CHAPTER 6

Coding and Billing Basics

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OVERVIEW OF PHYSICIAN CODING AND BILLING

With the increase in oversight and the continuous pressure to provide healthcare services in the most cost-efficient method, it's necessary to thoroughly understand the current reimbursement system to maintain an active and financially healthy practice. Physician services are routinely submitted to third-party payers in alpha- numerical as well as numerical codes for appropriate compensation.

This alpha numerical and numerical coding system is a translation of the information documented in the medical record. The purpose of this translation is appropriate compensation for the healthcare provider as well as data collection for analysis by the healthcare systems for all patients and their diseases. With HIPAA, documentation of the patient encounters is mandatory to justify the codes submitted to third-party payers for reimbursement. This applies not only to Medicare but to all other insurance carriers throughout the country. Therefore, documentation of the encounter with the patient is now not only important for good patient care, but also for third-party reimbursement and utilization of healthcare dollars.

DOCUMENTATION

General Principles of Documentation

The Golden Rules for documentation are, "If it is not documented, it did not happen and it is not billable. If it is illegible, it is not billable." With those guidelines in mind, the general principles of documentation for patient care are as follows:

- Chief complaint
- Relevant history
- Physical exam findings
- Diagnostic tests and their medical necessity
- Assessment/impression and/or diagnosis
- Plan/recommendation for care
- Length of visit, if counseling and/or coordination are provided
- Date of service and the verifiable, legible identity of provider

Third-party insurers are reviewing documentation to justify payment of services, data and utilization. This does not mean that every encounter will be reviewed prior to payment. However, third-party insurance companies have the right to review chart notes prior to payment if they choose. From a clinical aspect, the physician or other healthcare provider is looking at documentation for appropriate information to

continue care of the patient, as well as support for reimbursement.

The physician is responsible for selecting the diagnosis and the procedure codes based on the documentation created for the encounter. The diagnosis is the medical necessity for the procedure(s) or service(s) performed and needs to be as specific as possible. A fee is set for each **current procedural terminology (CPT)** code independent of what the carriers are reimbursing. The fee may be based on a percentage of Medicare, or it may be based on the cost of doing business for the practice. Many practices have an encounter form, "superbill" or route slip to communicate between the physician and the billing/coding staff about the nature of the services provided to the patient and the medical justification (diagnosis codes) for the encounter. The U.S. Centers for Medicare and Medicaid Services (CMS) publish a physician fee schedule each year that has **relative value units (RVUs)** assigned to each code. The RVU is determined by the work, malpractice and overhead expense for each code. The physician fee schedule also includes a conversion factor, which is a dollar amount determined by the U.S. Congress and the CMS. This conversion factor then is multiplied by the RVU for each code to determine the financial value of each code according to Congress and the CMS. A practice may want to use a percentage of this conversion factor and the RVUs for each code as published in the Federal Register to determine the fee schedule for the practice.

The coding systems currently in use for physician services are the **Healthcare Common Procedure Coding System (HCPCS),** which was created by the American Medical Association (AMA), and the International Classification of Diseases (ICD), which was created by the World Health Organization (WHO) and modified by the U.S. Health and Human Services Department. The HCPCS system is used for services, procedures, drugs and supplies. The **ICD-9-CM** *(International Classification of Diseases,* **9th edition, Clinical Modification)** codes are the diagnosis codes used to provide medical necessity for services and procedures. On October 1, 2015, a new system for diagnosis coding will be implemented: ICD-10-CM. This system will expand the number of codes available from 14,000 to >60,000. The codes will be alphanumeric and require more detailed specificity to code each patient encounter accurately.

DIAGNOSIS CODING

The ICD-9-CM codes have been available for use since 1977. However, only since 1989 have the ICD-9-CM codes been required for physician professional services. In the spring of each year, diagnosis codes are reviewed and new codes are created. At the same time, other diagnosis codes are revised to reflect the diseases and conditions physicians are treating. The new, revised and deleted code changes are published in the spring and are implemented for coding on Oct. 1 of each year. ICD-9 and ICD-10 coding guidelines are similar. The system has been changed to allow more diagnosis codes for specific diseases, to give more options for tracking morbidity and mortality for the Center of Disease Control and to have continuity with the World Health Organization. There is more flexibility with ICD-10 since there are more codes to choose as the appropriate diagnosis. Since the coding guidelines are similar for ICD-9 CM, emphasis will be placed on learning the new

ICD-10CM codes, which will become the standard coding system for use in physician practices.

ICD-10-CM coding system is arranged in the same format as the ICD-9CM book with the book divided into two sections: the index – an alphabetical list of terms and their corresponding code – and the tabular section – a sequential alphanumeric list of codes divided into chapters based on body system or condition. The Alphabetical Index is arranged with an index to Disease and Injuries, The Neoplasm Table, Table of Drugs and Chemicals and the Index to External Causes and injuries. The Tabular list contains categories and subcategories of codes. The format for the codes is alphanumerical, with each code beginning with an alpha character and then having a mix of alpha and numerical characters for each code. A valid code may range from three to seven characters.

These diagnosis codes are divided into chapters, sections, subsections and subcategories. The list below gives you a look at the code breakdown:

- First character of a three character category is a letter
- Second and third characters may be numbers or alpha characters
- Fourth and fifth characters define subcategories and also may be either alpha or numerical characters
- Sixth and seventh characters also may be either numerical or alphabetical. These characters are further divisions of the subcategories described in the first through fifth position of the ICD-10CM codes.

Unique to the ICD-10CM coding system is the use of the letter "X" as a placeholder when the diagnostic code needs to be expanded but there isn't a number or letter appropriate to use to complete the code expansion for a specific place. For example, an initial encounter for a scorpion sting would be coded as T63.2X1. The "x" is required to enable the expansion of the code to the seventh place to complete the code.

The Alphabetical Index section of the ICD-10CM books is arranged in the same manner as the ICD-9 CM book, with the exception that it lacks a hypertension table. The alphabetical section also has a guide to indicate with a √ when the code will need an additional digit to make for a complete code. The alphabetical section is considered the index for the numerical section of the book and should be used as a person would use any other index, as a beginning point to determine where to find the correct code. Behind the alphabetical section is the Neoplasm Table. The Neoplasm Table list contains diagnosis codes for malignant primary, malignant secondary, Ca in situ, benign, uncertain behavior, and unspecified behavior neoplasms. Some of these codes may require additional digits not shown in the Index. Again, to code completely, the codes will need to be selected from the Tabular section of the ICD-10CM book to verify laterality as well as specificity for the code. The third index in the alphabetical section is the Table of Drugs and Chemicals and the last index is the Table of External Cause or Accident Codes. Again, the appropriate manner for coding would be to use these sections as indexes and determine the appropriate code from the tabular section of the book.

The chapters in the tabular section are divided as follows:

- Chapter 1 – Certain Infectious and Parasitic Diseases (A00-B99)
- Chapter 2 – Neoplasms (C00-D49)
- Chapter 3 – Disease of the Blood and Blood-forming Organs and Certain Disorders Involving the Immune System (D-50-D89)
- Chapter 4 – Endocrine, Nutritional and Metabolic Diseases (E00-E89)
- Chapter 5 – Mental Behavioral and Neurodevelopmental (F01-F99)
- Chapter 6 – Diseases of the Nervous System (G00-G99)
- Chapter 7 – Diseases of Eye and Adnexa (H00-H59)
- Chapter 8 – Diseases of Ear and Mastoid Process (H60-H95)
- Chapter 9 – Diseases of Circulatory System (I00-I99)
- Chapter 10 – Diseases of the Respiratory System (J00-J99)
- Chapter 11 – Diseases of the Digestive System (K00-K95)
- Chapter 12 – Diseases of the Skin and Subcutaneous Tissue (L00-L99)
- Chapter 13 – Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)
- Chapter 14 – Diseases of Genitourinary System (N00-N99)
- Chapter 15 - Pregnancy, Childbirth and the Puerperium (O00-O9A)
- Chapter 16 – Certain Conditions Originating in the Perinatal Period (P00-P96)
- Chapter 17 – Congenital Malformations, Deformations and Chromosomal Abnormalities (Q00-Q99)
- Chapter 18 – Symptoms, Signs and Abnormal Clinical Findings (NEC)(R00-R99)
- Chapter 19 – Injuries, Poisoning and Certain Other Consequences of External Causes (S00-T88)
- Chapter 20 – External Causes of Morbidity (V01-Y99)
- Chapter 21- Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

Guidelines for Determining the Appropriate Diagnosis Code

1. The allergist should become familiar with the ICD-10CM book. Even though most practices today have all diagnosis codes accessible in an electronic format, at least one copy of a book should be available. This allows for cross-checking and referencing when there is a question regarding the appropriate diagnosis code for a patient's signs, symptoms or diseases. Even though most books are set up in the same format, each publisher has its own system. You should read the introduction for your specific book. It is important to understand when you need additional codes, what codes may be used only as secondary codes, and when you need additional information to have a complete code. This information is available in the general instructions, the chapter instructions or in the subsection instructions. If you rely completely on your diagnosis codes in your electronic practice management system or your electronic health record, you may not have the most accurate code for your patient encounters. Also, the direct translation of the code you are looking for has a good chance of being different from what you may have done in the past and may expect in ICD-10. If your system has been cross-walked from an ICD-9 coding system to an ICD-10 coding system, make sure you verify the accuracy of the codes. If a superbill is used as a communication tool within the practice, this tool also must be revised and updated with verification of the correct codes from the ICD-10 CM diagnosis coding book.

