Billing and Coding Guidelines for Allergy Testing & Allergy Immunotherapy

LCD ID
L34597

Allergy Testing (Medicare excerpts)

Billing Guidelines:
Evaluation and management (E/M) 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. (CPT guidelines)

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.

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. (CMS Pub *Medicare Claims Processing Manual* , Chapter 12 – Physicians/Nonphysician Practitioners, Section 200 – Allergy Testing and Immunotherapy, Rev.2997, Issued: 07-25-14, Effective: Upon implementation of ICD-10; 01-01-2012-ASC X12, Implementation: 08-25-2014 – ASC X12; Upon Implementation of ICD-10).
EXAMPLE

> *If a physician performs 25 percutaneous tests (scratch, puncture, or prick) with allergenic extract, the physician must bill code 95004, 95017 or 95018 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 unit's field.*

Part B providers indicate the number of tests (one for each antigen) in Box 24G of the 1500 claim form. (CMS Pub *Medicare Claim Processing Manual,* Chapter 26 – Completing and Processing Form CMS-1500 Data Set , Section 10.4 – Provider of Service or Supplier Information, Rev. 3083, Issued: 10-02-2014, Item 24G). On EMC claims enter the number in the service field.

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, 95017 or 95018 with 18 like services. If 36 are done, code 95004, 95017 or 95018 with 36 like services.

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).
Allergy testing is covered when clinically significant symptoms exist and conservative therapy has failed. Allergy testing includes the performance, evaluation, and reading of cutaneous and mucous membrane testing.

Standard skin testing is the preferred method when allergy testing is necessary. Each test should be billed as one unit of service per procedure code, not to exceed two strengths per each unique antigen. Histamine and saline controls are appropriate and can be billed as two antigens. The number of antigens should be individualized for each patient based on history and environmental exposure.

Non-covered testing:
Non-covered testing includes, but are not limited to, the following tests:
a. Sublingual Intracutaneous and subcutaneous Provocative and Neutralization Testing: *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.* (CMS Pub 100-03 *Medicare National Coverage Determinations (NCD) Manual,* Chapter 1, Part 2 Section 110.11 – Food Allergy Testing and Treatment (Rev. 1, 10-03-03).
b. Challenge Ingestion Food Testing: Challenge ingestion food testing has not been proven to be effective in the diagnosis of rheumatoid arthritis, depression, or respiratory disorders. Accordingly, its use in the diagnosis of these conditions is not reasonable and necessary within the meaning of §1862(a)(1) of the Act, and no program payment is made for this procedure when it is so used. (CMS Pub 100-03 *Medicare National Coverage Determinations (NCD) Manual,* Chapter 1, Part 2 Section 110.12 – Challenge Ingestion Food Testing (Rev. 1, 10-03-03).
c. Cytotoxic Food Tests: *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.* (CMS Pub 100-03 *Medicare National Coverage Determinations* (*NCD) Manual,* Chapter 1, Part 2 Section 110.13 –Cytotoxic Food Tests Rev. 1, 10-03-03).

Coding Guidelines:
Per the CMS Pub *National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services*, Chapter 11- CPT codes 90000-99999, K. Allergy Testing and Immunotherapy.

If percutaneous or intracutaneous (intradermal) single test (CPT codes 95004 or 95024) and "sequential and incremental" tests (CPT codes, 95017, 95018, or 95027) are performed on the same date of service, both the "sequential and incremental" test and single test codes may be reported if the tests are for different allergens or different dilutions of the same allergen. The unit of service to report is the number of separate tests. A single test and a "sequential and incremental" test for the same dilution of an allergen should not be reported separately on the same date of service. For example, if the single test for an antigen is positive and the physician proceeds to "sequential and incremental" tests with three additional different dilutions of the same antigen, the physician may report one unit of service for the single test code and three units of service for the "sequential and incremental" test code.

Photo patch tests (CPT code 95052) consist of applying a patch(s) containing allergenic substance(s) (same antigen/same session) to the skin and exposing the skin to light. Physicians should not unbundle this service by reporting both CPT code 95044 (patch or application tests) plus CPT code 95056 (photo tests) rather than CPT code 95052.

Evaluation and management (E/M) codes reported with allergy testing or allergy immunotherapy are appropriate only if a significant, separately identifiable service is performed. If E/M services are reported, modifier 25 should be utilized.

In general allergy testing is not performed on the same day as allergy immunotherapy in standard medical practice. Allergy testing is performed prior to immunotherapy to determine the offending allergens. CPT codes for allergy testing and immunotherapy are generally not reported on the same date of service unless the physician provides allergy immunotherapy and testing for additional allergens on the same day. Physicians should not report allergy testing CPT codes for allergen potency (safety) testing prior to administration of immunotherapy. Confirmation of the appropriate potency of an allergen vial for immunotherapy is an inherent component of immunotherapy. Additionally, allergy testing is an integral component of rapid desensitization kits (CPT code 95180) and is not separately reportable.

Obtaining informed consent is included in the immunotherapy service and should not be reported with an E/M code.

Allergen Immunotherapy (Medicare excerpts)

Billing Guidelines:
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."

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."

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.

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.

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.

Coding Guidelines:
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)!

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

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

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.

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.

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 field.

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.

For place of service the following is covered:

> 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 (11) and hospital settings (21, 22, 23).

Antigens
CMS Pub 100-02 *Medicare Benefit Policy Manual*, Chapter 15 - Covered Medical and Other Health Services, 50.4.4.1 - Antigens (Rev. 186, Issued: 04-16-14, Effective: 01-01 01, Implementation: 05-12-14) outlines the benefit for the supply of antigen use in immunotherapy.

Payment may be made for a reasonable supply of antigens that have been prepared for a particular patient if: (1) the antigens are prepared by a physician who is a doctor of medicine or osteopathy, and (2)

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 (who could be the patient) under the supervision of the doctor. The associations of allergists that CMS consulted advised that a reasonable supply of antigens is considered to be not more than a 12-month supply of antigens that has been prepared for a particular patient at any one time. The purpose of the reasonable supply limitation is to assure that the antigens retain their potency and effectiveness over the period in which they are to be administered to the patient.

Sublingual Immunotherapy (SLIT)
Sublingual immunotherapy (SLIT) involves the use of FDA approved allergenic extracts administered orally. In early 2014, the FDA approved oral administration of 3 allergenic extracts, two for grasses and one for ragweed. These extracts are not approved by the FDA for anyone over the age of 65 years. Medicare does not cover sublingual immunotherapy. *Effective October 31, 1988, 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.* (CMS Pub 100-03 *Medicare National Coverage Determinations Manual*, Chapter 1- Coverage Determinations, Part 2, Section 110.11 – Food Allergy Testing and Treatment).

Revision Effective date
10/01/2015

Revision History
05/01/2015 Annual review completed on 03/31/2015. All Medicare excerpts updated.

06/01/2014 Moved billing information about technical services and units of antigens from body of policy to billing and coding guidelines