

# Coding for the Allergist

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- I have nothing to disclose

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## 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

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## 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

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## 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.

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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)

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# What doesn't count toward total time?

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The performance of other  
services reported  
separately.

Travel.

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



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@aaaai.org](mailto:coding@aaaai.org).

### Coding Based on Time

New Patients		Established Patients	
99202	15-29 minutes	99211	No time reference
99203	30-44 minutes	99212	10-19 minutes
99204	45-59 minutes	99213	20-29 minutes
99205	60-74 minutes	99214	30-39 minutes
+99417*	75 minutes and beyond for each 15 minutes of time	99215	40-54 minutes
		+99417*	55 minutes and beyond for each 15 minutes of time

Document time in the medical record when used for the basis for the code.

Use time for coding whether or not counseling and/or coordination of care dominates the service.

Reimbursed procedures are excluded from total time.

Count the total time on the date of services: 99202-99215.

To count physician or another qualified health care professional's time spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

\*If a new patient/physician interaction occurred on a specific date of service and lasted for a total of 105 minutes, the correct coding would be: CPT 99205, 99417X2 units to equal the 105 minutes.

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and/or code, applicable

1/2

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## 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.**

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## 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.*

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# 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.*

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- 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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## Coding Based on Medical Decision Making

	<b>Straightforward</b> 99202/ 99212	<b>Low</b> 99203/ 99213	<b>Moderate</b> 99204/ 99214	<b>High</b> 99205/ 99215
<b>Problem</b>	1 self-limited or minor problem	<ul style="list-style-type: none"> <li>• 2 or more self-limited or minor problems, OR</li> <li>• 1 stable chronic illness, OR</li> <li>• 1 acute, uncomplicated illness</li> </ul>	<ul style="list-style-type: none"> <li>• 1 or more chronic illness with exacerbation, progression, or side effects for treatment, OR</li> <li>• 2 or more stable chronic illnesses, OR</li> <li>• 1 undiagnosed new problem with uncertain prognosis, OR</li> <li>• 1 acute illness with systemic symptoms</li> </ul>	<ul style="list-style-type: none"> <li>• 1 or more chronic illness with severe exacerbation, progression, or side effects of treatment, OR</li> <li>• 1 acute or chronic illness posing a threat to life or bodily function</li> </ul>
<b>Data</b>	Minimal or none	Limited: Must meet the requirement of at least 1 of 2 categories <b>Category 1:</b> Test and documents, any combination of 2 from the following: <ul style="list-style-type: none"> <li>• Review of prior external note(s) from each unique source</li> <li>• Review of the result(s) of each unique test</li> <li>• Ordering of each unique test</li> </ul> <b>Category 2:</b> Assessment requiring an independent historian(s)	Must meet at least 1 of 3 categories: <b>Category 1:</b> Any combination 3 of 4 below: <ul style="list-style-type: none"> <li>• Review of prior external note(s) from each unique source</li> <li>• Review of the result(s) of each unique test</li> <li>• Order each unique test</li> <li>• Assessment requiring an independent historian(s)</li> </ul> <b>Category 2:</b> Independent interpretation of tests performed by another physician <b>Category 3:</b> 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: <b>Category 1:</b> Any combination 3 of 4 below: <ul style="list-style-type: none"> <li>• Review of prior external note(s) from each unique source</li> <li>• Review of the result(s) of each unique test</li> <li>• Order each unique test</li> <li>• Assessment requiring an independent historian(s)</li> </ul> <b>Category 2:</b> Independent interpretation of tests performed by another physician <b>Category 3:</b> Discussion of management or test interpretation with external physician/other qualified health care provider not separately reported
<b>Risk</b>	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	<b>Examples only:</b> <ul style="list-style-type: none"> <li>• Drug therapy requiring intensive monitoring for toxicity</li> <li>• Decision regarding not to resuscitate or de-escalate care due to poor prognosis</li> </ul>

Final decision based on 2 out of the 3 elements at the same level or higher

applicable

2/2

## 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.

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- 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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Final decision based on 2 out of the 3 elements at the same level or higher

applicable

2/2

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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.*

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## Telemedicine

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# Telemedicine Types

## Asynchronous – Stored and Forwarded

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

## Synchronous

- 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

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- 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.

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# 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

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# 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

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- 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

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## 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

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## 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

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Diagnosis  
Coding

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- 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	J45.909	Unspecified asthma, uncomplicated
J30.2	Other seasonal allergic rhinitis	J31.0	Chronic rhinitis
J30.81	Allergic rhinitis due to animal hair and dander		
J30.89	Other allergic rhinitis		
J32.9	Chronic sinusitis, unspecified	J01.00	Acute sinusitis maxillary, unspecified
J45	Asthma	J69.8	detergent asthma
J45.30	Mild persistent Asthma	J82	eosinophilic asthma
J45.20	Mild intermittent asthma, uncomplicated	J60	miner's asthma
J45.40	Moderate persistent asthma, uncomplicated	R06.2	wheezing NOS
J45.51	Severe persistent Asthma with (acute) exacerbation	J67.8	wood asthma
		R06.2	wheezing

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## Excludes 1 combinations

K20	Esophagitis	K22.1	erosion of esophagus
K20.0	Eosinophilic esophagitis	K21.0	esophagitis with gastro-esophageal reflux
K20.8	Other esophagitis	K21.0	reflux esophagitis
K20.9	Esophagitis, unspecified	K22.1	ulcerative esophagitis
L50	Urticaria	L23.9	allergic contact dermatitis, unspecified
L50.1	Idiopathic urticaria	L56.3	solar urticaria
		T78.3XXA	Angioneurotic edema
		T78.3	giant urticaria
		T78.3	Quincke's edema
		T80.6	serum urticaria
		D84.1	hereditary angio-edema
R05	Cough	R04.2	cough with hemorrhage
		J41.0	smoker's cough
T78.01XA	anaphylaxis due to peanuts	T78.1XXA	Adverse food 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

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# 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

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# 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.

