the encounter is finished?

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#### Telephone calls – CPT 99441-99443

- Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment
- Private payers may vary in their reimbursement for telephone calls





#### Telephone calls - CPT 99441-99443

- CPT 99441-99443
  - CMS will pay for telephone calls without video capabilities as of March 30, 2020.
  - · May be used for new and established patient visits during the public health emergency
  - These are not considered telehealth codes. Do not use 95 modifier.
  - · Interim work RVU:
    - 99441-.25

5-10 minutes

- 99442 .50 11-20 minutes
- 99443 .75 21-30 minutes
- · These are time driven codes time must be documented
- There are restrictions regarding when the patient was last seen or will be seen.

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## CPT 99421-99423 Digital on-line services

- 99421- 99423 Online digital evaluation and management services for an established patient, for up to 7 days, cumulative time during the 7 days
  - 99421- 5-10 minutes
  - 99422 11-20 minutes
  - 99423 21 or more minutes





# CPT 99421-99423 Digital on-line services

- May only be reported when the billing practice has an established relationship with the patient.
- Individual service should be agreed to by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient agreement.

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#### CMS Specific codes

- G2012 Brief communication technology-based service provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M within the next 24 hours or soonest available appointment – 5-10 minutes – value is comparable to 99441
- G2010 Remote evaluation of recorded video and/or images submitted by an established patient (E.g., store and forward) including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service within the next 24 hours or soonest available appointment.

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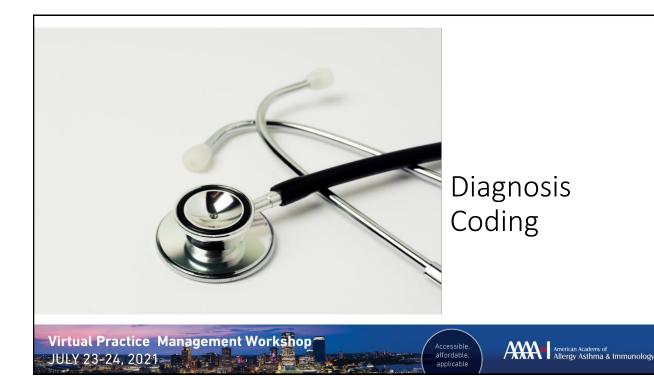


#### Allergist procedure codes for telemedicine

- CPT 94664 MDI instruction temporary approval during pandemic
- CPT 96160 Administration of patient-focused health risk assessment instrument with scoring and documentation per standardized instrument
- CPT 96161 Administration of caregiver focused health risk assessment instrument for the benefit of the patient, with scoring and documentation per standardized instrument





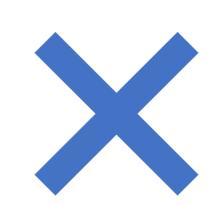


- Exclusions 1 -
  - Definition Indicates that the code excluded should never be used at the same time as the code above the Excludes 1 note. An excludes 1 is used when two conditions cannot occur together – per the ICD-10CM Coding guidelines
    - Examples:
      - Angioedema and Urticaria Excludes 1
      - Chronic rhinitis and allergic rhinitis excludes 1
      - Chronic rhinitis and vasomotor rhinitis excludes 1
      - Asthma (J45---) and wheezing Excludes 1
  - Exclusions 2
    - Definition Indicates that the condition is not part of the condition represented by the code but a patient may have both conditions at the same time. You may use both codes.

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Diagnosis Coding – Excludes 1: Two codes may not be coded together on the same claim

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CODE	DESCRIPTION	CODE	DESCRIPTION
J00	Acute nasopharyngitis (common cold)	J02.9	Acute sore throat, NOS
J30.1	Allergic rhinitis due to pollen		
j30.2	Other seasonal allergyic rhinitis	J45.909	Unspecified asthma, uncomplicated
j30.81	Allergyic rhninitis due to animal hair and dander	J31.0	Chronic rhinitis
J30.89	Other allergic rhinitis		
J32.9	Chronic sinusitis, unspecified	J01.00	Acute sinusitis maxillary, unspecified
J45 j45.30 j45.20 J45.40 J45.51	Asthma Mild persistent Asthma Mild intermittent asthma, uncomplicated Moderate persistent asthma, uncomplicated Severe peristent Asthma with (acute) exacebation	Ј69.8 Ј82 Ј60 R06.2 Ј67.8 R06.2	detergent asthma eosinophilic asthma miner's asthma wheezing NOS wood asthma wheezing

