Coding Updates for 2023/2024

Illinois Allergy Society

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Presented by

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- I have nothing to disclose

Goals for next hour

- Proposed updates for 2024
- Evaluation/Management Documentation
- Allergy Testing Procedures
- Pulmonary Procedures
- Allergy Immunotherapy Services
- Payer guidelines

Documentation

- If it isn't documented, it didn't happen.
- If it is illegible, it didn't happen.
- If it is cloned, it didn't happen.
  - The proof lies in the documentation, if audited.
  - The proof of the encounter for compliance is substantiated by the documentation.
  - Verbal confirmations are inadequate.
  - Documents need to be consistent to each other, with contemporaneously-documented dates, times and information to assure integrity.
  - Just do it right – and document it right – the first time, and you will see compliance improve.
  - Keep the documents from payers which advise you of changes in their policies.

Diagnosis Codes - 2024

- **D89.84 IgG4-related disease**
- Add Immunoglobulin G4-related disease
- **J31 Chronic rhinitis, nasopharyngitis and pharyngitis**
- Delete Use Additional code to identify:
- Delete exposure to environmental tobacco smoke (Z77.22)
- Delete exposure to tobacco smoke in the perinatal period (P96.81)
- Delete history of tobacco dependence (Z87.891)
- Delete occupational exposure to environmental tobacco smoke (Z57.31)
- Delete tobacco dependence (F17.-)
- Delete tobacco use (Z72.0)

Diagnosis Codes - 2024

- Add J44.89 Other specified chronic obstructive pulmonary disease
  - Add Chronic asthmatic (obstructive) bronchitis
  - Add Chronic emphysematous bronchitis
- R09.A Foreign body sensation of the circulatory and respiratory system
  - Add R09.A0 Foreign body sensation, unspecified
  - Add R09.A1 Foreign body sensation, nose
  - Add R09.A2 Foreign body sensation, throat globus
  - Add R09.A9 Foreign body sensation, other site

Evaluation and Management Codes 99202-99215

Utilization Curve for Allergists

- Latest data and percentages available from CMS for allergists
  - 99202 - 2.2%
  - 99203 - 34%
  - **99204 - 56.8%**
  - 99205 - 6.7%
  - 99211 – 4.1 %
  - 99212 - 4.8%
  - **99213 - 48.4%**
  - 99214 – 40.0%
  - 99215 – 2.7%

CMS Proposed Changes for 2024

- G2211 - Generally, it will be applicable for outpatient office visits as an additional payment, recognizing the inherent costs clinicians may incur when longitudinally treating a patient’s single, serious, or complex chronic condition. If finalized, we expect that establishing payment for this add-on code would have redistributive impacts for all other CY 2024 payments, which, comparatively are less than what we initially
- 9X015 - Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face; **initial 30 minutes**
- 9X016 **–** each additional 15 minutes
- 9X017 – multiple sets of care givers

CMS Proposed Changes 2014

- Split/shared visits:
- Maintain the current definition of substantive portion for CY 2024 that allows for use of either one of the three key components (history, exam, or MDM) or more than half of the total time spent to determine who bills the visit.

- Telehealth:
- telehealth services furnished to people in their homes be paid at the non-facility PFS rate to protect access to mental health and other telehealth services by aligning with telehealth-related flexibilities that were extended via the CAA, 2023.
- Direct Supervision:
- Permit the presence and immediate availability of the supervising practitioner through real-time audio and video interactive telecommunications through December 31, 2024. We believe that extending this definition of direct supervision through
- Modifier JW and JZ – Required for doses administered from a single dose container.
  - JZ – no discarded amount
  - JW – discarded amount

Medical Decision Making

- Time does not need to be documented if using MDM to support level of encounter.
- Medical decision making is not trackable by time on post payment review.
- History and Exam, again, are performed based on providers' and patient's needs.