2. Always use both the alphabetic and the tabular sections to select a diagnosis code. The alphabetical index will indicate with a √ after the code as an indication of the need for additional number(s) or letter(s) only provided in the Tabular section of the ICD-10CM book. In the Neoplasm Table, a – (dash) is added to indicate the need for additional information as well as the √ indicating an additional digit is needed.
3. Always code the reason why the patient sought medical advice as the primary diagnosis.
4. Do not code "probably," "possible" or "rule-out" diagnoses. When the patient's diagnosis is not definite, you should code signs and symptoms until the diagnosis is definite. The following coding guidelines in the ICD-10 CM book state:
    a. "Sign/symptom and "unspecified" codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter. Each healthcare encounter should be coded to the level of certainty known for that encounter.
    b. If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information isn't known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate "unspecified" code (e.g., a diagnosis of pneumonia has been determined, but not the specific type). Unspecified codes should not be reported when there are codes that more accurately reflect what is known about the patient's condition at the time of that particular encounter. It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code."
5. Code the diagnosis to the highest degree of clinical certainty by using the highest level of code. Asthma, for example, has a two digit subsection-code, J45. Asthma is further divided into subsections with a third digit explanation as follows:
    a. mild intermittent (J45.2)
    b. mild persistent (J45.3)
    c. moderate persistent (J45.4)
    d. severe persistent (J45.5)
    e. unspecified asthma (J45.9)

    The fifth digit for asthma indicates:

    a. uncomplicated (0)
    b. with acute exacerbation (1)
    c. with status asthmaticus (2)

    Therefore, a patient who has mild persistent asthma with an acute exacerbation would be coded with the diagnosis code J45.31.
6. If there is a comorbidity which is considered in the clinical judgment of the allergist in caring for the patient and the documentation supports the clinical consideration of that, these conditions also need to be coded. These codes would be listed as secondary codes to the

primary code the patient is being assessed for by the allergist. For example an asthmatic patient also has diabetes and the use of steroids for control and impacted by the diabetes.

7. Diagnosis codes for chronic diseases or conditions may be coded as often as the patient has encounters for the chronic condition(s). However, if the patient has an acute illness, this acute illness should be coded first and the chronic condition should be coded second. Added to the ICD-10 CM codes are codes for acute recondition conditions. For example, acute recurrent maxillary sinusitis is coded as a separate entity from "acute" or "chronic":
   a. acute maxillary sinusitis (J01.00)
   b. acute recurrent maxillary sinusitis (J01.01)
   c. chronic maxillary sinusitis (J32.0)
8. When a patient is seen for ancillary diagnostic services, the appropriate codes will be located in the "Z" chapter of the ICD-10CM book. This chapter is for encounters which have Factors Influencing Health Status and Contact with Health Services other than a sign, symptom or disease. These codes may be used as either a primary diagnosis code or a secondary diagnosis code depending on the circumstances of the encounter. The Z codes are divided into the following categories:
   a. Contact/exposure: These codes describe an encounter where the patient has exposure to a disease but does not show any signs or symptoms of the disease. The patient presents for evaluation of a suspected disease. These codes may be listed as primary but more commonly as secondary if the patient present with a complaint.
   b. Inoculations and vaccinations: The code Z23 if for inoculations and vaccinations for prophylactic inoculations against diseases.
   c. Status: Status codes indicate that a patient is either a carrier of a disease or has the sequelae or residual of a past disease or condition. This includes such things as the presence of prosthetic or mechanical devices resulting from past treatment. A status code is informative, because the status may affect the course of treatment and its outcome. A status code is distinct from a history code, which indicates that the patient no longer has the condition. Diagnosis codes in this category that will impact the allergist would be the following:
      i. Z79 – Long-term current drug therapy codes: Assign a code from the Z79 category if the patient is receiving a medication for an extended period as a prophylactic measure or as treatment of a chronic condition, or a disease requiring a lengthy course of treatment
      ii. Z88 – Allergy status to drugs, medications and biological substances
   d. History of Codes: There are two types of history of codes – personal history and family history. Personal history codes explain a patient's past medical condition that no longer exists and is not receiving any treatment, but that has the potential for recurrence, and therefore may require continued monitoring. Family history codes are for use when a patient has a family member(s) who has had a particular disease that causes the patient to be at higher risk of also contracting the disease. Personal

history codes may be used in conjunction with other diagnosis codes for follow up, and family history codes may be used in conjunction with screening codes to explain the need for a test or procedure. History codes are acceptable on any medical record and may alter the type of treatment ordered for a patient. Personal history codes may be used as primary codes, while family history should be used as additional codes for the reason for the patient encounter.

e. Screening: Screening is the testing for disease or disease precursors in seemingly well individuals so early detection and treatment can be provided for those who test positive for the disease. Testing to rule out or confirm a suspected diagnosis because the patient has some sign or symptom is a diagnostic examination, not a screening. In these cases, the sign or symptom is used to explain the reason for the test. Screening codes may be used as primary or secondary. Should a condition be discovered during the screening, then the code for the condition may be assigned as an additional diagnosis code. Third party payers may or not cover screening diagnosis codes without a sign, symptom or disease for the patient. It will depend on their policy with the patient.

f. There are many other categories of Z codes which will not impact the allergist on a daily basis but that the allergist should be aware of, for those instances when the codes would be required to accurately code the patient encounters.

9. With the change to ICD-10, some of the diagnosis codes will require second and third codes to complete the information necessary to process the claim appropriately. The subsection instructions for the J45 section (Asthma) indicate the necessity of an additional code to describe the patient's exposure to tobacco or tobacco use. These codes are secondary codes which will be listed after the J45 series code.
    a. The additional code choices required to complete coding for the J45 section for the patient with asthma are listed below. If none of the choices apply to the patient, then it would be appropriate to code only the J 45--- code for the asthma patient:
        i. Exposure to environmental tobacco smoke Z27.22
        ii. Exposure to tobacco smoke in the perinatal period P96.81
        iii. History of tobacco use Z87.891
        iv. Occupational exposure to environmental tobacco smoke Z57.31
        v. Tobacco dependence F17.-
        vi. Tobacco use Z72.0

10. The subsection instructions in the Tabular section also indicate diseases which are not to be coded in this section as "Excludes 1." For example, Detergent asthma is coded J69.8 and is not coded in the J45 section. "Excludes 2" are diseases where the condition represented by the code is not part of the codes in this section. An Exclude 2 note does mean it is acceptable to use both the code and the excluded code together when appropriate. An example is chronic obstructive asthma, J44.9, which is also the code for COPD.

11. Y codes used for explanations of the causes or morbidity should not be used as the first code on a claim but rather used as informative for the presenting diagnosis.
12. Coding for adverse effects, poisoning, underdosing and toxic effects are listed in the T36-T65 categories and are combination codes that include the substance that was taken as well as the intent. No additional external cause codes are required for poisonings, toxic effects, adverse effects and underdosing codes. The codes should be selected from the tabular section and not from the Table of Drugs. There may be a need to use more than one code if multiple medications or biological substances have been used. The definitions below are the different subcategories and how to code from these subcategories:
    - i. Adverse effects – A drug that has been correctly prescribed and properly administered: Assign the appropriate code for the nature of the adverse effect followed by the appropriate code for the adverse effect of the drug. (T36-T50). The code for the drug should have a fifth or sixth character and may need an "x" placeholder to be able to assign a fifth or sixth character.
    - ii. Poisoning – A medication has been used improperly, such as an overdose, wrong substance given, taken in error, or a wrong route of administration. If there is also a diagnosis of abuse or dependence of the substance, the abuse or dependence is assigned as an additional code.
    - iii. Underdosing – A medication is taken less than as prescribed. Codes from this section should never be assigned as the primary diagnosis codes. If a patient has a relapse or exacerbation of the medical condition for which the drug is prescribed because of the reduction in the dose, the medical condition itself should be coded as the primary diagnosis code. Noncompliance and/or complication of care codes are to be used with an underdosing code if indicated and known.
    - iv. Toxic effect – When a harmful substance is ingested or comes in contact with a person, this is classified as a toxic effect. The toxic effect codes are in categories T51-T65.

a. For all of the codes in the adverse effects, poisoning, underdosing and toxic effects chapter (Chapter 19), there is a requirement to add an additional character to the code for the associated intent. The associated intent is coded as the sixth character of the code in most subsections. The sixth character choices are:
    - i. 1 – accidental
    - ii. 2 – intentional self harm
    - iii. 3 – assault
    - iv. 4. – undetermined

b. The last requirement for these codes to be complete is the additional information regarding the encounter for adverse effect, poisoning, underdosing and toxic effects. The seventh character selections are:

i. A – Initial encounter – The patient is receiving active treatment for the condition. An example would be the initial evaluation and treatment for the patient or the evaluation and treatment by a new physician.
ii. D – Subsequent encounter – The patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase. Examples would be medication adjustments or other follow up visits following initial treatment.
iii. S – Sequela – This is used for complications or condition that arise as a direct result of a condition. This would not be a common seventh character for the allergist to be using. However, an example of this would be if a patient is given an antibiotic by you for an infection, and subsequently develops chronic diarrhea from that antibiotic, or osteopenia secondary to chronic steroid use.