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#### Excludes 1 combinations

K20	Esophagitis	K22.1 er	rosion of esophagus
K20.0	Eosinophilic eosphagitis	K21.0 es	sophagitis with gastro-esophageal reflex
K20.8	Other eosphagitis	K21.0 re	eflux esophagitis
K20.9	Eosphagitis, unspecified	K22.1 ul	cerative esophagitis
		L23.9 al	llergic contact dermatitis, unspecified
			olar urticaria
		T78.3XXA A	ngioneurotic edema
			0
		T78.3 gi	ant urticaria
		т78.3 🗖	uincke's edema
L50	Urticaria	T80.6 se	erum urticaria
L50.1	Idiopathic urticaria	D84.1 he	ereditary angio-edema
			, 3
		R04.2 cc	numb with homographs
205			ough with hemorrhage
R05	Cough	j41.0 sn	noker's cough
T78.01XA	anaphalysis due to peanuts	T78.1XXA A	dverse food reactions, not elsewhere classified
170.01AA	aliaplialysis due to pealidis	170.1AAA  AC	uverse roou reactions, not elsewhere classified

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#### Diagnosis Coding

- Use additional codes to identify infectious agents for tonsillitis, sinusitis, etc if you know
- J30 subsection
  - Excludes 1 J45.909 unspecified asthma
  - Excludes 1 rhinitis NOS (J31.0)
- L50 Urticaria
  - Excludes 1 angioneurotic edema (T78.3)
  - Excludes 1 contact dermatitis (L23.-)
- K20 Esophagitis
  - Excludes 1 Esophagitis with gastro-esophagel reflux (K21.0)

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#### **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

- Dermatitis due to substances taken internally
- Urticaria
- Pruritus

Codes from the T36-T50 will be sequenced second





#### 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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#### Diagnosis Coding

- Z codes
  - · Z codes may be listed as the primary diagnosis code
  - Z85.-- Personal history of malignant neoplasm of -----
  - Z23 Encounters for vaccinations. The procedure code required will identify the actual administration of the injection and the type(s) of immunizations given.
  - Z01.10 Encounter for examination of ears and hearing without abnormal findings
  - Z01.110 Encounter for hearing exam following failed hearing screening
  - Z01.82 "Encounter for allergy testing without complaint, suspected or reported diagnosis"
  - Z51.6 Encounter for desensitization to allergens
  - Z88.--- Allergy status to drugs, medications and biological substances





# Reimbursement Issues and challenges for 2021

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#### CMS Changes for 2021

- Conversion factor is now \$34.8931 a 3.75% increase for Part B payments for 2021.
- The Sequestration of 2% is suspended through the end of calendar year 2021.
- The 1.0 floor on the work Geographic Practice Cost Index through Calendar Year 2023.
- A moratorium on payment under the MPFS through at least 2023 for HCPCS Level II code G2211 a visit code for complexity of encounter.
- Appropriate an additional \$250 million to the FCC for its COVID-19 Telehealth Program authorized under the CARES Act.
- "Surprise billing" legislation that requires arbiters to settle disputes between providers and insurers.





Determine the patient's benefits prior to the appointment – possible?

What expectations does the patient have for the appointment?

# Patient's Concerns

Communication – who is the one reaching out to the patient?

Follow up – what is your protocol for

Collection –Telehealth – collection of co-pays?