Coding Based on Medical Decision Making

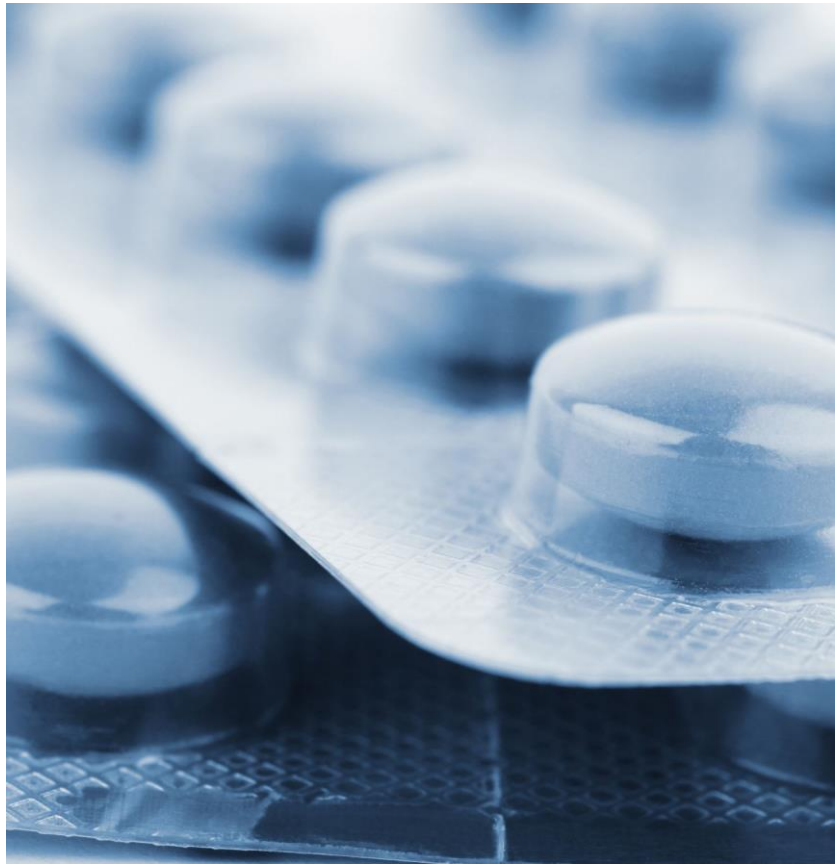
	Straightforward 99202/ 99212	Low 99203/ 99213	Moderate 99204/ 99214	High 99205/ 99215
Problem	1 self-limited or minor problem	• 2 or more self-limited or minor problems, OR • 1 stable chronic illness, OR • 1 acute, uncomplicated illness	• 1 or more chronic illness with exacerbation, progression, or side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

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

Prescription Drug Management - Risk level 4

- AMA website -

- *PRESCRIPTION DRUG MANAGEMENT Related to MDM: It was discussed and understand that it was intended for clinical judgment by clinicians. problem is, coders/auditors/coding educators are trying to use the tool for consistency.*
- *We need a way to insightfully apply the guidelines. Please elaborate on what constitutes Prescription Drug Management—is it enough to simply review a medication list, does there need to be management of the condition, etc.?*
- *Also, does a provider stating "there is a moderate risk for an over-the-counter medication" enough to justify a moderate level of risk re: patient management?*
- *There is no "blanket" guidance for services to represent specific levels of risk.The physician is responsible for assessing (and **documenting)** the level of risk of the services to be performed including medicine management, (prescription or OTC), based on a specific patient's risk factors and the risks typically seen with the drug. For example, an NSAID in a person with kidney disease or on anticoagulant is of greater concern that most prescription drugs. Simply reviewing a medication list does NOT constitute prescription drug management. The E/M workgroup will continue to monitor questions and consider clarifications and education to refine the guidance.*



2021 Revised E/M Coding Guidelines: 99202-99215

American Academy of Allergy Asthma & Immunology

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.