In summary, diagnosis codes need to support the services rendered. As of 2014, the electronic formats and the CMS 1500 forms are able to accept a maximum of 12 diagnosis codes per claim. The allergist will continue to use ICD-9CM codes until at least October 1, 2015. At that time, you should use the new ICD-10 CM codes and/or the ICD-9 CM codes for those payers which are not required to change to the new coding system.

It is important to link diagnosis codes to specific CPT procedure codes if multiple CPT procedure codes are performed and reported on one calendar day. Appropriate location for the service, whether it is clinic, outpatient or hospital, is required as well for accurate claim adjudication. Diagnosis codes are the medical necessity for the patient's evaluation. Appropriate selection of the diagnosis codes and the highest degree of specificity known for the patient at the time will support the allergist's decision to evaluate the patient as well as obtain the appropriate reimbursement for the patient's encounter.

PROCEDURE CODING

Healthcare Common Procedure Coding System

CPT-4 is a component of the HCPCS (Health Care Procedural Coding System). HCPCS codes were created by the AMA, and are maintained and renewed on a yearly basis by the AMA with the guidance of an editorial panel and advisory committee. The CPT (Current Procedural Terminology) Book is a standardized code set used to describe the medical, surgical and diagnostic services and procedures provided by physicians and other healthcare providers.

CPT codes are divided into three categories. Category I codes describe procedures which are accepted as standards of care codes and are also the primary codes used for reimbursement for physician and non-physician provider services from third-party payers and patients. Category II codes are used for performance measures and data collection. Category III codes are temporary codes for emerging technologies, services and procedures.

According to the general instructions for use of the CPT book, any procedures or services in any section of the

book may be used to designate the services rendered by any qualified physician or healthcare professional. CPT does not determine the reimbursement for services. This amount is determined by contracts between the healthcare providers and the insurance carriers that cover the provider's patient population. The CPT guidelines also indicate that any service or procedure performed should be documented in the patient's medical record to support the code(s) chosen. If a service or procedure provided by the physician or other healthcare provider is not described in the CPT book, the unlisted procedure code for the appropriate section should be chosen.

The Category I CPT codes are divided into six sections. Each section is further divided into subsections. Each section and subsection has instructions on the appropriate use of the codes. The codes in Category I are listed in numeric order with the exception of the evaluation and management codes (99201-99499), which are listed in the beginning of the book, because most physicians will use these codes in their practices.

The six sections of the CPT Category I codes are:

- Evaluation and Management (E/M) 99201-99499
- Anesthesiology 00100-01999
- Surgery 10021-69999
- Radiology 70000-79999
- Pathology and Laboratory 80000-89356
- Medicine 90000-99602

In addition to the Category I codes, the CPT book includes Category II codes, Category III codes and several appendices. Appendix A provides a list of all modifiers and descriptions of the modifiers. Appendix B provides a list of the additions, deletions and revisions to the CPT book that missed being published in the text of the last publication. Appendix C contains clinical examples for E/M services for the type of medical decision-making appropriate for a specific level. Appendix D is a summary of add-on codes. Appendix E gives a list of the codes that are exempt from modifier 51 (multiple procedures). Appendix F provides a list of the codes that are exempt from modifier 63 (procedures on infants weighing <4 kg). Appendix G gives a list of the codes that include conscious sedation. Appendix H is an alphabetic index of performance measures by clinical condition and topic. Appendix I is a list of genetic testing code modifiers, and Appendix J lists codes for electro-diagnostic medicine for sensory, motor and mixed nerve studies. Appendix K provides a list of codes that are pending FDA approval. Appendix L lists the vascular families, and Appendix M is a cross-walk to deleted codes from the last publication. Appendix N is a summary of re-sequenced CPT codes, and Appendix O lists the Multianalyte Assays with Algorithmic Analyses.

The CPT index gives a listing of all the codes. The different methods you may use to find a code in the index are:

1. Name of the procedure
2. Anatomic site or organ
3. Condition
4. Eponym – the name of the person who developed the procedure or service or who it is named for
5. Symptom
6. Common abbreviation

The Category II codes end in "F"; the Category III codes end in "T." All codes, in their categories, are placed prior to the appendices in the CPT book.

Category I codes are used for reimbursement of physician services and procedures. However, use of a CPT Category I code does not guarantee payment. Each carrier may have specific reimbursement guidelines that will indicate that a Category I code is not payable. For example, CMS (Medicare) will not pay for a spirometry (94010) and a flow-volume curve (94375) when they are performed on the same day.

Category II codes provide information on performance measures and data collection. There is no monetary value for these codes. Category II codes are not required for submission of claims for reimbursement at this time. PQRS (Physician Quality Reporting System) is currently optional but it is proposed to be a required component of coding in the future by Centers of Medicare and Medicaid Services. For 2015, CMS has proposed taking a small percentage of deductions from their allowed amount of payment on claims if the PQRS information is not provided by the providers. For other payers, however, it may or may not be necessary to include these codes on a claim when submitting for reimbursement.

Category III codes are used to track new procedures and technology. These codes are not recognized by payers as payable codes. These codes need to be used in addition to an unlisted procedure code to indicate to the payer/carrier the type of service being provided. The payer/carrier then may make a determination as to whether it chooses to reimburse for the new procedure and/or technology. Two category codes that may be used in the allergy practice are the following:

- 0243T – Intermittent measurement of wheeze rate for bronchodilator or bronchial-challenge diagnostic evaluations(s), with interpretation and report
- 0244T – Continuous measurement of wheeze rate during treatment assessment or during sleep for documentation of nocturnal wheeze and cough for diagnostic evaluation for three to 24 hours, with interpretation and report

The codes above have a sunset of January 2016. If there is not sufficient acceptance and use as a standard of care by January 2016, these codes will be deleted.

Monetary Value for CPT Procedure Codes

In 1992, Medicare established a value system for services provided to Medicare patients called the Resource-Based Relative Value System (or RBRVS). This system placed a value on each CPT code that was payable to Medicare based on resources. It replaced the old standard, which was "reasonable and customary" value. The resources the CMS used to determine a value for each code included physician work component, overhead component and malpractice. These values change on a yearly basis according to recommendations from the AMA and specialty societies. The Relative Value Scale Update Committee (or RUC) meets during the year to evaluate the recommendations and forward their recommendations to the CMS. In the fall of each year, the final rules and values are published by the CMS in the Federal Register, which establishes the CPT codes and the Medicare relative values assigned to those codes for the next year. Many third-party

carriers also use these RVUs to determine how they will reimburse for services provided to their beneficiaries. The third-party payers will pay differently than Medicare, however, because the conversion factor per RVU will be based on contract negotiations with the payer or the contract offered by the carrier.

Suggestions for Coding and Reimbursement Techniques and Tools

Purchase new coding tools on a yearly basis. You should have a diagnosis coding book, a CPT book and a HCPCS book. You also need to have the Correct Coding Initiative (CCI), a free publication available on the CMS website (www.cms.hhs.gov). The CCI is a bundling program that gives information as to which codes may be charged together and which ones cannot be charged together on the same day of service.

Read payer billing manuals and local carrier directives. The Joint Council of Allergy, Asthma & Immunology website (www.jcaai.org) and publications provide up-to-date information appropriate for allergy practices. Also be aware of the different carrier billing guidelines and know the website for each carrier in order to find its specific guidelines. Each Medicare carrier will have local carrier directives that are accessible to every physician posted on their websites. The CMS also has national guidelines on their website, as well as information, tools and manuals.

1. Education regarding coding should be provided continually for all physicians and their staff. In light of ICD-10, this includes every staff member having a role to help ease this transition. Making a plan prior to this transition with different levels of the staff will ensure the most success. The guidelines for carriers may change, and you are held accountable for knowing the changes and for appropriately submitting claims.
2. A compliance plan should be implemented to support and define all the coding and billing policies of the practice. Designate someone, often the compliance officer, to be the recipient of all coding and reimbursement information and to inform involved individuals of any relevant coding changes. This person also should orient new staff, including physicians, to ensure that updated resources are available in the practice, and should research any changes pertinent to the practice.
3. Electronic versions of several books and reference guides are now available for tablets/ IPads, as well as iOS and Android phones.