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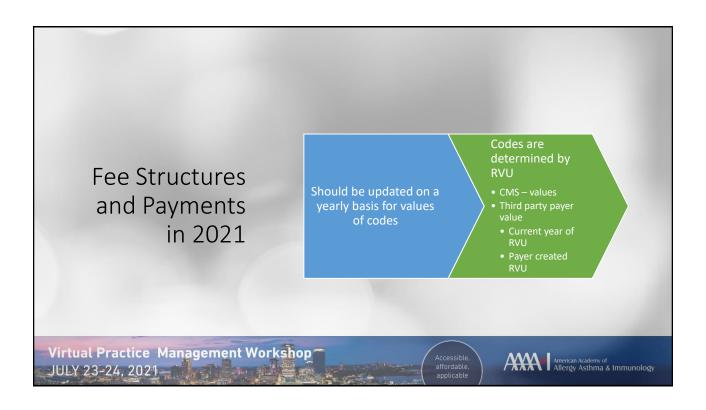


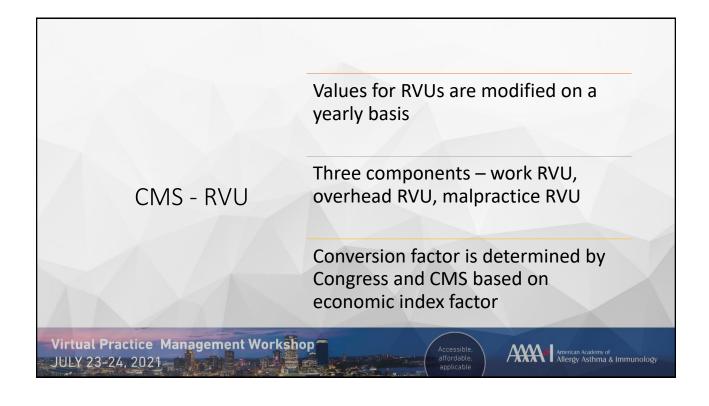


- What are you allowed to charge the patient?
  - Extra allergy tests?
  - Additional immunotherapy doses not covered by insurance?
  - · OIT?
  - Pre-authorizations?
  - Family leave act forms or asthma forms for school?
- When do you discontinue immunotherapy for financial reasons – or can you?
- Is there a limit on allergy testing or immunotherapy on a yearly basis









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

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<u>ode</u>	Description	<u>Status</u>	Work	<u>O/H</u>	<u>O/H</u>	Mal	Total NFac	Total Fac
95004	Percut allergy skin tests	A	0.01	0.10	0.10	0.01	0.12	0.12
95012	Exhaled nitric oxide meas	Α	0.00	0.57	0.57	0.01	0.58	0.58
95017	Perq & icut allg test venoms	Α	0.07	0.17	0.03	0.01	0.25	0.11
95018	Perq⁣ allg test drugs/biol	A	0.14	0.47	0.06	0.01	0.62	0.21
95024	Icut allergy test drug/bug	A	0.01	0.23	0.01	0.01	0.25	0.03
95027	Icut allergy titrate-airborn	A	0.01	0.12	0.12	0.01	0.14	0.14
95028	Icut allergy test-delayed	A	0.00	0.37	0.37	0.01	0.38	0.38
95044	Allergy patch tests	Α	0.00	0.15	0.15	0.01	0.16	0.16
95052	Photo patch test	Α	0.00	0.19	0.19	0.01	0.20	0.20
95056	Photosensitivity tests	Α	0.00	1.40	1.40	0.01	1.41	1.41
95060	Eye allergy tests	A	0.00	1.05	1.05	0.01	1.06	1.06
95065	Nose allergy test	Α	0.00	0.77	0.77	0.01	0.78	0.78
95070	Bronchial allergy tests	Α	0.00	1.00	1.00	0.02	1.02	1.02
95076	Ingest challenge ini 120 min	Α	1.50	1.89	0.59	0.05	3.44	1.97
95079	Ingest challenge addl 60 min	A	1.38	1.01	0.54	0.05	2.44	0.27
95115	Immunotherapy one injection	A	0.00	0.26	0.26	0.01	0.27	0.33
95117	Immunotherapy injections	A	0.00	0.32	0.32	0.01	0.33	0.00
95120	Immunotherapy one injection	1	0.00	0.00	0.00	0.00	0.00	0.00
95125	Immunotherapy 2/> injections	1	0.00	0.00	0.00	0.00	0.00	0.00
95130	Immntx 1 sting insect	1	0.00	0.00	0.00	0.00	0.00	0.00
95131	Immntx 2 sting insects	1	0.00	0.00	0.00	0.00	0.00	0.00
95132	Immntx 3 sting insects	1	0.00	0.00	0.00	0.00	0.00	0.00
95133	Immntx 4 sting insects	1	0.00	0.00	0.00	0.00	0.00	0.00
95134	Immntx 5 sting insects	1	0.00	0.00	0.00	0.00	0.00	0.09
95144	Antigen therapy services	A	0.06	0.41	0.02	0.01	0.48	0.09
95145	Antigen therapy services	A	0.06	0.93	0.02	0.01	1.00	0.09
95146	Antigen therapy services	A	0.06	1.77	0.02	0.01	1.84	0.09
95147	Antigen therapy services	A	0.06	1.75	0.02	0.01	1.82	0.09
95148	Antigen therapy services	A	0.06	2.59	0.02	0.01	2.66	0.09
95149	Antigen therapy services	A	0.06	3.47	0.02	0.01	3.54	0.09
95165	Antigen therapy services	A	0.06	0.39	0.02	0.01	0.46	0.09
95170	Antigen therapy services	A	0.06	0.27	0.02	0.01	0.34	2.97
95180	Rapid desensitization	A	2.01	1.85	0.87	0.09	3.95	0.00
95199	Allergy immunology services	С	0.00	0.00	0.00	0.00	0.00	0.12