Coding Based on Time

New Patients

99202	15-29 minutes
99203	30-44 minutes
99204	45-59 minutes
99205	60-74 minutes
+99417*	75 minutes and beyond for each 15 minutes of time

Established Patients

99211	No time reference
99212	10-19 minutes
99213	20-29 minutes
99214	30-39 minutes
99215	40-54 minutes
+99417*	55 minutes and beyond for each 15 minutes of time

***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.**

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.

Evaluation and Management Codes: Time CPT 99202-99215

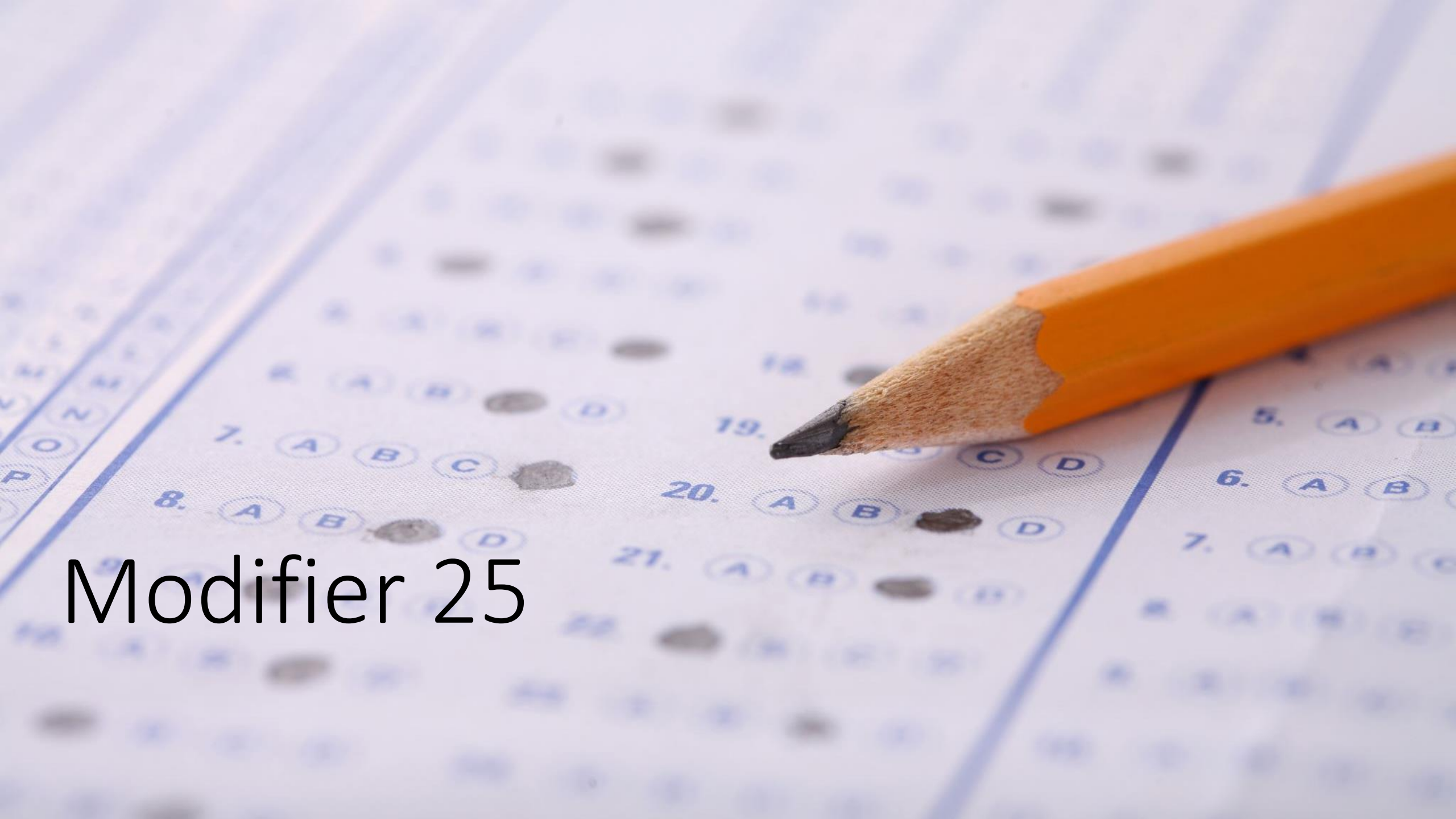
- Time is the total time on the date of the encounter.
- Includes both face-to-face and non face-to-face time personally spent by the provider on the day of the encounter.
- Does not include activities normally performed by clinical staff.
- Preparing to see the patient (review of tests).
- Obtaining 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).

