CHAPTER 6

Coding and Billing Basics

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OVERVIEW OF PHYSICIAN CODING AND BILLING

Physicians need to understand the reimbursement system in order to maintain an active and financially healthy practice. Physician services are routinely submitted to third-party payers in numeric codes for reimbursement.

The intent of having a coding system is to translate the information that is documented in the medical record into numeric codes. The purpose of this translation is to collect data and to enable the physician to be reimbursed for the services provided. With HIPAA, documentation is mandatory to justify the codes submitted to third-party payers for reimbursement. This applies not only to Medicare but also 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

A rule of thumb about documentation is "If it is not documented, it didn't happen and it is not billable. If it is illegible, it is not billable." So 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 for justification to pay for 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 supports the procedure 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 is then 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 AMA, and the International Classification of Diseases (ICD), which was created by 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 diagnosis codes used to provide medical necessity for services and procedures. In 2013, 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 specificity to code each patient encounter

This chapter will deal with the coding systems currently being used by allergy offices to communicate with third-party payers for reimbursement for services provided.

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 by use of HIPAA guidelines.

Most diagnosis coding books are divided into two sections: the alphabetic index and the tabular section. The tabular section is divided into chapters according to diseases of the different organ systems. The coding chapters are as follows:

1. Infectious and parasitic disease
2. Neoplasms
3. Endocrine, nutritional and metabolic disease and immunity disorders
4. Diseases of the blood and blood-forming organs
5. Mental disorders
6. Diseases of the nervous system and sense organs
7. Diseases of the circulatory system
8. Diseases of the respiratory system
9. Diseases of the digestive system
10. Diseases of the genitourinary system
11. Complications of pregnancy, childbirth and the puerperium
12. Diseases of the skin and subcutaneous tissue
13. Diseases of the musculoskeletal system and connective tissue
14. Congenital anomalies
15. Certain conditions originating in the newborn (perinatal) period
16. Systems, signs and ill-defined conditions
17. Injury and poisoning

Two supplemental sections in the diagnosis code book are the V codes and the E codes. **V codes** describe factors that are not described by an active disease. The V codes indicate that the patient has had a disease in the past but does not currently have the disease (e.g., a personal history of cancer that was treated successfully). V codes also indicate other factors such as family members who have had a disease that may impact the patient, or exposure to a disease such as personal exposure to tuberculosis. V codes are also used when a patient is not being seen for an active disease, such as when a patient presents for an annual physical with no complaint or for a work physical. **E codes** are used for external causes that affect or have caused the patient's complaint. They are usually used for injuries and accidents. They can also be used for overdoses or

poisonings. **E codes are always supplemental to another diagnosis code and are never used alone.** They are additional codes that accompany another diagnosis code. For example, a bee sting would be coded as 989.5, E905.3, which tells the payer that the patient was stung by a bee and it was an accident.

Following are some general rules about choosing diagnosis codes:

1. Become familiar with the ICD-9 book you are using. 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.
2. Always use both the alphabetic and the tabular sections to select a diagnosis code. Volume II of the ICD-9 contains the alphabetic listing, and it does not include exclusions, referrals or instructions for the codes, including the need for four- or five-digit sub-classifications.
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.
5. Code the diagnosis to the highest degree of certainty by using the highest level of code. For example, the three-digit code for asthma is 493. Asthma has a fourth digit that tells whether the asthma is intrinsic (1), extrinsic (0) or unspecified (9). Asthma then has a fifth digit that tells if the asthma is with an exacerbation (2), with status (1) or not otherwise specified (0). Therefore, a patient who has allergic asthma with an acute exacerbation would be coded with a diagnosis code of 493.02.
6. When other conditions exist at the time of the patient's encounter and they affect the primary reason why the patient is seeking medical advice, these conditions should also be coded.
7. When a patient is seen for ancillary diagnostic services, the appropriate V code should be listed first, and the diagnosis or condition that is the underlying reason for the tests should be listed second. If the patient is being sent out for radiology studies or lab work, the diagnosis for their presenting issues should be used, not a rule-out diagnosis.

8. 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.
9. V codes may be used to indicate a primary or a secondary diagnosis, depending on the patient' presenting problems and complaints.
10. E codes are never used as a primary diagnosis code.
11. The diagnosis **must support** the services rendered.
12. The CMS (Medicare) may accept up to eight diagnosis codes, but the diagnosis code needs to be linked to the specific service if more than one service is provided during one encounter.
13. Appropriateness of location for the service must be supported with supporting diagnosis codes.
14. Diagnosis codes substantiate the level of service provided.
15. Diagnosis codes substantiate the frequency of service.
16. The diagnosis code must be linked to the specific service provided.

The Future of Diagnosis Coding

On Oct. 1, 2013, ICD-10-CM is scheduled to become the diagnosis coding system for all providers to use for their claims. The code selection will increase from approximately 17,000 codes to >60,000 codes. The codes are being revised currently and will be revised continually, just as the ICD-9 codes are revised currently. The change to ICD-10-CM will help track diseases and provide more information about the patient's health conditions

For allergy practices, the coding for respiratory diseases will be categorized in the J chapter of the ICD-10-CM codes. As our codes now are in the 400 series, the ICD-10-CM codes will be assigned an alphabetic character for the first digit. The remaining four to seven digit codes will be a mixture of numbers and alpha characters. Having available more codes to choose from should provide providers with more options to describe a patient's condition with fewer codes. Also, many diseases will require secondary codes to describe other conditions that are also affecting the patient's care. For example, mild intermittent asthma uncomplicated will be coded

J45. 20. You will also code for additional conditions that may impact the asthmatic patient, such as tobacco exposure or use.