EVALUATION AND MANAGEMENT CODES

The E/M section of the CPT coding book describes patient encounters with the physician for all services other than procedures and miscellaneous services. The E/M services can be either problem-oriented or preventive in nature. The CPT book divides the E/M codes into multiple categories: office or other outpatient services; hospital observation; hospital inpatient services; consultations; emergency department services; critical care; nursing facilities – initial and subsequent; discharge; rest home; home services; prolonged services; case management; care

plan oversight; preventive and special evaluation and management. The appropriate code selection from this section is dependent on the place of service for the patient and the type of service. The most common services used in the allergist office are outpatient services, consultations and, occasionally, inpatient hospital services. Many of the codes in this section of the book have a time component associated with the code. The time component is not applicable, however, for selection of the code unless the encounter is >50% counseling and coordination of care. In these instances, the time component of the code is used to determine the appropriate level of service.

Office or Other Outpatient Service Codes

The new patient codes (99201-99205) are for services provided in the office and other outpatient facilities to evaluate a patient who is new to the practice. The CPT definition of a new patient vs. an established patient is a patient who has not received any face-to-face professional services by the physician or by another physician of the exact same specialty and subspecialty of the same group practice in the past three years. An established patient (codes 99211-99215) is one who has ongoing services provided by the physician or any physician of the exact same specialty and subspecialty in the same group practice. If a physician is covering for another physician, the patient encounters will be considered as if the absent physician were treating the patient. The only setting in which there is no difference in new or established patients is in the emergency setting. The established patient encounter (code 99211, nurse visit) does not require a physician to see the patient. However, it requires a chief complaint and it requires the physician to be in the suite to support the "incident to" guidelines set for supervision of physician staff.

Inpatient Hospital Service Codes

Hospital services are not differentiated according to whether the patient seeing the physician is a new patient or an established patient. Hospital services codes differentiate between the services during the initial encounter while the patient is admitted to the hospital and the subsequent care of the patient while in the hospital for that encounter. The codes for initial encounters (99221-99223) are for the initial work-up to place the patient in the hospital for care. The subsequent care codes (99231-99233) are for those services provided on a daily basis by the admitting physician and by any consulting physicians while the patient is hospitalized for the course of his/her illness. These codes are based on the patient history and exam and medical decision-making. Time is used to determine only the level of code if >50% of the encounter was counseling and coordination of care for the patient. If the CPT code is going to be determined by counseling and coordination of care, the counseling and coordination of care for the patient must be done by the physician, not the staff.

Consultation Codes

Consultations (99241-99245) can be performed in the office or outpatient setting, or in the hospital. Consults may be performed for an established or new patient as long as the criteria for the consultation codes are met. To support a consultation code, the physician consultant must be asked for his or her opinion and advice regarding a specific problem by another physician or appropriate source, the definition of which may be a nurse practitioner, a physician

assistant or another colleague. The request is either to recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem. The written or verbal request may be made by a physician or other appropriate source and documented in the patient's medical record by either the consulting or requesting physician or the appropriate source. The consultant physician may initiate diagnostic or therapeutic services at the same or a subsequent visit. The request for consultation must be documented in the patient's chart along with a report of the consultant's findings. The consultant physician then must communicate the findings to the physician or other appropriate source, either by documentation in a shared chart or by a written report to the requesting physician or other appropriate source. The history, exam and medical decision-making levels have the same requirements as those for a new patient.

Beginning in 2010, Medicare discontinued payment for consultation codes. The Federal Register indicates the consultation codes 99241-99255 are invalid for Medicare by using the status code "I" on the Physician RVU Fee Schedule. This guideline is specific to Medicare but may be adopted by other payers in the future. United Healthcare already has indicated it will not recognize consultation codes for their Medicare Advantage programs. All allergy practices should check with their third-party payers to see if the consultations codes are still recognized as appropriate codes for the plan's beneficiaries. In place of consultation codes, physicians are to use new patient or established patient codes for services performed in their offices or other outpatient facilities. Physicians also need to follow the guidelines appropriate for the new or established patient codes as published in the CPT book.

Inpatient services for Medicare patients and other patients whose plans do not recognize consultation will be coded differently. If a physician is asked to see a patient in the hospital as a consultant, the consulting physician will use the initial patient encounter codes (99221-99223). If you are the admitting physician and not the consulting physician, you will use the same codes (99221-99223), and in addition, you will need to indicate with the use of a modifier that you are the admitting physician. The modifier to indicate physician of record or admitting physician is AI. After the initial encounter with the patient, physicians will continue to use the subsequent care codes for hospitalized patients (99231-99233) as appropriate to the medical care provided to the patient.

Prolonged Services with Direct Patient Contact Codes

Prolonged services codes (99354-99357) are for those services when a physician or other healthcare provider is in direct patient contact providing care that is beyond the usual service in either the inpatient or outpatient settings (Table 6.1). Direct patient contact includes any additional non-face-to-face time exclusive of the patient's direct care. The direct patient contact services are provided in addition to a designated E/M service provided on the same calendar day. Either code 99354 or code 99356 is used to report the first hour of prolonged service on a given date, depending on the place of service. These codes should be used only once on a specific day. The time may be provided continuous or interval through the

calendar date. Prolonged services of <30 minutes are included in the base E/M code.

TABLE 6.1. CODES FOR PROLONGED SERVICES WITH FACE-TO-FACE TIME

Total duration of prolonged services	Code
<30 min	Included in the base E/M code
30-74 min	99354
75-104 min	99354, 99355 × 1
105-134 min	99354, 99355 × 2

Prolonged Services without Direct Patient Contact Codes (99358-99359)

Codes for prolonged services without face-to-face time are used when the physician reviews extensive records, and/or tests or communicates with other professionals and/or the patient/family before and/or after the face-to-face encounter. The non-face-to-face prolonged services codes may be reported on a different date than the primary service to which it is related. The services may be for extensive record review, and may be related to an E/M service performed earlier; service commences on receipt of past records. The service must be directly related to the face-to-face encounter with the patient and the encounter must have occurred or will occur.

Prolonged services lasting <30 minutes are included in the basic E/M services for the patient. Many third-party payers will not reimburse for prolonged services without a face-to-face visit with the patient. An example of a prolonged services situation would be a patient who has already seen the physician for a detailed history, detailed exam and moderate medical decision-making (99214). Then the patient requests a conference beyond the encounter, and this conference lasts an additional 35 minutes. The appropriate coding would be for a 99214 and a 99354. It is not appropriate to code for prolonged services and for an allergy test during the same period of time for which the allergy testing is being performed. This would be interpreted as "double-dipping" in the time component. Documentation of total time spent with the patient is required to support the coding of E/M plus prolonged services.

Pulmonary Codes

Pulmonary Function Codes. Most diagnostic codes have a professional and a technical component. Pulmonary function codes have a professional component (26 modifier), which is the interpretation of the results of the technical component. If the equipment is owned by the same group that does the interpretation, then the code (94010) is not divided into two components. The term for this code is called the global code. The entire five-digit code, without any modifiers, is charged for the services provided to the patient. If the technical component is owned by one entity (such as a hospital) and the physician works as a separate entity, then the code would be billed by appropriate component of the global code using the correct modifier (i.e., 26 or TC [technical component]).

Because pulmonary function codes are considered diagnostic studies, many of these services are provided by the ancillary staff under the supervision of the physician. According to the CMS, there are three types of supervision for the technical component of the diagnostic testing. Section 410.32(b) of the Code of Federal Regulations

requires that, with certain exceptions, diagnostic tests covered under 1861(s)(3) of the Social Security Act and payable under the physician fee schedule have to be performed under the supervision of an individual meeting the definition of a physician. When non-physician providers supervise diagnostic testing for Medicare patients or other patients whose insurance coverage follows the CMS "incident to" guidelines, the diagnostic testing would be charged under the non-physician's provider number. The allergy practice should check their third-party payer contracts to verify how non-physicians are to bill for their services. The definitions of the supervision guidelines are as follows:

- **General supervision.** The physician does not need to be on site when the services are performed. The staff may perform the services without the physician present. There must be a physician order for the diagnostic procedure. An example of this situation is simple spirometry (94010).
- **Direct supervision.** The physician must be in the office suite when the diagnostic service is performed but does not need to be face-to-face with the patient. The physician must be immediately available to provide assistance and direction for the pulmonary service. An example is spirometry, before and after bronchodilation (94060).
- **Personal supervision.** The physician must be with the patient while the diagnostic pulmonary function study is being performed. An example is the methacholine challenge (94070 and 95070).

Most pulmonary function studies require direct supervision when service is to be performed by nursing staff. Basic spirometry is the only general supervision situation. This information is available on the Physician Fee Schedule RVU for each calendar year.

Pulmonary Diagnostic Testing and Therapies (PFT) Codes. As of the 2014 edition of the AMA's CPT coding book, included under the subheading for the pulmonary function codes are directions for the provider that note that separate and identifiable E/M service should be reported in addition to the pulmonary function code. This will require the provider to use the 25 modifier on the E/M code when both services are provided.

The subsection heading also directs the provider as to when certain pulmonary function codes may be charged together and which pulmonary function codes are to be billed separately. The measurement of vital capacity (94150) is only billable when performed alone and is not a component of any other pulmonary function code. The vital capacity test (94150) represents the total volume of air a patient can expel during a slow full exhalation. It is used alone, for example, for monitoring neuromuscular diseases such as myasthenia gravis.

