Local Coverage Determination
Coding Guidelines

Contractor Name
Wisconsin Physicians Service (WPS)

Contractor Number
00951, 00952, 00953, 00954
05101, 05201, 05301, 05401,
05102, 05202, 05302, 05402, 52280

LCD Title
Allergy Testing and Allergy Immunotherapy

LCD Database ID Number

Contractor's Determination Number
ALRG 001

Medicare Regulations and Coding Guidelines

1. *Evaluation and management codes reported with allergy testing or allergy immunotherapy are appropriate only if a significant, separately identifiable service is administered. When appropriate, use modifier -25 with the E&M code to indicate it as a separately identifiable service. Obtaining informed consent is included in the immunotherapy. If E & M services are reported, medical documentation of the separately identifiable service should be in the medical record.*

2. Allergy testing is not performed on the same day as allergy immunotherapy in standard medical practice. These codes should, therefore, not be reported together. Additionally, the testing becomes an integral part to rapid desensitization kits (CPT code 95180) and would therefore not be reported separately.

Allergy Testing

1. *The MPFSDB fee amounts for allergy testing services billed under codes 95004-95078 are established for single tests. Therefore, the number of tests must be shown on the claim.*
   EXAMPLE
   If a physician performs 25 percutaneous tests (scratch, puncture, or prick) with allergenic extract, the physician must bill code 95004 and specify 25 in the units field of Form CMS-1500 (paper claims or electronic format). To compute payment, the Medicare carrier multiplies the payment for one test (i.e., the payment listed in the fee schedule) by the quantity listed in the units field.

2. Part B providers indicate the number of tests (one for each antigen) in Box 24G of the HCFA 1500 claim form. On EMC claims enter the number in the service field.

3. Interpretation of CPT codes: 95004 - 95078; use the code number which includes the number of tests which were performed and enter 1 unit for each test performed. For example, if 18 scratch tests are done, code 95004 with 18 like services. If 36 are done, code 95004 with 36 like services.

4. When photo patch tests (e.g. CPT code 95052) are performed (same antigen/same session) with patch or application tests, only the photo patch testing should be reported. Additionally, if photo testing is performed including application or patch testing, the code for photo patch testing (CPT code 95052) is to be reported, not CPT code 95044 (patch or application tests) and CPT code 95056 (photo tests).

5. **Non-covered testing:**
Non-covered services include, but are not limited to, the following services (some are not represented by specific CPT-4 codes). Some of these are based on statute and this is noted in italics.

   a. CIM 50-53
   Food Allergy Testing and Treatment--NOT COVERED-- (Effective for services furnished on or after October 31, l988.)
   Effective October 31, l988, sublingual intracutaneous and subcutaneous provocative and neutralization testing and neutralization therapy for food allergies are excluded from Medicare coverage because available evidence does not show that these tests and therapies are effective. This exclusion was published as a Final Notice in the ***Federal Register*** *on September 29, 1988.*

   b. CIM 50-2
   Cytotoxic Food Tests--NOT COVERED (Effective for services performed on or after August 5, l985).
   Prior to August 5, l985, Medicare covered cytotoxic food tests as an adjunct to in vivo clinical allergy tests in complex food allergy problems. Effective August 5, l985, cytotoxic leukocyte tests for food allergies are excluded from Medicare coverage because available evidence does not show that these tests are safe and effective. This exclusion was published as a HCFA Ruling in the ***Federal Register*** *on July 5, l985.*

Allergen Immunotherapy

Coding

1. *Always use the component codes (95115, 95117, 95144-95170) when reporting allergy immunotherapy services to Medicare. Report the injection only codes (95115 and 95117) and/or the codes representing antigens and their preparation (95144-95170). Do not use the complete service codes (95120-95134)!*

2. *Use CPT component procedure codes 95115 (single injection) and 95117 (multiple injections) to report the allergy injection alone, without the provision of the antigen.*

3. *Use CPT component procedure codes 95144-95170 (provision of antigens) to report the antigen/antigen preparation service when this is the only service rendered by the physician.*

4. *Use CPT procedure codes 95115/95117 and the appropriate CPT procedure code from the range 95145-95170 when reporting both the injection and the antigen/antigen preparation service (complete service). These instructions also apply to allergists who provide both services through the use of treatment boards.*

5. *The provision of antigens must be coded based on the specific type of antigen provided:*

· CPT code 95144 is used to report regular antigens, other than stinging insect. Use this code to report single dose vials. Use this code only when the allergist actually prepares the extract. Code 95144 (single dose vials of antigen) should be reported only if the physician providing the antigen is providing it to be injected by someone other than himself/herself. If this code is mistakenly reported in conjunction with an injection (95115 or 95117), payment will be made under code 95165.

· CPT procedure code 95165 is used to report multiple dose vials of non-venom antigens. Effective January 1, 2001, for CPT code 95165, a dose is now defined as a one- (1) cc aliquot from a single multidose vial. When billing code 95165, providers should report the number of units representing the number of 1 cc doses being prepared. A maximum of 10 doses per vial is allowed for Medicare billing, even if more than ten preparations are obtained from the vial. In cases where a multidose vial is diluted, Medicare should not be billed for diluted preparations in excess of the 10 doses per vial allowed under code 95165.

