

Looking for Monumental Ideas? Empower your Practice

2016 Practice Management Workshop
Washington DC
July 22-24, 2016
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- I have no disclosures

Coding: What's on the Horizon?

Governmental Policies

- New diagnosis codes – effective October 1, 2016
 - Grace period for use of unspecified codes lapse
- MIPS replaces Meaningful Use and PQRS
 - Reduction in fees 4%
 - Mandatory – 2020
- Value Based Modifiers
- HCC – Hierarchical Condition Categories
 - Government
 - Medicare advantage
 - Private payers

Third Party Payers

- Limits on allergy testing
- Limits on immunotherapy doses
- Post payment reviews
 - Documentation
 - Support of charges submitted
 - Justification

Different Formats of Practice

- Individual or group
- Hospital based practice
- Multispecialty based practice
- Differences in physician compensation
- Production versus revenue
- RVU's - how does this factor into compensation

Auditing Your Practice

- Workflow processes
- FTE – full time employees: How many are appropriate?
- Patient flow and satisfaction
- Revenue Cycle Management
 - Documentation
 - Coding
 - Collection – high deductibles

Expanding Your Practice

- Increase number of physicians
- Advanced practitioners (NPs, PAs, etc.)
 - Utilization
 - Effectiveness
 - Medicare guidelines versus private pay
 - State guidelines

Marketing Your Practice

- Yellow pages
- Facebook
- Twitter
- Snapchat
- Instagram
- You Tube
- Word of mouth
- Referrals from colleagues
- Participation in insurance plans

Marketing Your Practice

- Patient portals for general information
- Community involvement

Coding

- Foundation for:
 - Revenue
 - Quality measures
 - MIPS
 - PQRS
 - Meaningful Use
 - HCC
 - Alternative payment models

Diagnosis Codes for 2017

ICD-10CM in 2017

- October 1, 2016 revisions:
 - 1943 new codes
 - 422 revised codes
 - 305 deleted codes

ICD-10CM in 2016

- Codes specific to allergy specialty for 2017
 - Z51.6 - Encounter for desensitization to allergens
 - Z29.13 - Encounter for prophylactic Rho(D) immune globulin
 - K52.21 – Food protein-induced enterocolitis syndrome
 - K52.22 – Food protein-induced enteropathy
 - K52.29 – Other allergic and dietetic gastroenteritis and colitis

Chapter 3 – Disease of the Blood & Blood Forming Organs

- D89.4 Mast Cell activation syndrome and related disorders
 - D89.40 – Mast cell activation, unspecified
 - D89.41 – Monoclonal mast cell activation syndrome
 - D89.42 – Idiopathic mast cell activation syndrome
 - D89.43 – Secondary mast cell activation syndrome
 - Code also underlying etiology, if known
 - D89.49 – Other mast cell activation syndrome

Chapter 3 – Disease of the Blood & Blood Forming Organs

- D89.4 – Mast cell activation syndrome
 - Excludes 1: aggressive systemic mastocytosis (C96.2)
 - Cutaneous mastocytosis (Q82.2)
 - Indolent systemic mastocytosis (D47.0)
 - Malignant mastocytoma (C96.2)
 - Mast cell leukemia (C94.3-)
 - Mastocytoma (D47.0)
 - Systemic mastocytosis associated with clonal hematologic non-mast cell lineage disease (SM-AHNMD) D47.0

ICD-10CM in 2016

- Diagnosis codes for asthma
 - Proposed controlled and uncontrolled
 - Recommendations for new codes
 - Status –
- Diagnosis code changes for angioedema and urticaria
- Diagnosis code changes for anaphylaxis peanut and other tree nuts

Chapter 8 – Disease of the Ear and Mastoid Process

Added:

H90.A11- Conductive hearing loss, unilateral, right ear with restricted hearing on the contralateral side

H90.A12 – Conductive hearing loss, unilateral, left ear with restricted hearing on the contralateral side

H90.A21 – Sensorineural hearing loss, unilateral, rt ear, with restricted hearing on the contralateral side

H90.A22 – Sensorineural hearing loss, unilateral, left ear, with restricted hearing on the contralateral side

Chapter 8 – Disease of the Ear and Mastoid Process

- H90.A31 – Mixed conductive & sensorineural hearing loss, unilateral, right ear with restricted hearing on the contralateral side
- H90.A32 – Mixed conductive & sensorineural hearing loss, unilateral, left ear with restricted hearing on the contralateral side
- H93.A1 – Pulsatile tinnitus, right ear
- H93.A2 – Pulsatile tinnitus, left ear
- H93.A3 – Pulsatile tinnitus, bilateral