Spirometry (94010) is considered the basic foundation of pulmonary function testing. The patient's forced exhalation is a volume of air plotted with respect to time. With many types of equipment, the flow-volume curve can be determined as well. The flow-volume curve (94375) graphs the airflow vs. lung volume as the patient performs forced expiration and forced inspiration maneuvers. The CPT subsection instruction now bundles 94010 and 94375 together, and allows only one of the two codes to be charged for both services when both

services are performed during the same encounter. The subsection instruction also directs us to include the maximal breathing capacity code (94200) into a 94010 also.

The 94060 code is used for spirometry with a bronchodilator. The bronchodilator is included in the value of the code; only if the medication is purchased can medication be charged with a J code. You are not allowed to charge for administration of the bronchodilator. The subsection instructions of the CPT code book also direct allergists to include in the 94060 the flow-volume loop (94375) and the maximal breathing capacity (94200) when these services are performed before and after spirometry with a bronchodilator (94060).

The maximum voluntary ventilation (MVV; 94200) is a measurement in which the patient breathes as rapidly as possible for 10 seconds while total volume of air movement is measured. MVV often is included as part of simple PFT with spirometry, before and after bronchodilation or flow-volume curve. The 94200 code is bundled with 94010 and 94060. Codes 94200 and 94375 may be reported if they are the only tests provided during a session. Both tests need to have separate documentation of interpretations.

The bronchospasm provocation evaluation code (94070) is most commonly used for the pulmonary function portion of a methacholine challenge test. It also could be used for determination of multiple spirometries. Provocation evaluation coding requires a combination of two codes: 94070 for the multiple spirometric determinations, and 95070 for the administering of the bronchial inhalation agent. If you are performing a methacholine challenge, you would use the J7674 code for the methacholine. This would be charged per milligrams used during the testing.

Expired gas collection, quantitative, single procedure (94250) (separate procedure) applies to the collection and the reporting of the evaluation of expired air. This is reportable only when it is performed as a single procedure without any other pulmonary function testing.

Lung volumes measured by the use of plethysmography are coded 94726. If the plethysmography method is used to determine lung volume, it will include airway resistance testing. If lung volumes are measured using helium dilution or nitrogen washout procedures, the correct code will be 94727. This includes determination of the total lung capacity and all contributory lung volume determinations (residual volume and the functional residual capacity).

Impulse oscillometry (94728) is now defined as assessing airway resistance and may be reported in addition to gas dilution techniques (94727). Code 94728 is not to be reported in addition to a spirometry (94010), a pre- and post-spirometry with bronchodilator (94060), a bronchospasm provocation evaluation (94070), a flow-volume loop (94375) or a plethysmography (94726). Base spirometry (94010) and pre- and post-spirometry with bronchodilator (94060) are not included in the plethysmography code 94726. They also are not included in the gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes, code 94727.

Diffusing capacity (+94729) is now an add-on code. It is to be used in addition to the spirometric codes

(94010, 94060) as well as the flow loop (94375) and the plethysmography and the gas dilution codes (94726-94729).

The pulmonary compliance study code (94750) is used to report a study that identifies and quantifies lung elastic properties. It requires that an esophageal catheter be placed to measure esophageal pressure, to reflect pleural pressure.

The pulmonary stress test code (94620) is for a simple pulmonary stress test. It can be used for a "six-minute walk" or it may be used for multiple spirometries with exercise. Documentation and diagnoses will support the use of this code for a patient. The documentation must include more than oxygen levels in order to code for a simple pulmonary stress test.

Pressurized or nonpressurized inhalation treatment is coded with 94640. This is the appropriate code when a patient is in need of a nebulizer treatment for an acute airway obstruction and the treatment lasts less than one hour. The 94644 code is used for inhalation treatments lasting more than one hour, and 94645 is used for each additional hour after the first hour of inhalation treatment. Because codes 94644 and 94645 have a time component listed in the code, it is necessary to have time documented in the chart note to support the code.

Teaching patients to use their metered-dose inhalers, nebulizers or aerosol generators is coded with 94644. This code is bundled with 94060 because it is appropriate to teach the patient how to use the bronchodilator prior to use and prior to performing the second spirometry. The teaching code 94664 may be used in addition to an E/M code, and it may be reported one time per day per patient.

Pulse oximetry single determinations (94760) are included by many carriers as part of an E/M of service. The 94760 code is considered a vital sign for the patient. If multiple determinations are performed or if the patient has an overnight oximetry reading, these instances may be billable to the payer for coverage. The multiple determinations would be coded with 94761 and the overnight reading would be coded with 94762.

Nitric oxide expired gas determination (95012), or the measurement of eNO, has not been assigned a physician work RVU. Therefore, this would be billable only in an outpatient setting, not in a facility. This code is slowly gaining acceptance as a diagnostic tool in allergist practices. Medicare has the code listed as a payable code, but many other payers may not recognize it as a payable code. The 95012 code is used when determining the NO expired gas determination. A patient's eNO level is measured using specialized equipment and under the direct supervision of a clinician. The patient is instructed to exhale, place the testing device in the mouth and inhale to lung capacity. The clinician monitors the patient to ensure a steady compliance inhalation, and the device, which uses a chemiluminescence gas analyzer and integrated software to measure numbers of NO molecules at very low concentrations, determines the patient's eNO level. The reimbursement for this code varies by payer. Some payers consider the eNO determination code to be experimental and, therefore, the patient to be responsible for the charge.

If a procedure or service for pulmonary function studies is not described in the CPT book under one of the listed codes, then the appropriate manner to

code for the services would be to submit notes and use the unlisted procedure code 94799. Respiratory muscle strength measurements are reported correctly with this code as well.

Allergy Codes

Allergy Testing Codes. E/M services codes may be charged in addition to the allergy testing codes as long as the service is a significant and separately identifiable service. Like the pulmonary function codes, allergy testing codes include a professional and a technical component. In most instances in which the allergist has his or her own practice and employs the staff to perform services, the entire global code will be charged without any modifier to indicate a split between the professional and technical component. If you are a hospital based employed physician, your code would be only for the professional component since the hospital would be coding for the technical component if performed by hospital staff.

Percutaneous tests are coded for non-biologic/non-venom allergenic extracts with the 95004 code. This code includes the cost of performing the tests as well as the cost of the allergenic extracts being tested. The multi-test device is not a separately billable item. The intradermal test for non-biologic/non-venom allergenic extracts is coded as 95024. For either test, you would charge for the number of tests as well as for the controls. The interpretation and report of the test are included as part of the value of the allergy testing code. Therefore, if an E/M service is charged on the same day as the test, the E/M service must be significant and separately identifiable beyond the definition of the testing code. If the history and exam were only to enable the testing, the evaluation and management code would not be separately billable. Code 95017 is for allergy testing with any combination of percutaneous or intradermal methods, sequential, and incremental with venom antigens. The tests should have an immediate type reaction and include the interpretation and report of the tests. The number of tests should be specified to include all tests performed with either method.

Code 95018 is for allergy testing to any drugs or biologics. This code also should have an immediate type reaction and includes the interpretation and report of each test. The method is sequential and incremental for percutaneous and/or intradermal methods.

The appropriate code for performing intra-cutaneous tests that are sequential and incremental for airborne allergens is 95027. Some third-party payers recognize this code as an experimental code and will not cover it for their beneficiaries.

Code 95028 is for intra-cutaneous (intradermal) tests with allergenic extracts, delayed type reaction, and it also includes the reading and interpretation of the tests.

If a patient is being patch tested, the appropriate code is 95044 for the number of patches placed on the patient. When the patient returns for either interpretation or removal of the patches, it is appropriate to charge an E/M level of established patient care.

The testing component for the methacholine test is coded 95070. Again, this code can be used with methacholine or other compounds that demonstrate

a bronchial challenge. If antigens or gases are used, then the appropriate code would be 99071.

Ingestion Challenge Testing. 95076 is a time-driven code to cover the first 120 minutes of an ingestion challenge. This time is testing time – not face-to-face time. Code 95079 is for each additional 60 minutes of testing time. Included in the testing time is the assessment of the patient and monitoring of the patient's activities for an allergic reaction, including the time after the last dose has been administered and appropriate counseling of test results and what to do if a delayed reaction occurs. The pre-test and intra-test period may include blood pressure monitoring, and/or peak flow meter testing. Interventional therapy is reported as a separate service if intervention is necessary due to the patient's medical condition. The challenge immediately ends if an intervention is used and no further doses are given to the patient. Testing time does not include the time for evaluation and management, and time must be documented to support the use of these codes. The first hour of testing time (95076) is reportable after the first 61 minutes of this pre-test, intra-test, and post-test period has occurred. Code 95079 is reportable for an additional hour of testing time, and must include at least 31 minutes extra. 95079 is not to be coded as a stand-alone code, but rather as an "add on" code to 95076. The "+" in front of the code indicates the code is an "add-on" code to the base code 95076. 95079 may be charged again more than once per challenge as an add-on code for each additional hour of testing

Allergen Immunotherapy Codes. Allergen injection codes are usually 95115 for one injection and 95117 for two or more injections. The 95120 and the 95125 codes cover the injection plus the antigen. They do not have an RVU and are not recognized by the CMS. The codes 95130-95134 are for injection and provision of stinging insect venom. These codes also do not have an RVU for the CMS. The number of stinging insects determines the appropriate code whether you are using codes 95130-95134 or 95145-95149. Codes 95145-95149 are for the provision of stinging insect venom(s) separate from the injection, and the total number of stinging insect venoms in the dose determines the appropriate code. For example, mixed vespid venom would be coded with 95147, whereas both mixed vespid and honeybee venoms would be coded with 95148.