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# Patient's Concerns

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

What expectations does the patient have for the appointment?

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

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## Fee Structures and Payments in 2021

Should be updated on a  
yearly basis for values  
of codes

Codes are  
determined by  
RVU

- CMS – values
- Third party payer value
- Current year of RVU
- Payer created RVU

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## 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

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

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Code	Description	Status	Work	O/H	O/H	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	A	0.00	0.57	0.57	0.01	0.58	0.58
95017	Perq & icut allg test venoms	A	0.07	0.17	0.03	0.01	0.25	0.11
95018	Perq&ic 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	A	0.00	0.15	0.15	0.01	0.16	0.16
95052	Photo patch test	A	0.00	0.19	0.19	0.01	0.20	0.20
95056	Photosensitivity tests	A	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	A	0.00	0.77	0.77	0.01	0.78	0.78
95070	Bronchial allergy tests	A	0.00	1.00	1.00	0.02	1.02	1.02
95076	Ingest challenge ini 120 min	A	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	I	0.00	0.00	0.00	0.00	0.00	0.00
95125	Immunotherapy 2/> injections	I	0.00	0.00	0.00	0.00	0.00	0.00
95130	Immntx 1 sting insect	I	0.00	0.00	0.00	0.00	0.00	0.00
95131	Immntx 2 sting insects	I	0.00	0.00	0.00	0.00	0.00	0.00
95132	Immntx 3 sting insects	I	0.00	0.00	0.00	0.00	0.00	0.00
95133	Immntx 4 sting insects	I	0.00	0.00	0.00	0.00	0.00	0.00
95134	Immntx 5 sting insects	I	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	C	0.00	0.00	0.00	0.00	0.00	0.12

<u>CPT Code</u>	<u>MUE Value</u>	<u>MUE adjudication indicator</u>	<u>MUE Rationale</u>
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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<u>CPT Code</u>	<u>MUE Value</u>	<u>MUE adjudication indicator</u>	<u>MUE Rationale</u>
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

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## 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

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## Most Common Appeals

Evaluation and management service bundled with diagnostic testing – i.e., allergy testing

Evaluation and management service included with allergy injection

Allergy injection and Xolair not paid on same calendar day

Pulmonary function test and Evaluation and Management on same day

Xolair administration for chronic urticaria

Lack of medical necessity

Procedure is not medically necessary

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# Payer Audits

Review of allergy  
immunotherapy  
treatment

Allergy testing  
performed with  
an E/M

Xolair  
administration

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## Documentation

---

If it's not recorded, it did not happen!

---

If it is illegible – it did not happen!

---

If it is cloned – it doesn't count

---

Code to the level of knowledge at the  
time of the encounter.

---

Diagnosis codes should reflect  
documentation

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# Justifying Appeals

Documentation

LCD's

Medical Carrier Manual

Payer Billing Manual

Physician Peer Review

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## 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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## 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

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## Audit Response

Review your records

Know your risk

Have a third set of unbiased eyes read the notes

Respond in a timely manner

Communicate with the payer performing the review.

Negotiate

Seek counsel if you are high risk

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## Refunds

60 days on federal money to  
refund – otherwise FRAUD

Have a paper trail for your  
refund work

Have a policy in place which  
addresses refunds

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## 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 pre-procedure, 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.

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## 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

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## 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

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# CPT 95165 - Allergy Immunotherapy in 2021

Limits on the  
number of doses  
per Payer

Cigna

United Health  
Care

Aetna

- Limits are from 80-120 units per year are common

CMS – 30 units  
per day – MUE  
Edit

BCBS – adopting  
the MUE from the  
NCCI edits

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Payers requiring an  
order for all  
prescriptions for  
immunotherapy as well  
as refills of antigens

Third party payers  
requiring the number of  
anticipated doses be  
documented at the time  
or preparation of doses

Third party payers not  
allowing “off the board  
treatment”

Limits on the number of  
doses allowed per the  
carrier guidelines per  
year or per date

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**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	95170
Rapid Desensitization #Hr_____	95180

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## Immunotherapy

**95170 Whole body biting insect fire ants**

**95180 Rapid desensitization**

- Charge by time – Time must be documented
- Only time of desensitization test, not time in office
- Doses given for desensitization may also be charged
- Check your payers' coverage guidelines for diagnoses which are payable with the 95180.
- CMS does not cover foods or regular antigen rapid desensitization (95180)

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- 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 up dosing
  - Prolong services – staff or physician?

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# Questions?

- Thank you



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