Time – what doesn't count toward total time

- Performing other services reported separately.
- Teaching that is general and not limited to discussion that is required for the management of a specific patient.
- Analyzing tests results. Test results can be part of the MDM and count toward time or MDM.
- Traveling time.

Sample Documentation of Encounter Time

- I have personally spent ___min total time today in patient care. Time does not include any time spent for diagnostic tests performed and interpreted.
- I have personally spent ___ min total time today in preparation, patient care, and documentation for this visit, including the following: review of clinical lab tests; review of medical tests/procedures/services.
- I have personally spent ___ min performing pre-visit work today.
- I have personally spent ___ min present with the patient during today's visit.
- I have personally spent ___ min performing post-visit work today.



Modifier 25

Modifiers for 2023

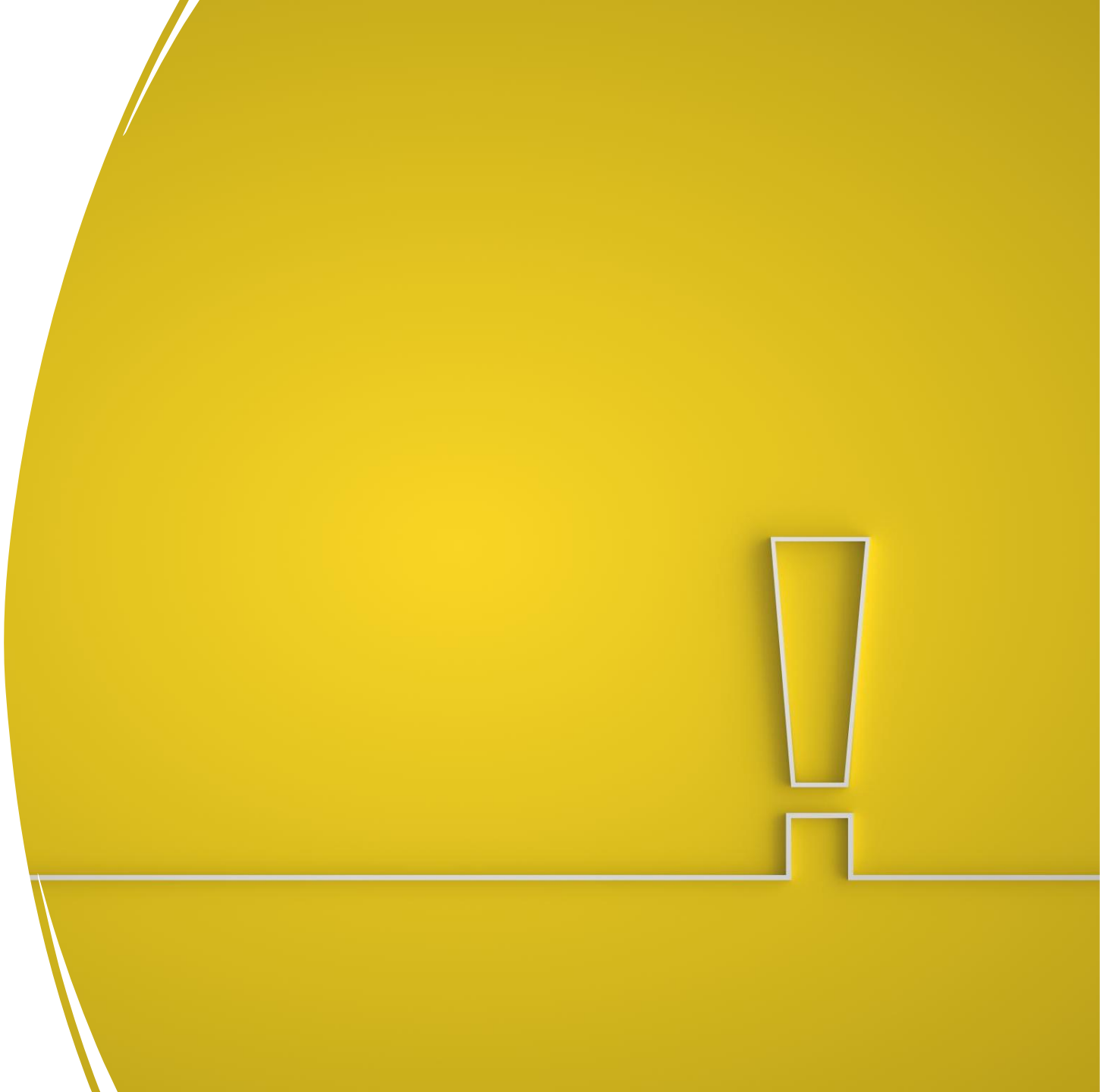
- Modifier 25
- CPT Definition: Significant, Separately Identifiable E & M Service by the same physician or other qualified health care professional on the same day of the procedure or other service:
  - It may be necessary to indicate that on the day a procedure or service identified by a CPT code was 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.