The provision of a single-dose vial is code 95144, which is most commonly used when a patient needs to take a single dose for a specific time frame or purpose.

Currently, there are two definitions of the code 95165 – the CPT definition and the CMS definition. CPT defines the 95165 code as the amount of antigen(s) administered in a single injection from a multiple-dose vial. CME defines the 95165 code as a 1-cc aliquot from a single multiple-dose vial. Diluted doses are not billable according to the CMS definition. If you are mixing a "set" for a Medicare patient, you will charge only for the vial that is designated as the maintenance vial. If you "dilute down," the diluted doses are not billable to Medicare. Medicare also requires you to provide the first dose prior to billing for the number of anticipated doses (1-cc each) the patient will receive.

For a non-Medicare patient, you would charge for all of the doses in the set according to the number of anticipated doses you expect the patient to receive. When the patient needs a refill on immunotherapy

solution, for a Medicare patient, billing would be for the number of ccs. provided,;and for a non-Medicare patient, the number of doses anticipated. The CPT code does not define a maximum number of doses, although individual carriers may have a maximum number of doses allowed per patient, either per calendar year or per billing.

Code 95170 is for desensitization to biting insects, such as fire ants. Rapid desensitization is coded as 95180, and is per hour of treatment time. It requires that time be documented to support the code. Some allergists are providing these services in their office. The 95180 code does not include the provision of antigens used in rapid desensitization, but does include the injections during the period of time desensitization is occurring.

Code 95199 is the unlisted procedure code to be used for those services not described by another code in the allergy immunology section. When submitting an unlisted procedure code to a payer, send supporting documentation for the services as well as the fees charged. For these services, it would be advised that the allergist have the patient sign a waiver to indicate the patient may be responsible for the services or procedure if the patient's insurance does not cover them.

Therapeutic Injection Codes. Therapeutic injections may be charged in addition to the medication code. Therapeutic injection codes also can be billed in addition to an E/M code as long as it is a physician encounter, not a nursing encounter (99211). The appropriate codes for therapeutic injections are 96372 for therapeutic services, 90471 for immunizations or G00008 for Medicare plus the medication codes. Xolair® (omalizumab) may be charged by using either 96372 or 96401, depending on your payer's/carrier's guidelines. CPT instructs the coder to use 96401 for monoclonal antibody agents and other biologic response modifiers. The subsection directions also indicate that it is only for "certain" monoclonal antibody agents. The subsection directions further clarify that the service should require physician work and/or clinical staff monitoring well beyond that of a therapeutic drug agent, because the incidence of severe adverse patient reactions is typically greater. Other carriers may have specific guidelines in their billing manuals.

CPT (Level I HCPCS) Modifiers and Their Appropriate Use

A CPT modifier is a two-digit number used to communicate that the description of the code may be changed, the circumstances for the patient may have changed, multiple services were provided at different times, or for different indications on the same calendar day. There are two levels of modifiers, Level I modifiers found in Appendix A of the CPT Coding Book and Level II modifiers found in the HCPCS Level II Coding Book.

The most common CPT modifiers to be used in an allergist's office:

Modifier 25 – Significant, separately identifiable evaluation and management service by the same physician or other qualified healthcare professional on the same day of the procedure of other services.

The definition of significant and separate identifiable evaluation and management services implies the service is provided beyond the usual pre- or post-

services of care associated with the therapeutic or diagnostic procedure performed on the same calendar day. It is defined and substantiated with appropriate documentation to support the "on and beyond" component of the evaluation and management service. It may be prompted by the symptoms or conditions but does not require a separate diagnosis code. It does help, however, to substantiate the service as separate and identifiable if the evaluation and management code has a different diagnosis from the one for the therapeutic or diagnostic services provided on the same calendar day. This may be indicated by linking the diagnosis specific to each service as different primary diagnoses. With many third party payers having bundling guidelines, which are a requirement the allergist follows, the unbundling of services becomes more of a challenge. In many instances it is necessary to use the modifier 25 to indicate the evaluation and management code was provided for assessment of multiple complaints along with the allergy testing of the patient on the same calendar date. If the patient is being provided the assessment only to enable allergy testing, then it would not be appropriate to bill for both the evaluation and management service and the testing on the same calendar day.

Modifier 26 – The professional component of a code. This modifier indicates only the professional component of the code is being reported. The technical component may be reported by a different entity.

Modifier 59 – Distinct procedural services. This modifier is to be used only for procedural services. It indicates a need to report separate non-E/M services individually when normally they are bundled into one code. The most common coding bundling edits are published by CMS as Correct Coding Edits. Many third party payers follow these guidelines or modify these guidelines to support the payment policies. A common example for the allergist would be when the patient has had a bronchodilation responsiveness test performed (94060) and a separate instruction is given to the patient for a different bronchodilator that the patient will be using at home. Included in the 94060 code is the instruction on the bronchodilator to accurately have a good test. However, if the patient needs a different bronchodilator at home and needs to be instructed on the appropriate technique, then it would be appropriate to code both the 94060 and the 94664 with the 59 modifier attached to the 94664. Modifier 59 is not to be used if another HCPCS modifier best describes the scenario; it is to be used only if no other modifier is appropriate.

Modifier 76 – Repeat procedure by the same physician or other qualified healthcare provider.

This modifier indicates two exact same services were provided on the same calendar day. The second service received the 76 modifier to indicate the necessity of the repeat services. This is not a modifier to be used on E/M services, but it would be appropriate if two nebulizer treatments were performed on the same calendar day. The appropriate reporting would be 94640, and then 9464076.

Modifier 77 – If a different provider under the same tax ID provided the repeat service, then the appropriate modifier would be modifier 77.

If any surgical procedures are performed by the allergist and the procedures have global days associated with the procedures, there would be a need to use additional modifiers for payment of services

within the global period. All modifiers are listed with explanations in the appendix of the CPT book and are listed in numerical order for easy reference and understanding.

HCPCS Level II Codes: Medications, Supplies and Other Codes Required Specifically by Third Party Payers

HCPCS Level II codes and descriptors are five position codes approved and maintained jointly by the alpha-numeric editorial panel, which consists of Health Insurance Association of America, Blue Cross and Blue Shield Association and Centers for Medical Services. These codes represent services not described in Level I codes as well as additional services for drugs, supplies and other services required for reporting services by the panel mentioned above. CMS has expanded the number of codes in its specific section to report the PQRS codes. This section is the “G” section of the HCPCS book. There are also alpha modifiers, which are considered Level II modifiers used to communicate information to the third party payer. These modifiers may be specific to a certain payer or recognized by multiple payers. The HCPCS Level II codes are used to provide additional information for reporting not only drugs, supplies and durable medical supplies but also statistical information.

The most common use of the HCPCS Level II book for the allergist will be to report medications purchased and used in medical practice, the use of alpha modifiers to indicate additional information for appropriate payment, and the use of “G” code for CMS for PQRS reporting. The HCPCS Level II book is generally organized in the following format, depending on the publisher of the book:

HCPCS Index
Table of Drugs Index
HCPCS Level II Codes with descriptions beginning with Alpha modifiers

The sections of this publication that an allergist will use most frequently are the G codes for PRQS data, the J codes for medications and alpha modifiers to indicate something unique with a CPT category I code. There may be requests from third party payers to use other codes that are specific to their guidelines, and these are listed in the HCPCS Level II Coding book. An example of this is the code for oxygen, S1201, which may not be recognized by CMS but may be recognized by Blue Cross or Blue Shield. S8110 is for the physician interpretation of a peak flow, which has no category I code in the CPT Book.

An example in which an alpha modifier may be used would be the GA modifier – when a service is provided that is not covered for medical necessity by a patient’s insurance, but the patient and the provider feel it is necessary and the patient is willing to pay for the service.

J codes, as previously stated, are for numerical reporting of medication given to the patient as part of their evaluation and treatment. These codes are described not only with their generic names but many times also with their trade names for differentiation of medications; this is not an endorsement of any trade name medications. Immunosuppressive drugs used most commonly in an allergist’s office are in the J7500-J7600 section of the HCPCS Level II book. These codes also are described per a set quantity,

and when determining the correct code, make sure the correct one is chosen. This may mean reporting multiple units for the total quantity given to the patient to accurately code for the patient's medication.

