

CPT coding for the allergist

Gary N. Gross, MD *Dallas, Tex*

Key words: CPT coding, insurance, Medicare, modifiers, reimbursement

It is appropriate that this topic be covered in a section of the Journal related to experience-based rather than evidence-based clinical practice. As physicians, we would like to have some scientific or logical basis for what we do, and coding defies science and logic. Coding is an evolving area that has no firm foundation or practical precision. This area of medical practice is one we all either ignore or deny for as long as possible. The reality is that we all need to know about coding and documentation for proper reimbursement. The growing awareness of this need is evidenced by the high enrollment for coding workshops at our annual meetings and the hundreds of e-mail questions about coding the Joint Council of Allergy, Asthma, and Immunology (JCAAI) receives each month. The evolutionary quality of CPT coding is apparent from at least one of the coding books sold each year, *CPT Changes for 200X*. The 2006 version of this book contains 276 new codes, 108 deleted codes, and 70 revised codes.

As allergists, we need to know a small section of CPT specific codes, as well as the evaluation and management (E&M) codes. The allergy-specific codes are generally found in the coding section 95004 through 95199. These allergy codes are easy to use with some specific knowledge and understanding. Questions arise in instances such as the venom codes, where a patient receiving mixed vespid with 3 venoms and honey bee with 1 venom should be coded as 4 venoms (95148) rather than 3 venoms (95147) plus 1 venom (95145). The answer to many coding questions can be found in careful reading of the CPT book headings or the CPT Assistant (referenced in the CPT book).

The E&M codes might pose greater difficulties in trying to determine the proper code for each patient encounter. These difficulties are not unique to allergy, nor are the concerns about the amount of time required to code correctly.¹ The E&M codes have been the subject of a

Abbreviations used

E&M: Evaluation and management

JCAAI: Joint Council of Allergy, Asthma, and Immunology

RUC: Relative Value Update Committee

number of studies demonstrating the lack of uniformity in coding, even among experts. These coding errors are usually honest differences in interpretation of the basic components of the encounter.² The components used to determine level of service are history, physical examination, and medical decision making. Occasionally a physician might bill for a higher level of service than the documentation of the visit warrants. If this overbilling is in fact an honest error, then the physician might be questioned about the charge and required to show how she or he will avoid such errors in the future. A compliance plan might be required for the practice if one is not already in place. The JCAAI provides a compliance plan for the allergist's office and online courses in coding and compliance. If there is a pattern in the errors and they are repetitive, monetary penalties and a request for reimbursement of the overpayment might follow. Similarly, some physicians might intentionally undercode with the hopes of not appearing on anyone's radar screen. Unfortunately, this practice is as likely to trigger an audit and definitely leaves the physician with less money than she or he rightly deserves. The obvious solution is to learn enough about E&M coding to quickly code the majority of patient encounters and have tools readily available to correctly code the unusual patient visits.

If coding were as simple as learning the codes and definitions in the CPT book, we would all be experts. However, 2 further aspects of coding can create more questions. To understand the first coding dilemma, one needs to know a little about how reimbursement is determined for CPT codes. There are 3 components of reimbursement attached to a CPT code: physician work, practice expense, and malpractice expense. The physician work component is evaluated by the American Medical Association Relative Value Update Committee (RUC) and based on input from the specialty, as well as the committee's perception of relative work values. The practice expense is determined by time and motion-type surveys, with pricing based on standard tables available to the practice expense advisory committee of the RUC. It is important for the practicing allergist to participate in

From the Dallas Allergy and Asthma Center.

Received for publication November 1, 2005; revised November 28, 2005; accepted for publication November 29, 2005.

Reprint requests: Gary N. Gross, MD, Dallas Allergy and Asthma Center, 5499

Glen Lakes Dr, #100, Dallas, TX 75231. E-mail: ggross144@earthlink.net.

J Allergy Clin Immunol 2006;117:257-8.