CPT Code	<b>MUE Value</b>	MUE adjudication indicator	MUE Rationale
95004	80	3 Date of Service Edit: Clinical	Clinical: CMS Workgroup
95012	2	3 Date of Service Edit: Clinical	Clinical: Data
95017	27	3 Date of Service Edit: Clinical	Clinical: Society Comment
95018	19	3 Date of Service Edit: Clinical	Clinical: CMS Workgroup
95024	40	3 Date of Service Edit: Clinical	Clinical: Data
95027	90	3 Date of Service Edit: Clinical	Clinical: Data
95028	30	3 Date of Service Edit: Clinical	Clinical: Data
95044	80	3 Date of Service Edit: Clinical	Clinical: Data
95052	20	3 Date of Service Edit: Clinical	Clinical: Data
95056	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
95060	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
95065	1	3 Date of Service Edit: Clinical	Clinical: Data
95070	1	3 Date of Service Edit: Clinical	Clinical: Data
95076	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
95079	2	3 Date of Service Edit: Clinical	Clinical: Society Comment
95115	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
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CPT Co	ode MUE Valu	ue MUE adjudication indicator	MUE Rationale
95115	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
95117	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
95120	0	3 Date of Service Edit: Clinical	CMS Policy
95125	0	3 Date of Service Edit: Clinical	CMS Policy
95130	0	3 Date of Service Edit: Clinical	CMS Policy
95131	0	3 Date of Service Edit: Clinical	CMS Policy
95132	0	3 Date of Service Edit: Clinical	CMS Policy
95133	0	3 Date of Service Edit: Clinical	CMS Policy
95134	0	3 Date of Service Edit: Clinical	CMS Policy
95144	30	3 Date of Service Edit: Clinical	Clinical: Data
95145	10	3 Date of Service Edit: Clinical	Clinical: Data
95146	10	3 Date of Service Edit: Clinical	Clinical: Data
95147	10	3 Date of Service Edit: Clinical	Clinical: Data
95148	10	3 Date of Service Edit: Clinical	Clinical: Data
95149	10	3 Date of Service Edit: Clinical	Clinical: Data
95165	30	3 Date of Service Edit: Clinical	Clinical: Data
95170	10	3 Date of Service Edit: Clinical	Clinical: Data
95180	6	3 Date of Service Edit: Clinical	Clinical: Data
95199	1	3 Date of Service Edit: Clinical	Clinical: CMS Workgroup

#### National Correct Coding Initiative

- What is the Medicare National Correct Coding Initiative (NCCI)
- NCCI Procedure-to-Procedure (PTP) code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together for payment
- Medically Unlikely Edits (MUEs). An MUE is a maximum number of Units of Service (UOS) allowable under most circumstances for a single Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code billed by a provider on a date of service for a single beneficiary.
- For information about the Medicaid NCCI program, refer to The National Correct Coding Initiative in Medicaid webpage

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#### Examples from the NCCI edits

