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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Secure Allergen Immunotherapy Reimbursement That's Nothing to Sneeze At

Tip: Use unlisted code 95199 for food allergies

If denials for allergy claims are getting under your skin, follow these five steps for making the best possible case for reimbursement.

Step 1: Asses The Allergy Agony

Treating a patient for allergies is a complex process that requires separate codes for each stage of testing and treatment.

The first step of coding allergen immunotherapy is determining if a patient qualifies for carrier-covered skin testing, says **Mary Porter, CPC**, coder with **Allergy and Asthma Associates** in Christianburg, VA. Many carriers require patients exhaust other treatment methods such as medication and avoidance before they can be covered for allergen immunotherapy. For example, Medicare carrier Trailblazer Health's (which covers Maryland, Virginia, the District of Columbia, and Texas) requirements for skin testing include "patient hypersensitivity cannot be satisfactorily managed by medication or avoidance."

There are a number of diagnosis codes that support skin testing. Porter most commonly sees 477.0 (Allergic rhinitis; due to pollen), but other allowable diagnoses include 477.8 (...due to other allergen), 493.00-493.02 (Asthma; extrinsic asthma), 493.20-493.22 (...chronic obstructive asthma), 989.5 (Toxic effect of other substances, chiefly nonmedicinal as to source; venom), and 708.0-708.1 (Urticaria).

Warning: Medicare will often have several codes in one area of diagnosis, but will exclude two or three codes in a family, notes Porter. Example: Virginia's Trailblazer Medicare accepts 708.8 (Urticaria, other specified urticaria), but not 708.9 (...urticaria, unspecified).

Step 2: Administer Skin Testing

Once the patient qualifies for skin testing, the physician determines which allergens the test should include based on the patient's history, likely exposure in his or her geographic area, and type and length of symptoms, says Porter.

The office should code each individual scratch test the physician or nurse performs, broken down by allergen type. You should report 95004 (Percutaneous tests [scratch, puncture, prick] with allergenic extracts, immediate type reaction, specify number of tests) for allergens such as pollen, mold, mildew, grasses, trees, and dust mites, or 95010 (Percutaneous tests [scratch, puncture, prick], sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, specify number of tests) for allergens such as penicillin, horse serum (used in vaccines) or insect venoms (bee and wasp stings), and enter the number of scratch tests in the units box, says **Chrissy Letsen, CPC**, education and auditing specialist for **Metropolitan ENT** in Alexandria, VA. Do not bill each individual test on a separate line.

Example: An allergist tests a patient for reactions to dogs, cats, ragweed, oak, maple, penicillin, dust mites, and bees. **You report:** 95004 x 4 units for the ragweed, oak, maple, and dust mites, and 95101 x 4 units for the dog, cat, penicillin, and bee stings.

Snag: Most carriers will not cover testing for food allergens, but if you do submit a claim for this service, report a diagnosis of 477.1 (...due to food) and link it to 95199 (Unlisted allergy/clinical immunology service or procedure), says

Letsen.

Exception: Some Medicare carriers, such as Virginia Trailblazer, will cover food allergy testing, notes Porter. The carrier lists V15.01-V15.07 (Other personal history presenting hazards to health; allergy, other than to medicinal agents...) as diagnoses that cover skin testing.

If the patient shows a strong reaction to a scratch that is a combination of allergens and the physician wants to test the components individually, you may report those additional tests in the session as well.

Also, if a suspected allergen shows up negative on a scratch test, the physician can choose to perform intracutaneous or intradermal tests, the injection of an allergen directly into the skin. CPT provides four codes for intradermal testing that divide the codes by type of allergen, amount of allergen, and reaction speed:

95015 - Intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, specify number of tests

95024 - Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, specify number of tests

95027 - Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, specify number of tests

95028 - Intracutaneous (intradermal) tests with allergenic extracts, delayed type reaction, including reading, specify number of tests

Like the scratch tests, you code per prick. **Example:** A patient undergoes intradermal testing for dust mites, bee venom, and Kentucky bluegrass pollen. **You report:** 95027 x 2 units (for the mites and pollen) and 95015 x 1 (for the bee venom).

Key: If a patient comes in with typical allergy symptoms such as stuffy nose and itchy, drippy eyes, and the skin testing comes back negative, we bill the signs and symptoms (such as 478.1 -Other diseases of the respiratory tract; other diseases of the nasal cavity and sinuses) and receive payment, notes Porter.

Step 3: Prepare the Extract

Once the physician knows the causes of a patient's allergies, you can order the extract. You really need to watch your units when coding, and here's why: For Medicare, a billable dose is defined as 1 cc, while many injections are often far less than that (usually only .5 cc).

Policy Example: New York's Empire Medicare local coverage determination (LCD) states the following: "When billing 95165, providers should report the number of units representing the number of 1cc doses being prepared. A maximum of 10 doses per vial is allowed for Medicare billing, even if more than 10 doses are obtained from the vial. Medicare should not be billed an additional amount of these diluted doses under code 95165."

Example: Your physician orders a 5 cc vial from which the nurse will administer 10 doses. **You code:** 95165 (Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens [specify number of doses]) x 5 units. This is the correct coding because you must code based on the number of ccs in the vial, not on the number of clinical doses the patient will receive.

Step 4: Bill Number, Not Amount

Injections for allergen immunotherapy differ from other injections because you only bill for the number of injections, not for the substance injected (Remember: you've already billed for the extract in Step 3). You should select one of the following two injection codes:

95115 -Professional services for allergen immunotherpay not including provision of allergenic extracts; single injection

95117 -...two or more injections

Pitfall: When reporting either of these codes, you may only enter a unit of "1" on the claim sheet. 95117 covers any number of shots beyond one, so you only need report it once, says Porter.

Step 5: Append Modifier 25 To Same Day E/M

Common problem: While patients commonly have office visits the same day as allergy testing, this dual-purpose appointment can result in adverse reaction from the carrier if it considers an office visit included in allergy immunotherapy and append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure of other service) to the office visit code and clearly document the reason for the visit.

Example: A patient comes in suffering from stuffy nose, watery eyes, and a developing cough. He insists it's only his allergies, but the physician insists on performing an exam to ensure the patient does not have a cold, as a patient may not receive allergy immunotherapy when sick. The physician determines the patient is only experiencing allergy symptoms and allows him to receive his shot. **You code:** 99212-25 (Office or other outpatient visit...) as this is a problem-focused exam, along with 95115 x 1 (always report the code with the higher RVUs first).

Another example: A nurse notices a patient's injection area is red and itching only 10 minutes after receiving two shots. She decides to monitor the patient to ensure the patient is only having a local and not a systemic reaction. She monitors the patient's vitals for another 30 minutes and applies ice and salve to the injection site. The patient shows no further symptoms and leaves the office.

You should report the nurse's services with 99211-25, as the service does not require the presence of a physician, and 95117 x 1 unit for the two shots.