Modifier 25 - continued

- 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.

Payer website statement

- **Coverage and Claims**
- “We take on the administrative burden so you can focus on getting patients the care they need, and get paid in a timely manner.”



Allergy Diagnostic Procedures

Allergy Diagnostic Testing

- CPT 95004, 95024, 95017, 95018– Allergy Skin Testing
  - Included in the RVU value is .01RVU for physician work component, in addition to over head expense and malpractice
  - Medical necessity for the quantity of tests should be documented
  - Testing should be documented separately from E/M
  - Interpretation of the test (all tests) should be documented separately.
  - Remember you are charging for all of the tests
  - Controls by CMS guidelines (NCCI Manual)

Highmark BC/BS policy 3/23

- Allergy testing may be considered medically necessary in the diagnosis of allergies by **ANY ONE** of the following techniques:

- Direct Skin Test with **ANY ONE** of the following techniques:
  - Percutaneous (scratch, prick, or puncture) testing when IgE-mediated reactions occur with **ANY ONE** of the following indications:
    - Inhalants; **or**
    - Foods; **or**
    - Hymenoptera (stinging insects); **or**
    - Specific drugs (penicillin's and macromolecular agents).
  - Intracutaneous (intradermal) testing when IgE-mediated reactions occur with **ANY ONE** of the following indications:
    - Inhalants; **or**
    - Foods; **or**
    - Hymenoptera (stinging insects); **or**
    - Specific drugs (penicillin's and macromolecular agents).

- A cumulative total of 70 percutaneous **or** 40 intracutaneous tests allowed per benefit year.

https://www.cms.gov/files/document/medicare-ncci-policy-manual-2023-chapter-11.pdf

- 18. Some allergy testing CPT codes (e.g., 95004, 95017-95052) are reported based on the number of individual tests performed. CMS payment policy does not allow including testing of positive or negative controls in the number of tests reported. For example, if percutaneous testing (CPT code 95018) with penicillin allergens administering 6 allergens plus a positive and negative control is performed, only 6 tests may be reported for CPT code 95018.