Correct Coding and Bundling Guidelines

In 2006, CMS created coding guidelines for services reported for a single provider on one calendar day for an individual patient. The edits are revised quarterly and were created to stop fragmented billing by providers. The providers are obligated to correctly code for their services, so knowing bundling guidelines per payer is necessary. The most common bundling guidelines are published and posted by CMS. The third-party payers edit these guidelines or create their own guidelines per their contracts. There are payment modifiers assigned to the codes that are bundled. These payment modifiers indicate whether two codes with medical necessity may be billed separately or whether there is no circumstance under which both codes may be billed together. An example for the allergist is code 9410 (spirometry) and 94375 (flow volume loop), which has a payment indicator of 0. This payment indicator signifies there are no circumstances when CMS will pay for both codes on the same date of service for the same patient. The allergy testing codes and the evaluation and management codes have a payment indicator of 1. This signifies that if the definition of the 25 modifier is accurate for the encounter and assigned to the evaluation and management code, then both may be coded together on the same calendar day for the same patient. This became a requirement when the interpretation and report definition was added to the allergy testing codes. The addition of a modifier is required to "unbundle" two codes when it is medically necessary for the care of the patient. The appropriate modifiers for the allergist to consider most commonly are modifier 25 and modifier 59. These bundling edits may be found at www.cms.hhs.gov/cci.

LEVELS OF SERVICE SELECTION FOR EVALUATION AND MANAGEMENT CODES

The components of an E/M services code are history, exam, medical decision-making, counseling, coordination of care, nature of the presenting problem and time.

Requirement for New/Consult Patient vs. Established Patient

The history, exam and medical decision-making need to be at the same level or higher to support the level of care for a new patient or consult. For an established patient encounter, two of the three components must be at the same level or higher to support the level of care. The history and/or exam must be appropriate to the patient's presenting problem; therefore, medical decision-making always will be one of the components for an established patient encounter.

History Component

History components include history of the present illness (HPI), review of systems (ROS) and family and social history. The details of each history component are listed below.

HPI:

- Chief complaint – reason for encounter
- Location – specific to area of body
- Quality – pain described as dull or sharp; wound described as jagged, dirty or clean
- Severity – measured on a scale
- Duration – how long the complaint has lasted
- Context – how the complaint occurred
- Modifying factors – what has alleviated symptoms
- Signs and symptoms – additional information from the patient

In 2007, the CMS carriers clarified that the HPI component must be obtained by the physician. Although ancillary staff may question the patient regarding the chief complaint, that activity does not meet criteria for documentation of the HPI. The information gathered by ancillary staff (e.g., registered nurse, licensed practical nurse or medical assistant) may be used as preliminary information, but needs to be confirmed by the physician. The ancillary staff may write down the HPI as the physician dictates and performs it. The physician must review the information as documented, recorded or scribed and must write a notation that he/she reviewed it for accuracy and performed it as written (adding to it as necessary) and signing his/her name.

Reviewing information obtained by ancillary staff and writing a declarative sentence does not suffice for the HPI. An example of unacceptable HPI documentation would be "I have reviewed the HPI and agree with above."

ROS:

- Ten systems are required for a complete ROS.
- Pertinent positives and negatives must be documented.
- A notation of negative for the remaining ROS may be documented for the remaining systems. Some third-party payers may require documentation of 10 systems individually.
- The ROS may be documented by staff and/or the patient.
- The ROS must be reviewed by the physician, who must note that the information was reviewed.
- The ROS may be separate from, or part of, the HPI.
- One statement will not satisfy both the HPI and ROS components.

Family and social history:

- Past – events in the patient's medical/surgery history
- Family – diseases that may have an effect on the patient's health
- Social – age-appropriate environmental and social factors that affect the patient

Examination Component

For the examination component, all abnormal findings must be described. Normal findings can be indicated as a negative finding, but it is recommended that all negative and/or positive findings be documented. The allergy specialty has a specific exam as of 1997. At this time, either the 1997 or 1995 exam guidelines may be adopted (see Table

6.2). Most electronic medical records (or EMRs) incorporate the 1997 guidelines into their software for physicians to use. The 1997 examination guidelines are much more specific and indicate specific findings to be documented, whereas the 1995 guidelines are generalized per organ system and thus the provider must document specific findings.

A/I Exam, 1995 Exam Components. See Table 6.3 for a categorization of the required exam components. The components for each system are listed here.

Organ Systems	Body Areas
Constitutional	Head, including face
Eyes	Neck
Ear, nose and throat	Chest, including breasts and axillae
Cardiovascular	Abdomen
Respiratory	Genitalia, groin, buttocks
Lymphatic	Back
Gastrointestinal	Each extremity
Integumentary	
Genitourinary	
Musculoskeletal	
Neurologic/psychiatric/ hematologic/immunologic	

A/I Exam, 1997 Guidelines. See Table 6.4 for a categorization of the required exam components. The elements for each system are listed here.

Constitutional (all)

- Three vital signs
- Appearance

Head and face (all)

- Head and face
- Palpation or percussion of face

Eyes (one)

- Inspection of conjunctivae and lids

Ears, nose, mouth and throat (all)

- Otoscopic exam of auditory canals and tympanic membranes
- Inspection of nasal mucosa, septum and turbinates
- Inspection of teeth and gums
- Examination of oropharynx

Neck (one)

- Neck
- Thyroid

Respiratory (all)

- Auscultation of lungs
- Assessment of respiratory effort

Cardiovascular (all)

- Auscultation of heart
- Observation and palpation of peripheral vascular system

Gastrointestinal (all)

- Examination of abdomen
- Examination of liver and spleen

Lymphatic (one)

- Palpation of lymph nodes in neck, axillae, groin or other location

Extremities (one)

- Inspection and palpation of digits and nails

Neurologic/psychiatric (one)

- Time, place, person orientation
- Mood and affect

Other

- Additional exam components determined by the physician that are appropriate for patient's presenting complaint

Medical Decision-Making (see Medical Decision-Making box, p. 32)

Medical decision-making coding includes the number of diagnoses and treatment options, the amount of data and the complexity of data and risk. All three components are described below.

Diagnosis and treatment options:

- New problem – a problem new to the physician
- Established problem, stable – a known diagnosis that is stable
- Established problem, worsening – a known diagnosis that is worse
- Established problem, improved – a known diagnosis that has improved
- Work-up planned – a new complaint for which additional work-up is planned
- No work-up planned – new complaint(s) for which no additional work-up is planned

Coding for the amount and complexity of data component is composed of the following information, which is obtained, ordered or reviewed during the encounter:

- Review/order lab tests
- Review/order routine x-rays
- Review/order test from medicine section
- Discuss test results with performing physician
- Decide to obtain old records and documents
- Document direct visualization and independent interpretation

The risk component is composed of the present problem, diagnostic procedure or management option. The risk is determined by the component of the highest level to determine the overall risk for the patient.

Presenting problems are described as:

- Minimal – one self-limited or minor problem
- Low – two or more self-limited or minor problems, one stable chronic illness or one acute uncomplicated illness/injury
- Moderate – one or more chronic illness with mild exacerbation, two or more stable chronic illnesses, undiagnosed new problem with uncertain prognosis, acute illness with systemic symptoms or acute complicated injury
- High – chronic illness with severe exacerbation or acute or chronic illness/injury that may pose a threat to life or bodily function

The component for diagnostic procedures ordered is described as:

- Minimal – lab tests requiring venipuncture, x-rays, ultrasound
- Low – superficial needle biopsies, skin biopsies, PFTs

- Moderate – diagnostic endoscopy, deep needle or incisional biopsy
- High – diagnostic endoscopy with risk factors

Management options are described as:

- Minimal – rest, gargles, elastic/superficial dressings
- Low – over-the-counter drugs, saline washes, minor surgery, physical therapy
- Moderate – minor surgery with risk, elective major surgery, prescription drug management
- High – elective major surgery with risk, emergency major surgery, decision not to resuscitate or de-escalate care because of poor prognosis, drug therapy requiring intensive monitoring for toxicity, high morbidity and mortality without treatment

The level of medical decision-making depends on the number of diagnoses, the amount and complexity of the data and the risk. The appropriate level is determined by choosing the level where the middle component rests, or where two out of three of the components meet. For example, a new patient presents with asthma and allergic rhinitis. The patient is allergy tested, has a PFT and is placed on a prescription medication. The appropriate level of medical decision-making would be moderate for this patient. If a comprehensive history and a comprehensive exam were also performed and documented, the physician would code for a 99204 level of service.

Physician Tools

Templates to fulfill the documentation requirements for the appropriate level of service are a common resource. They help the physician record sufficient documentation to support the level of medical decision-making required. Templates provide legibility and remind the physician to document encounters legibly and completely. Templates may be in an electronic format or may be in the form of a paper chart. The template can utilize a check-box system as long as the check-box system is uniquely completed for each patient and abnormal findings are described. Many Electronic Medical Record (EMR) systems have built in templates to cross check your work.

In the future, it may be necessary to provide information to insurance companies for compliance and utilization of medical resources. This documentation may be easier to provide in an electronic format vs. a paper format.