Chapter 10 – Respiratory

Chapter Instruction changes
Use additional:
history of tobacco dependence (Z87.891)
Verbiage change from history of tobacco use

Chapter 11 – Disease of Digestive System

- K52.21 – Food protein-induced enterocolitis syndrome
- K52.22 – Food protein-induced enteropathy
- K52.29 – Other allergic and dietetic gastroenteritis and colitis

Chapter 12 – Disease of the Skin

- Dermatitis and eczema (L20-L30)
 - Excludes 2: stasis dermatitis (I87.2)
- L50.2 Urticaria due to cold and heat
 - Excludes 2: familial cold urticarial (M04.2)

Chapter 18 – Signs, Symptoms

- R53.1 Weakness
 - Excludes 1 – sarcopenia (M62.84)
- R63.0 – Anorexia
 - Excludes 1: Loss of appetite of nonorganic origin (F50.89)
 - Change in Code number
- R73.03 – Prediabetes
- R73.09 – Other abnormal glucose

Chapter 19 – Other & Unspecified Effects of External Causes (T66-T78)

- T78.05 – Anaphylactic reaction due to tree nuts and seeds
 - Excludes 2: Anaphylactic reaction to peanuts (T78.01)
- T78.1 – Other adverse food reactions, not elsewhere classified
 - Use additional code to identify the type of reaction is applicable

Chapter 19 – Other & Unspecified Effects of External Causes (T66-T78)

- T78.4 – Other unspecified allergy
 - Excludes 1:
 - Allergic diarrhea (K52.29)
 - Allergic gastroenteritis & colitis (K52.29)
 - Food protein-induced enterocolitis syndrome (K52.21)
 - Food protein-induced enteropathy (K52.22)

Chapter 21 – 2017 Changes

- Codes specific to allergy specialty for 2017
 - Z51.6 - Encounter for desensitization to allergens
 - Z29.13 - Encounter for prophylactic Rho(D) immune globulin

ICD-10CM in 2017

- Diagnosis codes for asthma
 - Proposed Controlled and Uncontrolled
 - Recommendations for new codes
 - Status –
- Diagnosis code changes for angioedema and urticaria – no change

ICD-10CM in 2016

- Assess your ICD-10 progress using key performance indicators
- Address opportunities for improvement
- Maintain your progress

ICD-10CM in 2016

- Assessing your progress:
 - KPI – Key Performance Indicators
 - Productivity
 - Reimbursement
 - Claims submission
 - Denials
 - Appeals

ICD-10CM in 2016

- Pre ICD-10CM baseline data versus post data
- Clearinghouses
- System vendors
- Third party billers

ICD-10CM in 2016

- Examples – KPI
 - Days to billing
 - Days to payment
 - Claim acceptance, rejections
 - Reimbursement rate
 - Coder productivity
 - Requests for additional information
 - Payer edits
 - Use of unspecified codes

ICD-10CM in 2016

- Addressing your findings
 - Feedback system
 - Staff
 - Physicians and other providers
 - Clinical documentation and code selection
 - Prior to ICD-10 versus post – changes
 - Who selects diagnosis codes
 - Default codes
 - Problem list for patients and diagnoses

ICD-10CM in 2016

- Addressing your findings:
 - Educational resources for providers, coders and other staff members
 - Continuing or only one time
 - Revision of tools to enable process
 - Checking software for correctness of diagnosis code descriptions and diagnosis code number
 - Asking questions for accuracy versus using a unspecified code or previous code which is incorrect
 - Review of 7th character requirements and secondary codes

ICD-10CM in 2016

- Computer system issues:
 - All available upgrades implemented
 - Technical problems with systems
 - Testing after upgrades are provided for accuracy

ICD-10CM in 2016

- Payer Issues
 - Medicare LCD's for your geographic area
 - Blue Cross, Aetna, Cigna, UHC
 - Policies accurate for standard of care and in compliance with previous diagnosis codes for medical necessity
 - Find a representative to work with at the local level

ICD-10CM in 2016

- Maintain and monitor progress
 - Medical policy changes for a payer
 - System change with an effect on accuracy of diagnosis codes
 - System cannot be changed or updated
 - Request for new code or revision of diagnosis code to the ICD-10 Coordination and Maintenance committee
 - ICD-11 CM ???