Allergy testing – Challenges codes

- CPT 95076, 95079 – Oral Challenge
  - 95076 – first 120 minutes
  - 95079 – each 60 minutes after the first 120
- Subcutaneous or injection challenge
  - CPT Code – no specific code included in the allergy section for test
  - Options
    - Code for the injections – CPT 96372 X the number of injections
    - Code for an unlisted procedure – CPT 95199 and price comparable to time for oral challenge
- Time documentation is required for challenges
- E/M – only if you can support the 25 modifier
- Pertinent history and exam to enable testing included in the time for challenge

Aetna Policy

- This CPB has been revised to:
- (i) delete intradermal (intracutaneous) testing to foods from coverage due to the high false-positive rate and increased risk of anaphylaxis;
- (ii) state the following -- (a) percutaneous allergy testing can be repeated if there are new sensitivities during or after allergen immunotherapy;
    - (b) performance of both percutaneous allergy tests and IgE RAST tests (blood) for the same allergens is considered not medically necessary; and
- (c) immunotherapy for the treatment of tree nut allergy that is not FDA approved is considered experimental and investigational.
- This CPB is revised to state that Ara h 2 testing is considered medically necessary for persons with suspected peanut allergy; and other component-derived diagnostic testing (CRD) is considered experimental and investigational for evaluation of food allergy.

Pulmonary Services

Pulmonary Function Testing

- Documentation as a separate procedure from the E/M
- Spirometry – flow volume loop – CPT 94010, CPT 94375
- Pre and Post with bronchodilator – CPT 94060
- Inhalation treatment – CPT 94640
- Nebulizer demonstration – CPT 94664

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 instruction
94060	94200		19960101	*	1	HCPCS/CPT procedure code definition
94060	94375		19960101	*	0	CPT Manual or CMS manual coding instruction
94060	94640		19960101	*	1	CPT Manual or CMS manual coding instruction
94060	94650		19960101	20030331	1	Standards of medical/surgical practice
94060	94664		19980401	*	1	Standards of medical/surgical practice
94060	94728		20120101	*	0	CPT Manual or CMS manual coding instruction
94060	94770		19960101	20201231	1	Standards of medical/surgical practice
94060	95071		19960101	20201231	1	Mutually exclusive procedures
94060	96360		20090101	*	1	Standards of medical/surgical practice
94060	96365		20090101	*	1	Standards of medical/surgical practice
94060	**96372**		**20090101**	*****	**1**	**Standards of medical/surgical practice**
94060	96374		20090101	*	1	Standards of medical/surgical practice
94060	96375		20090101	*	1	Standards of medical/surgical practice
94060	96376		20090701	*	1	Standards of medical/surgical practice
94060	96377		20170101	*	1	Standards of medical/surgical practice
94060	96523		20190401	*	0	CPT Manual or CMS manual coding instruction

Allergy Immunotherapy

Oral Immunotherapy Treatment Coding

- There is not a specific code for OIT
- Check with payers for coverage and guidance specific to the payer
- Keep the information to support your coding from the payer
- Consider oral challenge (CPT 95076, 95079) if the patient has not had a challenge in recent past for initial visit – otherwise E/M
- Updosing encounters – E/M

Oral Immunotherapy Treatment Coding

- Updosing encounters: Physician? Staff? Involvement
  - Physician
    - Appropriate E/M
    - If by time only may use CPT 99417 for prolong physician time in addition to CPT 99215.
  - Staff
    - May add on the physician E/M if time is on and beyond staff allowed time

E/M	Typical Staff time	Prolong services 1st hour	Each add't 30 minutes
99212	24	54-98	99
99213	27	57-101	102
99214	40	70-114	115
99215	45	75-119	120

Oral Immunotherapy Treatment Coding

- **Documentation for Staff prolong time**
- The total duration of the visit, including the start and end times
- A clear explanation of the medical necessity for the extended time, including the complexity of the patient's condition or the need for additional counseling, coordination of care, or treatment planning.
- A description of the specific activities performed during the additional time.
- Confirmation that the additional time was spent under the direct supervision of the billing physician
- **99415 - .56**
- **99416 - .26**
- **Payable codes from CMS**.

