Core Value:

Develop and Implement Best Practices, Both Clinical and Business, Across the Entire Organization.

Coding Pearls, 2013

Presented by: David Brown, MD
AAAAI Annual Conference
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San Antonio, TX
Office Visit Based on Time

- **CMS & CPT guidelines state**: In the case where counseling and/or coordination of care dominates (more than 50%) of the physicians/patient and/or family encounter (face-to-face time in the office or other outpatient setting, floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

- **CMS & CPT documentation guidelines**: If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/floor activities to coordinate care.
Billing by Time Continued…

Consider using time in the following scenarios

- Diagnostic results, impression and/or recommended diagnostic studies or prognosis
- Risks and benefits of management (treatment) options
- Instructions for management (treatment) and/or follow-up
- Importance of compliance with chosen management (treatment) options
- Risk factor reduction
- Patient and/or family education
- If a family member is seen to discuss patient’s case (Medicare will not pay)

CPT Code/Face-to-Face Time/Counsel Time>50%

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Nurse visit – 99211 and When to Use It...

99211 is defined as:

- “An office or outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician”.

- Presenting problems are usually minimal and typically require five minutes to perform these services.
When to use 99211

- The patient must be established.
- The clinical staff-patient encounter must be face to face.
- The presence of a physician is not required.
- The service must be separate from other services performed on the same day.
- If there is already a CPT code (such as 95115 for administering an Allergy Shot) for a service do not use 99211. (Unless instructed by the carrier)

Examples:

- A patient has a local reaction to immunotherapy that requires additional history, dosage requirements and examination. Carefully document these services. Report the immunotherapy, such as 95115 and the nurse’s evaluation (99211) appended with modifier -25.

- The Physician recently changed allergy medications and wants the nurse to evaluate the effect on the patient before giving him a three-month prescription of the medicine. The nurse evaluates (99211) the patient’s response to the medication, possible side effects and consults the Physician for appropriate dosage adjustments.
The Benefits of 99211

- Only five 99211 encounters in a week will result in $5,000+ per year. ($20 per visit)

- Most practices already provide a number of 99211 services but fail to capture those charges.

- No Key components are required. Documentation is required.
Are you clear on how to report MDI/PDI training using CPT Code 94664?

Code 94664’s descriptor specifies demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device. Part of teaching the proper technique in using an inhaler (either propellant-driven or dry powder) is to demonstrate and evaluate. In this respect, the code would seem appropriate to use for demonstration and evaluation.

Append Modifier 25 to the E&M Code, add 59 to the training code 99213-25
94664-59

Modifier 59 states a distinct procedural service was performed
Allergy Relief Act – Training (ARAT)

- Not all payers will reimburse 94664. If practices abuse 94664, probably fewer payers will pay. To support reporting 94664, documentation should include an indication of medical necessity.
- Some insurance companies are reimbursing up to $40.00 for training that is appropriately documented
- The training needs to be documented in the chart. Below is an example of how the documentation may look:

  - Taught/Reviewed technique to patient & parent ____________.
  - Return demonstration performed correctly / incorrectly / needs coaching
  - Correct verbal confirmation given by patient ________________.
  - Spacer used: Inspirease / aerochamber / aerochamber with mask
  - Reviewed oral care
  - Counting puffs reviewed
  - Peak Flow Meter education given and return demonstration performed
  - Employee Initials __________.
CMS continues to reimburse for tobacco cessation for any smoker including asymptomatic patients

Medicare will cover up to 2 individual attempts per year and up to four sessions for each attempt, thus covering up to eight sessions per Medicare patient who uses tobacco

Commercial Carrier benefits are subject to specific plan policies. Before providing service, benefit eligibility and payer coding requirements should be verified

Commercial Carriers accept codes 99406 and 99407
Tobacco Cessation - Medicare

99406 – Symptomatic smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
Medicare Fees are $12 - $14 for up to a 10 minute visit
If all eight visits are used Fees are up to $112 per Medicare patient

Use Code G0436 for Medicare Asymptomatic patients

99407 – Symptomatic smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
Medicare Fees are $25 - $30 for an intensive >10 minute visit
If all eight visits are used Fees are up to $240 per Medicare patient

Use Code G0437 for Medicare Asymptomatic patients

Use Diagnoses: 305.1 – Non-dependent tobacco use disorder
V15.82 – History of tobacco abuse
Ingestion Challenge – DELETED CODE

- **95075** - Ingestion challenge test sequential and incremental ingestion of test items, eg, food, drug or other substance such as metabisulfite.