· CPT procedure codes 95145-95149 and 95170 are used to report stinging insect venoms. Venom doses are prepared in separate vials and not mixed together -except in the case of the three vespid mix (white and yellow hornets and yellow jackets). Use the code within the range that is appropriate to the number of venoms provided. If a code for more than one venom is reported, some amount of each of the venoms must be provided. Use of a code below the venom treatment number for the particular patient should occur only for the purpose of "catching up" (see coding guideline # 7).

· The antigen codes (95144-95170) are considered single dose codes. To report these codes, specify the number of doses provided.

· If a patient's doses are adjusted (e.g., due to reaction), and the antigen provided is actually more or fewer doses than originally anticipated, make no change in the number of doses billed. Report the number of doses actually anticipated at the time of the antigen preparation. These instructions apply to both venom and non-venom antigen codes.

6. *The physician should make no change in the number of doses for which he/she bills even if the patient's doses are adjusted. The number of doses anticipated at the time of the antigen preparation is the number of doses that should be billed. If the patient actually receives more doses than originally planned (due to a decrease in the amount of antigen administered during treatment) or fewer doses (due to an increase in the amount of antigen administered), no change should be made in the billing.*

7. *When a venom regimen requires that antigens be mixed from more than one vial for administration and, due to a dose adjustment of one of the antigens, one vial is depleted before the other, the physician may bill for "catch-up" doses of the short antigen. This must be done in a manner that synchronizes the preparation back to the highest venom code possible in the shortest amount of time. To catch up, the physician would bill only the amount of the depleted vial needed to catch-up with the other vials. This will permit the physician to get back to preparing the full number of venoms at one time and billing the doses of the "cheaper" higher venom codes. Use of a code below the venom treatment number for the particular patient should occur only for the purpose of "catching up"*

8. *A visit to an allergist, which yields a diagnosis of specific allergy sensitivity but does not include immunotherapy, should be coded according to the level of care rendered.*

9. Use CPT procedure code 95180 (rapid desensitization) when sensitivity to a drug has been established and treatment with the drug is essential. This procedure will also require frequent monitoring and skin testing. The number of hours involved in desensitization must be reported in the unit's field.

10. *Allergy Shots and Visit Services on Same Day*
Effective for services provided on or after January 1, 1995, visits may not be paid with allergy injection services 95115 through 95199 unless the visit represents another separately identifiable service. Modifier code -25 is used with the visit code to report the patient's condition required a significant, separately identifiable visit service above and beyond the allergen immunotherapy service provided.

11. **Place of Service**
CPT procedure codes 95115, 95117 and 95144 are payable only in an office setting (11). CPT procedure codes 95145-95170 are payable in the office (11) and in a hospital outpatient department (22). These codes are also payable in a skilled nursing facility (31), but only if the physician is present. CPT procedure codes 95060, 95065, 95180 are payable in office and hospital settings (21, 22, 23).

Hospital Inpatient Claims:

- The hospital should report the patient's principal diagnosis in Form Locator (FL) 67 of the UB-04. *The principal diagnosis is the condition established after study to be chiefly responsible for this admission.*
- *The hospital enters ICD-9-CM codes for up to eight additional conditions in FLs 67A-67Q if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may not duplicate the principal diagnosis listed in FL 67.*
- For inpatient hospital claims, the admitting diagnosis is required and should be recorded in FL 69. (See CMS Publication 100-04, *Medicare Claims Processing Manual,* Chapter 25, Section 75 for additional instructions.)

Hospital Outpatient Claims:

The hospital should report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67. If no definitive diagnosis is made during the outpatient evaluation, the patient's symptom is reported. *The hospital enters the full ICD-9-CM codes in FLs 67A-67Q for up to eight other diagnoses that coexisted in addition to the diagnosis reported in FL 67.*

Antigens

1. **Supply of Antigen:**
Payment may be made for a reasonable supply of antigens that have been prepared for a particular patient when:

- *The antigens are prepared by a physician who is a doctor of medicine or osteopathy; and*
- *The physician who prepared the antigens has examined the patient and has determined a plan of treatment and a dosage regimen.*

Antigens must be administered in accordance with the plan of treatment and by a doctor of medicine or osteopathy or by a properly instructed person under the supervision of the doctor.
Effective January 1, 2001, the Health Care Financing Administration (HCFA) has revised the regulation limiting the supply of antigens that can be prepared by a physician for a particular patient at one time. The limitation is changed from a 12-week supply to a 12-month supply. This regulation is revised with the stipulation that it is a physician's responsibility to furnish only a supply that would remain stable and potent over the time period for which they are administered.

2. *For antigens provided to patients on or after November 17, 1996, Medicare does not cover such antigens if they are to be administered sublingually, i.e., by placing drops under the patient's tongue. This kind of allergy therapy has not been proven to be safe and effective. Antigens are covered only if they are administered by injection.*

Revision Effective date

07/16/2012

Revision History

06/01/2012 -This guideline is effective for J-8 providers in Michigan MAC B 07/16/12, Michigan MAC A 07/23/12, Indiana MAC A 07/23/12 and Indiana MAC B 08/20/12.

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