Diagnosis Coding Review

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

Basics of Diagnosis Coding

- Chapter 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.

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
 - Dermatitis due to substances taken internally
 - Urticaria
 - Pruritus
 - Erythema
- Codes from the T36-T50 will be sequenced second

Basics of Diagnosis Coding

- Status - indicates that a patient is either a carrier of a disease or has the sequelae or residual of a past disease or condition
 - The status code is informative, because the status may affect the course of treatment and 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

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

ICD-10 Issues

- Toxic effect of venoms – T63.421 through T63.484
 - Most Medicare MAC’s have corrected the ICD-10CM codes for venoms
 - The LCD’s for MAC’s may have initially only the Z codes or only the T codes
 - Z codes for venoms –
 - Z91.030 Bee allergy status
 - Z91.038 Other insect allergy status
 - Letters were sent to the Medicare MAC’s requesting the mapping to the appropriate diagnosis codes for bee venom therapy

ICD-10 Issues

- Aetna – medical policy – reviewed for appropriate codes for pulmonary function codes as well as allergy testing and immunotherapy codes
 - A letter to the medical director has been sent for their consideration of appropriate mapping to diagnosis codes specific to allergist

Questions Regarding ICD-10 Codes

- What is the difference between L23 “Allergic Contact dermatitis” Codes and L25 “Contact Dermatitis” Codes?
- Should Asthma severity codes be based on the most recent Guidelines which note that medication step up therapy that controls symptoms fixes the code severity or does using older Guideline standards of symptom & PFT findings still fixes the severity?

Questions Regarding ICD-10 Codes

- What in the world does J30.2 “other seasonal rhinitis” mean compared to J30.1 Allergic rhinitis due to pollens? Should you always use J30.9 “AR, unspecified” if you do not document by allergy tests??
- Who is responsible if a EHR vendor has a system that can not code more than 4 dx codes on the initial electronic bill even if the electronic record can document 12 dx codes?

ICD-10 Issues

- We billed skin prick testing (95004) for one of our patients to BCBS with the personal history code for egg allergy. BCBS has denied it, stating they don't allow payment for skin testing for any history codes (Z codes)
- Can we use an anaphylaxis code if they are not actively having symptoms (since they are avoiding food)?
- Can we use a symptoms code (i.e. L27.2 dermatitis due to ingested food) if they don't currently have the symptom (again due to avoidance of the food in question)?

ICD-10 Issues

- If your documentation of skin testing indicates a positive allergy to "dust mite" can your impression in dictation read "allergic rhinitis," or should it read "allergic rhinitis-dust mite?"
- A patient is having nasal stuffiness and is allergy tested which showed reaction to house dust mites, diagnosis allergic rhinitis J30.89. If the patient is negative on skin testing what would be the correct coding, J30.0 vasomotor rhinitis or J31.0 chronic rhinitis?
- If a patient is allergic to dust mites is there a code for that, or would I just use J30.89 for other allergic rhinitis?
- If a patient is allergic to mold, is there a code for that, or would I just use J30.2 for other seasonal allergic rhinitis?

ICD-10 Issues

- Allergy skin testing an infant before giving peanuts or tree nuts? Especially in context of LEAP protocol?
- Asymptomatic sibling of food allergic patient is brought in for discussion of food allergy and selected tests for common food allergens. What is the appropriate diagnosis code?

ICD-10 Issues

- What is the appropriate code to use for a child that is labeled "peanut allergic" due to a skin test positive sensitizations but has never consumed a peanut? Would you use the Z91.010 or T78.01x? Also would you use the A or D status if you at follow up visits?
 - The T78.0---- codes are for anaphylactic reaction due to food
 - Code for the patient's reaction – signs, symptoms, adverse reaction, dermatitis, etc.
 - Z91 – codes are history of allergies to foods

ICD-10 Issues

- If we use the unspecified code for a diagnosis, for example dermatitis, will it be automatically rejected? What if we are still working up the cause, you must guess the possible culprit such as dermatitis contact cosmetic. Is this the case or can you start unspecified and alter after testing complete?
- If patient has history of anaphylaxis to penicillin would I code T88.6 or Z88.0, or can I use both?

