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Part B Insider (Multispecialty) Coding Alert

Allergy Immunotherapy: 95165: This Payer Cites Ongoing Problems With Allergy Shot Coding

Hint: Limit number of units you bill to the size of the vial.

Although you might think you've got the allergy shot coding rules committed to memory, one Part B MAC is hoping you'll revise some of those traditions.

On July 31, NGS Medicare distributed a notification to Part B practices alerting them to tighten up their claims for 95165 (Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens [specify number of doses]).

"Investigations by the OIG in 2002 and again by the Program Safeguard Contractor in 2015 have demonstrated that claims for CPT® code 95165 are sometimes billed incorrectly," the alert stated, adding that providers should keep in mind that per CMS guidelines, one unit of 95165 equals one cc of the antigen.

Therefore, if the doctor administers four ccs of a vial, then he should report four units of 95165. "Billing one unit of 95165 per one cc holds true regardless of the number of injections, and/or number of antigens," NGS said in the alert. "Additionally, once an antigen maintenance mix is created and billed it cannot be further diluted for additional charges."

However, despite the "one unit per cc" rule, Medicare does have several caveats as follows, according to chapter 12 of the Medicare Claims Processing Manual:

- If a physician prepares a 20cc multi dose vial, he can bill Medicare for 20 doses, since the practice expense is calculated based on the assumption that the physician will remove multiple one cc doses from the vial. "If a physician removes two cc aliquots from this vial, thus getting only 10 doses, he may nonetheless bill Medicare for 20 doses because the practice expense for 20 doses reflects the actual practice expense of preparing the vial."
- If a physician removes multiple ½ cc doses from a 10 cc multi dose vial for a total of 20 doses, he can only bill Medicare for 10 doses, which is the maximum billable for the 10 cc vial. "Billing for more than 10 doses would mean that Medicare is overpaying for the practice expense of making the vial," CMS says.
- If, however, a physician prepares **two** 10cc multi-dose vials, he can bill Medicare for 20 doses. But the doctor can remove as many doses from those vials as he wants. "For example, the physician may remove ½ aliquots from one vial, and one cc aliquots from the other vial, but may bill no more than a total of 20 doses," CMS says.
- If a physician prepares a five cc multi-dose vial, he can bill Medicare for five doses. However, if the physician removes ten ½ cc doses from the vial, he can still bill only five doses because the practice expense of preparing the vial is the same, without regard to the number of additional doses that are removed from the vial.

Translation: In essence, the maximum number of units you can report for any vial is the same as the number of ccs included in the vial itself.

Get to Know These Other Allergy Shot Rules

With fall allergy shot appointments already filling your schedule, it's a good time to refresh your memory on how to report these services in general now that you've got the 95165 rules under your belt.

When your physician provides only the injections for the allergy immunotherapy and the allergenic extracts for the injections came from another source, you should code for the injections only, depending on the number of injections provided. If your physician provided only one injection, reach for CPT® code 95115 (Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection).

If your physician provides more than one injection, use 95117 (Professional services for allergen immunotherapy not including provision of allergenic extracts; 2 or more injections) to report the allergy immunotherapy services that your physician performed. The code involves the observation service (to check for allergic reactions) that your physician performed after the injection. Keep in mind that these codes only represent the administration of the extract prepared by your physician or someone from your facility.

Reminder: If your physician administered the antigens sublingually (i.e., by placing drops under the patient's tongue), then you cannot claim reimbursement for the service. Note that antigen(s) administration is covered only if it is injected by your provider.

Know the Codes for Allergenic Extract Preparations

Along with knowing the codes to report injections-only, you'll best capture your provider's services for allergenic extract prep if you apply the appropriate code. Most payers recognize 95144 (Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single dose vial[s] [specify number of vials]) or 95165 to report the provision of the allergenic extracts, whether the allergenic extracts are mixed or prepared by a person of another facility or by the same individual providing the injections.

Be sure to report the correct code, dependent upon whether or not single dose vials are prepared, or the more common multi-dose vial. For single dose vials, report the total number of vials prepared for the patient. For multi-dose vials, report the number of one cc doses prepared (even if the patient will not be given a one cc dose at a given encounter).

Don't Forget to Report E/M Services When Performed

You may be unsure about reporting E/M services along with allergy immunotherapy codes. The allergy administration codes include a pre-procedure evaluation to ensure that the patient is able to receive the injection and a post-procedure evaluation period to determine if the patient is in jeopardy of an allergic reaction, so you cannot report an E/M code unless a separate identifiable service is performed. Obtaining informed consent is included in the immunotherapy.

Remember that you have to an appropriate E/M code (such as 99212-99215, Office or other outpatient visit for the evaluation and management of an established patient...) depending on the level of E/M services provided when a separate service is performed in addition to the allergy immunotherapy. Add modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) to help the payer know that a separate service has been performed in addition to the allergy immunotherapy. Include documentation of the separately identifiable service that has been performed.

Example: Your physician assesses a patient suffering from severe pain and fever due to a peritonsillar abscess (475), and the patient receives her scheduled bimonthly series of allergy immunotherapy for allergic rhinitis due to dander (477.2). Your physician performs and documents a level-three E/M service. You should report 99115 and 99213 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components... Physicians typically spend 15 minutes face-to-face with the patient and/or family) along with the modifier 25 appended to 99213.