- Medicare Fees are $60-$70 per office visit

- You can only charge ONE unit for most carriers
Ingestion Challenge – NEW CODE

Good News!

• **95076** - Ingestion challenge test sequential and incremental ingestion of test items, eg, food, drug or other substance); **initial 120 minutes of testing**
  - Test must last at minimum 61 minutes in order to bill. If less than 61 minutes bill appropriate E/M level visit.
  - Medicare Reimbursement - approx $117

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<th>Malpractice Expense</th>
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Good News!

- **95079** - Ingestion challenge test sequential and incremental ingestion of test items, e.g., food, drug or other substance); **each additional 60 minutes of testing**

- Medicare Reimbursement - approx $83

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Bad News!
Denials may be received from some insurance companies that do not recognize the new codes

- **95076** - Ingestion challenge test sequential and incremental ingestion of test items, eg, food, drug or other substance); *initial 120 minutes of testing*
- **95079** - Ingestion challenge test sequential and incremental ingestion of test items, eg, food, drug or other substance); *each additional 60 minutes of testing*
Percutaneous & Intradermal – Deleted Codes

• **95010** — Percutaneous tests (scratch, puncture, prick sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, *including test interpretation and report by a physician*, specify number of tests.

• **95015** — Intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, *including test interpretation and report by a physician*, specify number of tests.
Good News!

- 95017 – Allergy testing, any combination of **percutaneous** (scratch, puncture, prick) and **intracutaneous** (intradermal), sequential and incremental, with **venoms**, immediate type reaction, including test interpretation and report, specify number of tests

Note: Removed from description - including test interpretation and report **by a physician**

<table>
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<th>RVU Components (by modifier)</th>
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<tr>
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</table>
Good News!

- 95018 – Allergy testing, any combination of **percutaneous** (scratch, puncture, prick) and **intracutaneous** (intradermal), sequential and incremental, with **drugs or biologicals**, immediate type reaction, including test interpretation and report, specify number of tests

Note: Removed from description - including test interpretation and report by a physician

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- 95018 – Allergy testing, any combination of **percutaneous** (scratch, puncture, prick) and **intracutaneous** (intradermal), sequential and incremental, with **drugs or biologicals**, immediate type reaction, including test interpretation and report, specify number of tests
Percutaneous Testing — REVISED CODE

OLD Description
• 95004 – Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests

NEW Description (effective 1.1.13)
• 95004 – Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests

RVU Components (by modifier)

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Intracutaneous Testing — REVISED CODE

OLD Description
• 95024 – Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests

NEW Description (effective 1.1.13)
• 95024 - Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests

RVU Components (by modifier)

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Venom Billing

• #XXO##????

• CARRIER SPECIFIC

• Some carriers allow “anticipated dose” per vial.

• Some carriers allow “anticipated dose” per CPT code.
Venoms – Anticipated Dose per CPT code

• This scenario bills venom by “anticipated dose” for each venom CPT code

  • 95145 Full set (includes maintenance vial which is 12 units & two build up vials which is 8 units) = 20 units
  • 95146 Full set (includes 2 maintenance vials = 24 units & four build up vials which = 16 units) = 20 units
  • 95147 Full set (includes 1 maintenance vial = 12 units & two build up vials = 8 units) = 20 units
  • 95148 Full set (includes 2 maintenance vials = 24 units & four build up vials = 16 units) = 20 units
  • 95149 Full set (includes 3 maintenance vials = 36 units & six build up vials = 24 units) = 20 units
  • Summary – Units billed on full set of the above codes = 20
    Units billed on maintenance vial = 12
  • The correct way to bill Medicare.
Cluster Immunotherapy

95180 - Rapid desensitization procedure, **each hour**
(eg, insulin, penicillin, equine serum) The patient is given small but increasing dosages of the allergen every hour.

- Procedure usually takes 2 hours
- Medicare Reimbursement approx - $133 per hour
- Physician work unit – 2.01
### Cluster Immunotherapy Schedule for Inhaled Allergens

<table>
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<tr>
<th>Visit</th>
<th>Date</th>
<th>Time Given</th>
<th>Dose (ml)</th>
<th>Total Time in Office</th>
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<th>Nurse Initials</th>
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There must be at least one day between shots. There is a 30 minute wait between shots and after the last shot of the day.

**Precautions:**
- Consider pre-medication on the day of cluster therapy and if pre-medicating, be consistent.
- 1-2 clusters per week
- Asthma should be stable. Check peak flow rate and/or FEV1 if needed.
- Be cautious with patients with high skin reactivity