94060	94010	19960101	*	0	HCPCS/CPT procedure code definition
94060	94011	20110701	*	1	Misuse of column two code with column one code
94060	94012	20110701	*	1	Misuse of column two code with column one code
94060	94150	20120101	*	1	CPT Manual or CMS manual coding instructions
94060	94150	19970101	19970101	9	CPT "separate procedure" definition
94060	94160	19960101	19970331	0	Standards of medical / surgical practice
94060	94200	19960101	*	1	HCPCS/CPT procedure code definition
94060	94375	19960101	*	0	Standards of medical / surgical practice
94060	94620	19960101	19960101	9	Mutually exclusive procedures
94060	94640	19960101	*	1	CPT Manual or CMS manual coding instructions
94060	94650	19960101	20030331	1	Standards of medical / surgical practice
94060	94664	19980401	*	1	Standards of medical / surgical practice

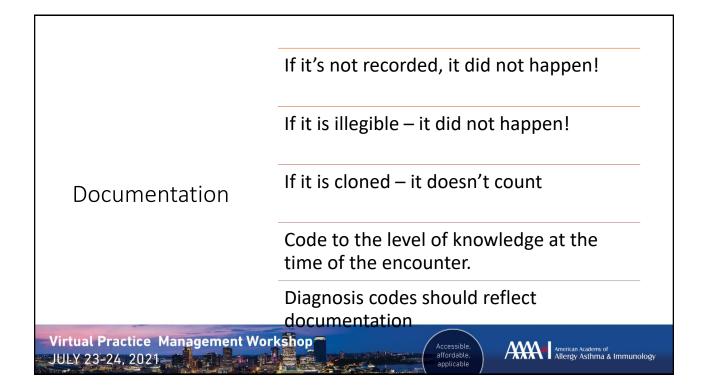
#### Payer Reviews

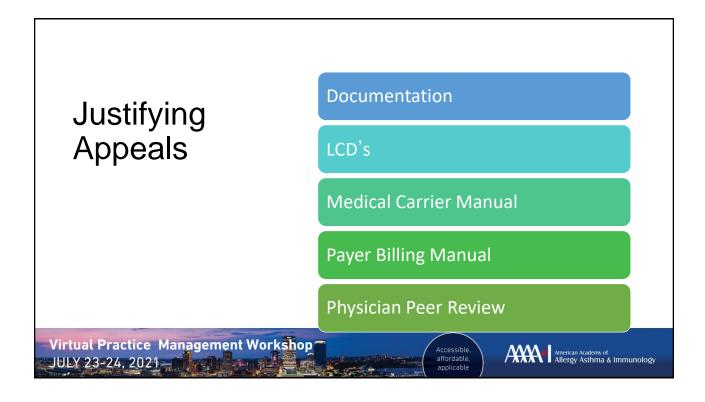






# Payer Audits Review of allergy immunotherapy treatment Xolair administration





#### Coding and Payer reimbursement Issues

- CPT 95018 for drug testing pre and subcutaneous may be charged on the same day as an oral challenge?
- How do you code for an injection challenge?
- When can you code for the first hour of an oral challenge?

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Accessible, affordable, applicable applicable

Applicable

#### Coding and Payer reimbursement Issues

- Number of Test performed
- Number of Doses charged
- Medical Necessity for allergy testing and an E/M on the same calendar date
- Payment for E/M and diagnostic services on the same calendar day
- Incident to services with mid levels
- Levels of services provided

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- Modifier 25 review and scrutiny of its use
- Allergy immunotherapy dosing
- MUE NCCI Edits
- Increase in premiums for patients deductibles for surgical procedures and diagnostic procedures









#### Helpful tools - Modifiers

- Modifier 25
- CPT Definition: Significant, Separately Identifiable E & M Service by the same physician or other qualified health care professional on the same day of the procedure or other service:
  - It may be necessary to indicate that on the day a procedure or service identified by a CPT code was
    performed, the patient's condition required a significant, separately identifiable E/M service above
    and beyond the other service provided or beyond the usual preoperative and postoperative care
    associated with the procedure that was performed......may be prompted by the symptom
    or condition for which the procedure and/or service was provided. As such different diagnoses are
    not required for reporting of the E/M on the same date.