0091-6749/\$32.00

© 2006 American Academy of Allergy, Asthma and Immunology

doi:10.1016/j.jaci.2005.11.031

these surveys of physician work and practice expense when asked because the survey responses become part of the data on which the committee will determine a value of the service, which in turn directly affects allergists' reimbursement. The RUC then makes recommendations to the Centers for Medicare and Medicaid Services, where the final decision is made regarding physician work and practice expense values. Malpractice expense (the smallest component) is largely determined by geographic area and specialty. Because the specific inputs the practice expense committee has considered in determining the price of a code (eg, cotton balls, syringes, and minutes of nursing time) are not easily discernable to the practitioner, confusion can arise in correct coding. For instance, it was only in the 2005 CPT book that there was information that the bronchodilator cost was not included in the code for bronchodilator responsiveness (94060). The 2004 CPT book gave no indication of whether the drug could be charged in addition to the test. Other examples of this potential confusion abound.

The second aspect of coding that creates difficulties for us all is that some carriers and insurance companies will accept some codes, as well as code pairs, and others will not. One company might pay for the time and effort spent to properly educate an asthmatic patient about proper use of an inhaler (CPT code 94664), whereas another company might make the decision that the service is included with the E&M visit. Although these decisions can be appealed, it is costly to do so. Medicare and other payers might determine that some codes are simply not reimbursable, even though they are in the CPT book and clearly defined. These encounters can be frustrating for all of us as we try to care for our patients.

Some simple lessons from the CPT book can make a big difference in reimbursement. Using modifiers (found inside the front cover of the CPT book) can determine whether you will be paid. Modifier -25 is attached to an E&M visit code when a significant and separately identifiable E&M service is performed by the same physician on the same day as a procedure (eg, skin testing or pulmonary function testing). If the modifier is not used, the insurance company might pay for the lower of the 2 charges. Knowing the units of a code can also determine what you are paid. Drug desensitization (eg, penicillin or aspirin) and rush immunotherapy, which require constant monitoring to prevent or treat systemic reactions, can be billed on an hourly basis during the time of desensitization using code 95180, with hours in the units box on the insurance form. These procedures are labor intensive and associated with a greater potential for anaphylaxis requiring this constant monitoring. Because different insurance

carriers have different payment policies, it is best to get prior authorization before doing unusual expensive procedures. Some insurance companies will pay for qualified, nonphysician health care professionals to teach patients about asthma (98960-98962). This reimbursement also might vary by company.

How can we as practicing allergists best deal with these cumbersome and evolving rules of coding? What resources do we have to call on? We must first accept the fact that coding rules are here to stay. There have been attempts to change and simplify the coding system at least twice in the past 5 years, but they have failed. Once we accept that coding in some form is here to stay, we should learn to code by reading the CPT book (at least that part that pertains to allergists) and take courses where appropriate. Staying current with the changing codes requires quick access to current books (CPT codes must be current as of January 1st of each year). If an unusual circumstance arises that is not part of our usual daily practice, a penicillin desensitization perhaps, we should look for correct coding of the procedure through the Internet, colleagues who do the procedure regularly, or our national allergy organizations. We should stay up to date on coding practices, just as we do with changes in immunotherapy and asthma management. This information does not necessarily translate into better patient care, but it certainly can provide us with better reimbursement for the hours that we put into patient care. Resources for this coding information include online courses provided by the JCAAI, practice management seminars provided by the Academy, and other courses designed for physicians and practice administrators.

Allergists also need to look to the future and try to prepare for it. Changes in technology, therapeutics, government regulations, and the health care system mean changes in the way allergy will be practiced. To offer high-quality care to patients, allergists, as well as all physicians, must be able to adapt to changes in the environment in which we practice. Contributing to the efforts of our national societies can help promote this high-quality patient care, maintain reimbursement for our services, and encourage collegiality within the specialty of allergy.

REFERENCES

1. Lasker RD, Marquis MS. The intensity of physicians' work in patient visits- implications for the coding of patient evaluation and management services. *N Engl J Med* 1999;341:337-41.
2. King MS, Sharp L, Lipsky MS. Accuracy of CPT evaluation and management coding by family physicians. *J Am Board Fam Pract* 2001;14:184-92.