Allergic rhinitis will be coded in the J chapter as well. Allergic rhinitis caused by pollens will be coded J30.1 and contact urticaria will be coded L50.6. All allergists will be required to invest in some training and time to convert their practices to ICD-10-CM, and to learn the coding guidelines required to code appropriately with the new codes. The time component required for the process will depend on the size of the practice. All providers will need to have a general understanding of how the codes are assigned. A mapping between the ICD-9-CM and the ICD-10-CM should be performed sometime in 2012 to prepare for the conversion to ICD-10 in 2013. Using the current coding list and comparing the current list to the ICD-10-CM list should give an allergist a good idea of how much time and investment will be required for all providers and staff to learn the new system for diagnostic coding.

PROCEDURE CODING

Healthcare Common Procedure Coding System

CPT-4 is a component of the HCPCS. 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. CPT 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 are the primary codes used for reimbursement for physician's 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 what is 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 practice.

The six sections of the CPT Category I codes are:

- Evaluation and management (E/M) codes 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 electrodiagnostic 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. The last, Appendix N, is a summary of re-sequenced CPT codes.

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 or made the procedure or service famous
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 listing does not guarantee payment. Each carrier may have specific carrier 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. In the future, however, it may 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 carrier the type of service being provided. The

carrier can then 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 3-24 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 or 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. The final rules and values are published by the CMS in the Federal Register in the fall of each year, 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

1. Purchase new coding tools on a yearly basis. You should have a diagnosis coding book, a CPT book and a HCPCS book. You should also have the Correct Coding Initiative (CCI), a free publication available on the CMS web site (http://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.
2. Read payer billing manuals and local carrier directives. **The Joint Council of Allergy, Asthma & Immunology** has a web site (http://jcaai.org) and publications that provide up-to-date information appropriate for allergy practices. You should also be aware of the different carrier billing guidelines and know the web site for each carrier in order to find specific guidelines for the carrier. Each Medicare carrier will have local carrier directives posted on their web site that are accessible to every physician. The CMS also has national guidelines on their web site, as well as information, tools and manuals.
3. Education regarding coding should be provided continually for all physicians and their staff. The guidelines for carriers may change, and you are held accountable for knowing the changes and for appropriately submitting claims.
4. 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 should also orient new staff, including physicians, to ensure that updated resources are available in the practice, and should research any changes pertinent to the practice.

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 history, exam and medical decision-making. Time is used only to determine 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 another appropriate source 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 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 must then 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 has already 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 office 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 health care provider is in direct patient contact providing care that is beyond the usual service in other 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 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. For nonphysician providers to 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 nonphysician's provider number. The allergy practice should check their third-party payers contracts to verify how nonphysicians 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 2012 edition of the AMA's CPT coding book, included under the subheading for the pulmonary function codes are directions for the provider that separate and identifiable E/M service should be reported in addition 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 is 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 us to include in the 94060 the flow-volume loop (94375) and the maximal breathing capacity (94200) when these services are performed with the 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 is often 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 could also be used for other agents for determination of multiple spirometries. Provocation evaluation coding requires a combination of two codes: 94070 for the multiple spirometric determinations and the administering of the bronchial inhalation agent 95070. 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 a single procedure without any other pulmonary function testing.

Lung volumes measured by the use of plethysmography are coded with 94726. If 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 are also 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 or 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 NO 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 patient's NO level is determined by the device, which uses a chemiluminescence gas analyzer and integrated software to measure numbers of NO molecules at very low concentrations. 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 94799.

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.

Percutaneous tests are coded for 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 is not a separately billable item. The intradermal test for 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.

The 95010 and 95015 codes are the testing codes for biologics, drugs and venoms. Both the percutaneous and intradermal tests will often be performed at the same time for these services. These tests are also charged per test with a total quantity. The codes 95010 and 95015 also include the interpretation and report for the test.

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

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 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.

The 95075 code is used for the ingestion challenge test. The test includes the time during which the patient is given small quantities of a substance to determine whether the patient has an allergic reaction. If a separate and significant E/M service is performed in addition to the ingestion challenge test, then an E/M services code could be used in addition to the ingestion challenge test.

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 appropriate code is determined by the number of stinging insects 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 appropriate code is determined by the total number of stinging insect venoms in the dose. For example, mixed vespids venom would be coded with 95147, whereas both mixed vespids and honey bee 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 only charge for the vial that is designated as their 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 their immunotherapy solution, billing would be for the number of cubic centimeters provided for a Medicare patient and the number of doses anticipated for the non-Medicare patient. The CPT code does not define a maximum number of doses. However, individual carriers may have a maximum number of doses allowed per patient, either in a calendar year or per billing.

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.

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. an 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 will always 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 it 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. The 1995 guidelines are generalized per organ system and thus the provider must document specific findings, vs. the 1997 guidelines, which indicate the specific findings to be documented.

Allergy/Immunology 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	

Allergy/Immunology 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)

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.

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 multisystem 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 physicians' 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 web site, management tools and technology: http://www.aaaai.org/practice-resources/management-tools-and-technology.aspx.

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

Centers for Medicare and Medicaid Services for Local and National Carrier Directives, Physician Fee Schedule for RVUs and Medicare conversion factor page: https://www.cms.gov/physicianfeesched.

Joint Council for Allergy, Asthma & Immunology web site: www.jcaai.org.

TM Consulting, Inc. Allergy-specific coding seminars and practice management services: e-mail Teresathom@aol.com.