ICD-10 Issues

- Please provide coding help for angioedema. I am seeing conflicting information on which codes to use. (T78.3 vs. T78.4...)
- T78.3 – Angioneurotic edema – includes
 - Allergic angioedema, Giant urticarial, Quincke's edema
 - Excludes 1 – serum urticarial, urticarial (L50.-)
- T78.4 - Other and unspecified allergy
 - Excludes specified types of allergic reaction such as
 - Allergic diarrhea, allergic gastroenteritis and colitis, dermatitis, hay fever, etc
 - T78.40X-Allergy unspecified – includes allergic reaction NOS
 - Hypersensitivity NOS

ICD-10 Issues

- How do I code for a patient who thinks she might be allergic to Lidocaine, a local anesthetic? My reading gets me to T41.3X5 or T41.45X, but they are apparently not billable codes. I assume this is because the X needs to be filled in. How do I do that? On a separate issue, how would I code for someone who had intra-operative anaphylaxis?
 - the Z88.4 for allergy status to anesthetic agents
 - T88.2XXA Shock due to anesthesia, T88.6XXA anaphylactic reaction due to adverse effect of correct drug or medication properly administered and then code for the medication as well.

ICD-10 Issues

- Oral allergy syndrome –
 - T78.1XXA,D, or S other adverse food reactions, not elsewhere classified
 - Use additional code to identify the type of reaction
- If a patient has sinusitis and a culture has not been done to determine the bacteria, can we use the unspecified code J01.00 "Acute Maxillary Sinusitis Unspecified"?
- When we make vials, do we have to know what the tobacco status is for each patient and add the Z-code to the other codes?
- Every time a patient comes in for an allergy shot, do we need to use the tobacco status code for every patient?
- Where do you indicate the tobacco status? On the shot card?

2016 Changes for Allergy Practices

CPT Revisions for 2016

- 99415 - RVU value .25
 - Prolonged clinical staff face-to-face time beyond the E/M service (99201-99215) provided
 - Provider is available to provide direct supervision
 - Time does not need to be continuous
 - Time spent providing other services does not count
 - Time must be greater than 45 additional minutes from E/M

CPT Revisions for 2016

- +99416 – Prolong clinical staff time each additional 30 minutes – RVU .02
 - Use typical time as defined in CPT for base E/M (99201-99215)

CPT Revisions for 2016

- Revisions to instructions to behavior change interventions, individual (99406-99409)
 - To charge in addition to E/M must be “separate and distinct” – use the 25 modifier
 - Includes:
 - Assessing readiness for change and barriers to change
 - Advising a change in behavior,
 - Assisting by providing specific suggested actions
 - Motivational counseling
 - Arranging for services
 - Follow-up

Allergy Services in 2016

- Drug Testing (95018)
 - Per the NCCI MUE portion there is a limit of 19 for this code on a calendar date.
 - Penicillin testing
 - Charge for the percutaneous and the intradermal tests (95018)
 - Charge for the oral challenge (95076) – only if you meet the definition of the code
 - Clinically:
 - If penicillin skin testing is performed with only penicilloypolylysine and penicillin G, initial administration of penicillin, depending on the pretest probability of the patient being allergic, may need to be done via **graded** challenge (ie, 1/100 of the dose, followed by the **full dose**, assuming no reaction occurs during a brief observation period).
- Documentation to support this service????
- Intramuscular drug challenge? Coding

Allergy Services in 2016

- Limits on the number of doses per payer
- Cigna
- United Health Care
- Aetna
- Limits are from 80-120 units per year are common
- CMS determined that the contractor’s discretion for coverage of allergen immunotherapy is most appropriate

Allergy Services in 2016

- FDA approved SLIT therapy
 - Grass, ragweed approved for SLIT therapy
- SLIT therapy not approved by FDA
 - Cash for patients
 - Do not use the 95165 since it doesn’t meet the guidelines for a CPT code
- HyQvia – unlisted biologic J3590
 - Preauthorization
 - May need to send cost
 - Appeal letter to medical director/allergist

Modifiers for 2016

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.

Modifiers for 2016

- 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.

Modifier Changes for 2016

Modifier 59 – Distinct Procedural Service

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.