TABLE 6.2. COMPARISON CHART OF E/M GUIDELINES

	1995 E/M Guidelines	**1997 E/M Guidelines**
History (HX)	Chief complaint or reason for visit **HPI** • Brief: 1-3 elements • Extended: ≥4 elements **ROS** • 14 organ systems available • Problem pertinent: 1 system • Extended: 2-9 systems • Complete: ≥10 systems **Past, family and social HX** • 1 item related in any area • Complete: 2 or all 3 areas	Chief complaint or reason for visit **HPI** • Brief: 1-3 elements • Extended: ≥4 or more elements **ROS** • 14 organ systems available • Problem pertinent: 1 system • Extended: 2-9 systems • Complete: ≥10 systems **Past, family and social HX** • 1 item related in any area • Complete: 2 or all 3 areas
Physical Exam	**Problem-focused** • 1 organ system • Exam of affected area **Expanded problem-focused** • 2-4 organ systems **Detailed exam** • 5-7 organ systems **Comprehensive exam** • 8 organs/areas documented	**Problem-focused** • 1-5 elements of specialty exam **Expanded problem-focused** • 6-11 elements of specialty exam **Detailed exam** • 12 elements documented **Comprehensive exam** • All systems with indication of all, and 1 element from remaining systems
Medical Decision-Making	**Areas: 2 of 3 must be met** • No. of diagnosis/management options • Amount and/or complexity of data • Risk of complications and/or morbidity/ mortality See Medical Decision-Making box	**Areas: 2 of 3 must be met** • No. of diagnosis/management options • Amount and/or complexity of data • Risk of complications and/or morbidity/ mortality
Counseling and Coordination of Care	• When >50% of the face-to-face visit is spent with the patient, providing counseling and/ or coordination of care, the CPT code may be selected based on "total time" spent with the patient • Documentation must support the time factor and include the discussion	• When >50% of the face-to-face visit is spent with the patient, providing counseling and/ or coordination of care, the CPT code may be selected based on "total time" spent with the patient • Documentation must support the time factor and include the discussion

TABLE 6.3. 1995 E/M CODES COMPONENT REQUIREMENTS

CONSULT- 3 of 3	**99251**	**99252**	**99253**	**99254**	**99255**
CONSULT-3 of 3	**99241**	**99242**	**99243**	**99244**	**99245**
NEW PT-3 of 3	**99201**	**99202**	**99203**	**99204**	**99205**
HISTORY (HX)					
CHIEF COMPLAINT	Required	Required	Required	Required	Required
HX of PRESENT ILL.	Brief (1–3)	Brief (1–3)	Extended (4+)	Extended (4+)	Extended (4+)
ROS		Problem pertinent (1)	Extended (2–9 systems)	Complete (10+ systems)	Complete (10+ systems)
PAST HX			Pertinent-1	Complete-1ea	Complete-1ea
FAMILY HX			Pertinent-1	Complete-1ea	Complete-1ea
SOCIAL HX			Pertinent-1	Complete-1ea	Complete-1ea
EXAM	Examine affected body area or organ system (1)	Examine 2-4 affected areas/systems and other related areas/systems	Extended exam affected area and related organ systems (5-7 systems)	Complete single/multisystem exam (8)	Complete single/multisystem exam (8)
MED. DECISION-MAKING	**(2 of the 3 must be met or exceeded)**				
MGMT/OPTION DX	Minimal (1)	Minimal (1)	Limited (2)	Multiple (3)	Extensive (4)
AMT DATA/COMPLEX	Minimal (1)	Minimal (1)	Limited (2)	Moderate (3)	Extensive (4)
RISK OF COMPLICAT.	Minimal	Minimal	Low	Moderate	High
ESTABLISHED PT					
2 OF 3	**99211**	**99212**	**99213**	**99214**	**99215**
TIME	**5 min**	**10 min**	**15 min**	**25 min**	**40 min**
HISTORY (HX)					
CHIEF COMPLAINT	Required	Required	Required	Required	Required
HX PRESENT ILL.		Brief	Brief	Extended	Extended
ROS			Prob. pertinent	Extended	Complete
PAST HISTORY				Pertinent-1	Complete
FAMILY HISTORY				Pertinent-1	Choice of 2
SOCIAL HISTORY				Pertinent-1	ele PFS HX
EXAM		Examine affected body area or organ system (1)	Examine affected body area and other related organ system (2-5)	Extended exam affected body area and related organ system (5-7)	Complete single-system or multi-system exam (8)
MED. DECISION-MAKING					
MGMT/OPTION DX		Minimal (1)	Limited (2)	Multiple (3)	Extensive (4)
AMT DATA/COMPLEX		Minimal (1)	Limited (2)	Moderate (3)	Extensive (4)
RISK OF COMPLICAT.		Minimal	Low	Moderate	High

TABLE 6.4. 1997 E/M CODES COMPONENT REQUIREMENTS

CONSULT-HOSPITAL	**99251**	**99252**	**99253**	**99254**	**99255**
CONSULT-3 of 3	**99241**	**99242**	**99243**	**99244**	**99245**
NEW PT-3 of 3	**99201**	**99202**	**99203**	**99204**	**99205**
HISTORY (HX)					
CHIEF COMPLAINT	Required	Required	Required	Required	Required
HX of PRESENT ILL.	Brief (1–3)	Brief (1–3)	Extended (4+)	Extended (4+)	Extended (4+)
ROS		Problem pertinent (1)	Extended (2–9 systems)	Complete (10+ systems)	Complete (10+ systems)
PAST HX			Pertinent-1	Complete-1ea	Complete-1ea
FAMILY HX			Pertinent-1	Complete-1ea	Complete-1ea
SOCIAL HX			Pertinent-1	Complete-1ea	Complete-1ea
EXAM	Perform/ document 1–5 elements	Perform/ Document at least 6 Elements	Perform/ document at least 12 elements	Perform/ document all elements: all elem—shaded 1 ele—unshaded	Perform/ document all elements: all elem—shaded 1 ele—unshaded
MED. DECISION-MAKING	**(2 of the 3 must be met or exceeded)**				
MGMT/OPTION DX	Minimal (1)	Minimal (1)	Limited (2)	Multiple (3)	Extensive (4)
AMT DATA/COMPLEX	Minimal (1)	Minimal (1)	Limited (2)	Moderate (3)	Extensive (4)
RISK OF COMPLICAT.	Minimal	Minimal	Low	Moderate	High

ESTABLISHED PT 2 OF 3	99211	99212	99213	99214	99215
TIME	5 min	10 min	15 min	25 min	40 min
HISTORY (HX)					
CHIEF COMPLAINT	Required	Required	Required	Required	Required
HX PRESENT ILL.		Brief	Brief	Extended	Extended
SYSTEM REVIEW			Prob. pertinent	Extended	Complete
PAST HISTORY				Pertinent-1	Complete:
FAMILY HISTORY				Pertinent-1	Choice of 2
SOCIAL HISTORY				Pertinent-1	ele PFS HX
EXAM		Perform/ Document 1–5 elements	Perform/ document at least 6 elements	Perform/ document at least 12 elements	Perform/ document all elements: all elem—shaded 1 ele—unshaded
MED. DECISION-MAKING					
MGMT/OPTION DX		Minimal (1)	Limited (2)	Multiple (3)	Extensive (4)
AMT DATA/COMPLEX		Minimal (1)	Limited (2)	Moderate (3)	Extensive (4)
RISK OF COMPLICAT.		Minimal	Low	Moderate	High

MEDICAL DECISION-MAKING

New patient or consult	**99201 Straight-forward**	**99202 Straight-forward**	**99203 Low complexity**	**99204 Moderate complexity**	**99205 High complexity**
Established (est) patient	**99211**	**99212 Straight-forward**	**99213 Low complexity**	**99214 Moderate complexity**	**99215 High complexity**
No. of diagnoses or treatment options		Minor problem; self-limited; est problem—stable	Est. problem—worsening; new problem—stable; new problem	Multiple established problems	New problem w/ work-up planned
Amount of data		Ordered tests in 1 CPT area	Ordered tests in 2 CPT areas or discussed test results with other MD	Invasive diagnostic tests; review old history (hx)/ records; order tests in 3 CPT areas	Review old hx/records; order tests in at least 3 CPT areas
Risk		Rest; gargle; bandages; comfort items; liquids; OTC drugs	OTC drugs or PFT	Prescription drug mgmt; IV fluids; acute illness w/ systemic symptoms	Intensive drug therapy w/monitoring; acute life-threatening illness
Average time w/consult	15 min	30 min	40 min	60 min	80 min
Average time w/new patient	10 min	20 min	30 min	45 min	60 min
Average time w/est patient	5 min	10 min	15 min	25 min	40 min

Note: 99201-99205 and 99241-99245 are the same for a new patient.

Time: If >50% of the physician's time is spent face-to-face with the patient discussing various counseling components, the visit may be coded based on time, but only if the **chart documentation** supports the time. The documentation must list the total time of the encounter and that coding was based on "counseling regarding …."

Counseling components:

- Diagnostic results
- Prognosis
- Risks and benefits of treatment options
- Impressions
- Instructions for management
- Importance of compliance with chosen treatment options
- Risk factor reductions
- Patient and family education

REFERENCES

AAAAI website, management tools and technology: www.aaaai.org/practice-resources/management-tools-and-technology.aspx.

American Medical Association, CPT coding information page: www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.page?.

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