Allergy Immunotherapy CPT 951665

Coding for CPT 95165

- Two definition of a dose –
  - CPT – A dose is the antigen(s) administered in a single injection from a multi-dose vial
  - CMS – A dose is 1cc by volume

Third party payers

Limits on the number of doses allowed per year or per date of service.

Limits may be the same as CMS for date of service (30 units) for CPT 95165

Limits for venom is 10 per date of service

Aetna

- Currently – initial year 120 doses
- Subsequent Year 90 doses

- Definition of a dose is per CPT

Anthem

- **Medically Necessary:**
- Supervision (including preparation) and provision of 150 allergen/antigen preparations or less per 12 months of subcutaneous allergy immunotherapy is considered **medically necessary** for the first year, including the build-up phase.
- Supervision (including preparation) and provision of 120 allergen/antigen preparations or less per 12 months of subcutaneous allergy immunotherapy is considered **medically necessary** after the first year as maintenance therapy.
- Definition of a dose is per CPT

United Healthcare updated policy as of 2023

4/1/23

"Coding Clarification: CPT 95165 or 95199 should be reported with 95115 or 95117 for subcutaneous allergen immunotherapy given in the office/ambulatory setting and furnished by a physician or other qualified health care practitioner.

CPT 95165 or 95199 reported without 95115 or 95117 is reported for the supervision of preparation and provision of antigens for allergen immunotherapy and furnished without a physician or other qualified health care practitioner (i.e., homeadministration/selfadministration)"

USP 797 Guidelines

- **21.8 Documentation for Compounding Allergenic Extract Prescription Sets**
- All facilities where allergenic extract prescription sets are prepared must have and maintain written or electronic documentation to include, but not limited to, the following:
  - SOPs describing all aspects of the compounding process
  - Personnel training records, competency assessments, and qualification records including corrective actions for any failures
  - Certification reports of the PEC, if used, including corrective actions for any failures
  - Temperature logs for refrigerator(s)
  - CRs for individual allergenic extract prescription sets (see Box 10)
  - Information related to complaints and adverse events including corrective actions taken
  - Investigations and corrective actions

USP 797 Guidelines

- **21.6 Labeling for Allergenic Extract Prescription Sets**
- The label of each vial of an allergenic extract prescription set must display the following prominently and understandably:
- Patient name
- Type and fractional dilution of each vial, with a corresponding vial number
- BUD – Beyond Use Date
- Storage conditions

Compounding Records must include per USP 797

- Name, strength or activity, and dosage form of the CSP*
- Date and time of preparation of the CSP*
- Assigned internal identification number (e.g., prescription, order, or lot number)
- A method to identify the individuals involved in the compounding process and individuals verifying the final CSP
- Name of each component
- Vendor, lot number, and expiration date for each component for CSPs prepared for more than one patient and for CSPs prepared from nonsterile ingredient(s)
- Weight or volume of each component
- Strength or activity of each component
- Total quantity compounded
- Final yield (e.g., quantity, containers, number of units)
- Assigned BUD and storage requirements
- Results of QC procedures (e.g., visual inspection, filter integrity testing, pH testing)
- If applicable, the CR must also include:
- MFR reference for the CSP*
- Calculations made to determine and verify quantities and/or concentrations of components

*CSP – Compound Sterile Preparation

Documenting for Review for Coding CPT 95165

- CPT 95165 definition:
- Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy……..
  - Provider billing should be on site – “supervision”
  - Documentation to support the order for new and refill doses
  - Number of anticipated doses should be documented
    - Every patient should not be identical for number of doses
  - Work component should be supported on the date of the claim
  - Limit per payer as per date of service or yearly allowed amount

Outsourcing allergen preparation - coding

- CPT 95120, 9525 – for injection of allergen immunotherapy, includes allergenic extract.
- CPT 95130-95135 for injection of stinging insect venom, includes allergenic extract.
- CMS – does not recognize codes - third party payers may

Questions

- Remember
- If it Isn’t documented, it didn’t happen.
- Thank you for attending.