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#### Modifier 25

- Medicare Definition per the NCCI:
- Modifier 25 may be appended to E&M services reported with minor surgical procedures (global period of 000 or 010 days) or procedures not covered by global surgery rules (global indicator of XXX). Since minor surgical procedures and XXX procedures include preprocedure, intra-procedure, and post-procedure work inherent in the procedure, the provider should not report an E&M service for this work. Furthermore, Medicare Global Surgery rules prevent the reporting of a separate E&M service for the work associated with the decision to perform a minor surgical procedure whether the patient is a new or established patient.





#### Modifier 59

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E-M services performed on the same day.

Modifier 59 is used to identify procedures/services, other than E/M services that are not normally reported together but are appropriate under the circumstances.

Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion or separate injury not ordinarily encountered or performed on the same day by the same individual.

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#### Modifier 59

- However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.
- Modifier 59 should not be appended to an E/M Service. To report a separate and distinct E/M service with a non- E/M service performed on the same date, see modifier 25.
- See also HCPCS Modifiers





#### Modifier 76

 Modifier 76 – Repeat Procedure or Service by same physician or other qualified health care professional.

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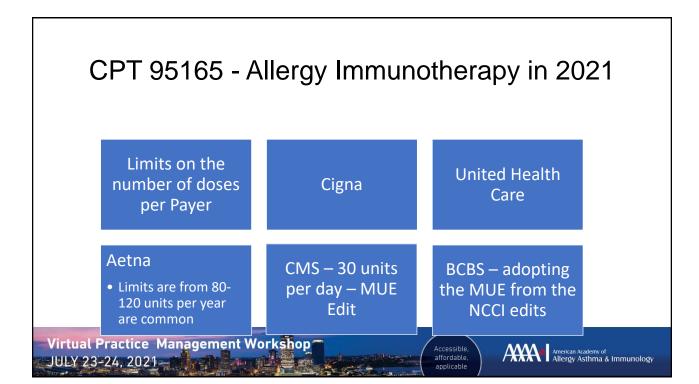


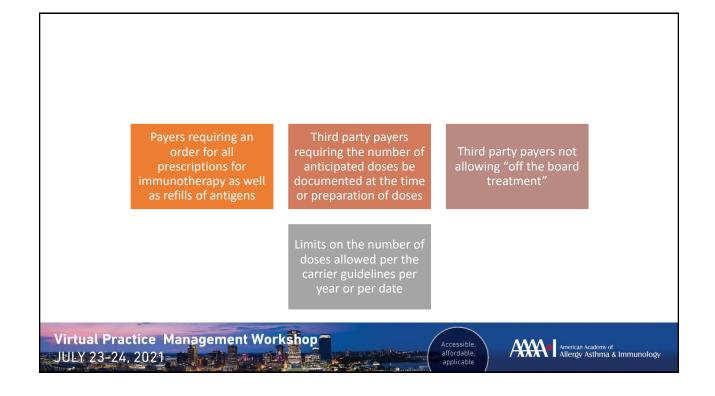
#### HCPCS Level II Modifier - JW

- JW Drug amount discarded/not administered to any patient
  - Use JW to identify unused drugs or biologicals from single use vial/package that are appropriately discarded. Bill on separate line for payment of discarded drug/biological
  - RAC Audits for wastage not necessary









# ALLERGEN IMMUNOTHERAPY Allergen-Mult. Dose #\_\_\_\_\_Doses 95165 Allergen - Single Dose #\_\_\_\_ 95144 Venom Antigen - 1 single stinging 95145 Venom Antigen - 2 single stinging 95146 Venom Antigen - 3 single stinging 95147 Venom Antigen - 4 single stinging 95148 Venom Antigen - 5 single stinging 95149

Whole Body - biting insect

Rapid Desensitization #Hr\_

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95170

95180



#### 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
- Check your payers' coverage guidelines for diagnoses which are payable with the 95180.
- CMS does not cover foods or regular antigen rapid desensitization (95180)

**Immunotherapy** 





- 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.

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#### OIT – Oral Immunotherapy

- Follow your payers guidelines
- Obtain pre-authorizations prior to beginning OIT
- Options for coding:
  - 95076, 95079 if the patient hasn't been challenged recently for initial encounter
  - 95180 if allowed per payer (parenteral administration)?
  - E/M evaluation and management encounters for follow up updosing
  - Prolong services staff or physician?