Modifier Changes for 2016

Modifier 59 – continued

- 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 Changes for 2016: Medicare

- XE – Separate Encounter: A service that is distinct because it occurred during a separate encounter
- XS – Separate Structure: A service that is distinct because it was performed on a separate organ/structure
- XP - Separate Practitioner: A service that is distinct because it was performed by a different practitioner
- XU – Unusual Non-overlapping service: The use of a service that is distinct because it does not overlap usual components of the main service

Modifiers for 2016

- **XE** – *“Separate encounter, a service that is distinct because it occurred during a separate encounter.” This modifier should only be used to describe separate encounters on the same date of service.*
- **Example** – *Patient presents for an allergy immunotherapy injection. Later in the day patient returns with a reaction and requires additional care. If additional injections are given, you would need the XE on the procedures performed.*

Modifiers for 2016

- **XS** – *“Separate Structure, a service that is distinct because it was performed on a separate organ/structure”*
- **Example-**

Modifiers for 2016

- **XP** – *“Separate Practitioner, a service that is distinct because it was performed by a different practitioner”*
- **Example:** *A different physician see the patient for a different diagnosis on the same calendar date as a previous encounter. Both providers are within the same tax id group.*

Modifiers for 2016

- **XU** – *“Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service”*
- **Example:** *Patient has a pre and post spirometry (94060). An educational session is held with the patient for a different bronchodilator to be used at home. (94664xu)*

Modifiers for 2016

- X{EPSU} Modifiers may also be used on spirometry or allergy testing codes to show different services.
- X{EPSU} Modifiers are more descriptive than Modifier 59
- Some edits may require only the use of the X{EPSU} modifiers
- For bilateral procedures – LT, RT are also appropriate modifiers

2016 Revisions for CMS

- OIG –Office of the Inspector General Work Plan
- NEW physicians–referring/ordering Medicare services and supplies. We will review select Medicare services, supplies and durable medical equipment (DME) referred/ordered by physicians and non-physician practitioners to determine whether the payments were made in accordance with Medicare requirements.
- CMS requires that physicians and non-physician practitioners who order certain services, supplies and/or non-physician DME are required to be Medicare-enrolled physicians or practitioners and legally eligible to refer/order services, supplies and DME

2016 Revisions for CMS

- NEW Physician home visits – reasonableness of services. We will determine whether Medicare payments to physicians for evaluation and management home visits were reasonable and made in accordance with Medicare requirements. Since January 2013, Medicare made \$559 million in payments for physician home visits. Physicians are required to document the medical necessity of a home visit in lieu of an office or outpatient visit.

2016 Revisions for CMS

- NEW Prolonged services—reasonableness of services. We will determine whether Medicare payments to physicians for prolonged evaluation and management (E/M) services were reasonable and made in accordance with Medicare requirements. Prolonged services are for additional care provided to a beneficiary after an evaluation and management service has been performed. Physicians submit claims for prolonged services when they spend additional time beyond the time spent with a beneficiary for a usual companion evaluation and management service. The necessity of prolonged services are considered to be rare and unusual.

Audits

Why Audit Your Practice?

- Efficiencies of work flow
- Financial benefits equal the efforts of the practice
- Fraud – internal or external
- Adapt to changes when they occur
- Documentation changes to support better coding on a continual basis
- Frequency – every year, every six months???

Allergy Practices and Audits

- Number of tests 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 advanced practitioners
- Levels of services provided

Incident To Guidelines

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

Incident To 2016 Guidelines

- **Incident To Policy for Calendar Year 2016**
In the calendar year 2014 PFS final rule, CMS required that, as a condition for Medicare Part B payment, all “incident to” services and supplies must be furnished in accordance with applicable state law.
- The definition of auxiliary personnel was also clarified to require that the individual furnishing “incident to” services must meet any applicable requirements to provide such services, including licensure, imposed by the state in which the services are furnished.

Incident To 2016 Guidelines

- In some cases, the physician or practitioner supervising the service is not the same individual treating the patient more broadly.
- CMS is finalizing a proposal to specify that, in those cases, only the supervising physician or practitioner may bill Medicare for “incident to” services.
- Additionally, CMS is finalizing a proposal to require that auxiliary personnel providing “incident to” services and supplies cannot have been excluded from Medicare, Medicaid, or other Federal health care programs by the Office of Inspector General, or have had their enrollment revoked for any reason at the time that they provide such services or supplies.

Allergist Coding Curve

	National		National
99201	.22%	99241	.52%
99202	2.87%	99242	3.48%
99203	29.71%	99243	30.42%
99204	55.52%	99244	54.02%
99205	11.68%	99245	11.56%

Allergist Coding Curve

	National
99211	3.44%
99212	5.67%
99213	53.74%
99214	34.56%
99215	2.6%

Audit Response

- Know your risk
- Seek counsel if you are high risk
- Review your records
- Have a third set of unbiased eyes read the notes
- Respond in a timely manner
- Communicate with the payer performing the review
- Negotiate

Questions???

Thank you
