01 PROCUREMENT OF IMMUNOTHERAPY

Allergy Immunotherapy:

CPT 95165 is billed by # of doses.

180 doses is generally what is billed for*

The reason for this is that this is the number of immunotherapy doses that are being prepared for ONE YEAR of therapy.

Doses are every other day, so basically 365 days, divided by 2 (minus the change) gives you 180 doses.

$13.68 p/dose is the average Medicare rate (or minimum rate) at which each unit is billed and paid by insurance.

Depending on your practice's billing model, many offices bill 2 times this rate or more.

**IMMUNOTHERAPY MUST BE BILLED OUT AT LEAST 3 BUSINESS DAYS AFTER TESTING

Relevant ICD-10 Codes

The below ICD-10 list represents codes that are commonly related to CPTs (95004 for skin testing) and 95165 This list is a partial list of ICD-10 Codes that Support Medical Necessity.

CONSIDER A MINIMUM OF FOUR ICD-10 CODES IN SUPPORT OF EITHER/BOTH CPT's.

Group 1 Codes

ICD-10 Codes	Description
B44.81	Allergic bronchopulmonary aspergillosis
H10.11	Acute atopic conjunctivitis, right eye
H10.12	Acute atopic conjunctivitis, left eye I
H10.13	Acute atopic conjunctivitis, bilateral
H10.31	Unspecified acute conjunctivitis,right eye
H10.32	Unspecified acute conjunctivitis, left eye
H10.33	Unspecified acute conjunctivitis,bilateral
H10.411	Chronic giant papillary conjunctivitis, right eye
H10.412	Chronic giant papillary conjunctivitis, left eye
H10.413	Chronic giant papillary conjunctivitis, bilateral
H10.44	Vernal conjunctivitis
H10.45	Other chronic allergic conjunctivitis
H16.261	Vernal keratoconjunctivitis, with um and corneal involvement, right eye
H16.262	Vernal keratoconjunctivitis, with Wand corneal involvement, left eye
H16.263	Vernal keratoconjunctivitis, with Wand corneal involvement, bilateral
H65.01	Acute serous otitis media, rightear
H65.02	Acute serous otitis media, left ear
H65.03	Acute serous otitis media, bilateral

ICD-10 Codes	Description
H65.04	Acute serous otitis media, recurrent, right ear
H65.05	Acute serous otitis media, recurrent, left ear
H65.06	Acute serous otitis media, recurrent, bilateral
H65.21	Chronic serous otitis media, right ear
H65.22	Chronic serous otitis media, left ear
H65.23	Chronic serous otitis media, bilateral
H65.411	Chronic allergic otitis media, rightear
H65.412	Chronic allergic otitis media, left ear
H65.413	Chronic allergic otitis media,bilateral
H65.491	Other chronic nonsuppurative otitis media, right ear
H65.492	Other chronic nonsuppurative otitis media, left ear
H65.493	Other chronic nonsuppurative otitis media, bilateral
H66.91	Otitis media, unspecified, right ear
H66.92	Otitis media, unspecified, left ear
H66.93	Otitis media, unspecified, bilateral
J01.00	Acute maxillary sinusitis, unspecified
J01.01	Acute recurrent maxillary sinusitis
J01.10	Acute frontal sinusitis, unspecified
J01.11	Acute recurrent frontal sinusitis
J01.20	Acute ethmoidal sinusitis, unspecified
J01.21	Acute recurrent ethmoidal sinusitis
J01.30	Acute sphenoidal sinusitis,unspecified
J01.31	Acute recurrent sphenoidal sinusitis
J01.40	Acute pansinusitis, unspecified
J01.41	Acute recurrent pansinusitis
J01.80	Other acute sinusitis
J01.81	Other acute recurrent sinusitis
J01.90	Acute sinusitis, unspecified
J01.91	Acute recurrent sinusitis, unspecified
J04.0	Acute laryngitis
J04.30	Supraglottitis, unspecified, without obstruction
J04.31	Supraglottitis, unspecified, with obstruction
J05.0	Acute obstructive laryngitis [croup]
J30.0	Vasomotor rhinitis
J30.1	Allergic rhinitis due to pollen
J30.2	Other seasonal allergic rhinitis
J30.5	Allergic rhinitis due to food
J30.81	Allergic rhinitis due to animal (cat) (dog) hairand dander
J30.89	Other allergic rhinitis
J31.0	Chronic rhinitis
J31.1	Chronic nasopharyngitis
J31.2	Chronic pharyngitis
J32.0	Chronic maxillary sinusitis
J32.1	Chronic frontal sinusitis

ICD-10 Codes	Description
J32.2	Chronic ethmoidal sinusitis
J32.3	Chronic sphenoidal sinusitis
J33.0	Polyp of nasal cavity
J33.8	Other polyp ofsinus
J34.3	Hypertrophy of nasalttwbjnates
J34.81	Nasal mucositis (ulcerative)
J34.89	Other specified disorders of nose and nasal sinuses
J35.01	Chronic tonsillitis
J35.02	Chronic adenoiditis
J35.03	Chronic tonsillitis and adenoiditis
J35.1	Hypertrophy of tonsils
J35.2	Hypertrophy ofadenoids
J35.3	Hypertrophy of tonsils with hypertrophy of adenoids
J45.20	Mild intermittent asthma, uncomplicated
J45.21	Mild intermittent asthma with(acute) exacerbation
J45.22	Mild intermittent asthma withstatus asthmaticus
J45.30	Mild persistent asthma,uncomplicated
J45.31	Mild persistent asthma with(acute) exacerbation
J45.32	Mild persistent asthma Withstatus asthmaticus
J45.40	Moderate persistent asthma,uncomplicated
J45.41	Moderate persistent asthma with(acute) exacerbation
J45.42	Moderate persistent asthma with status asthmaticus
J45.50	Severe persistent asthma,uncomplicated
J45.51	Severe persistent asthma with (acute) exacerbation
J45.52	Severe persistent asthma withstatus asthmaticus
J45.901	Unspecified asthma with (acute) exacerbation J45 .902
	Unspecified asthma with status asthmaticus J45.909
	Unspecified asthma, uncomplicated
J45.991	Cough variant asthma
J45.998	Other asthma
K29.30	Chronic superficial gastritis without bleeding
K29.60	Other gastritis without bleeding
L20.0	Besnier's prurigo
L20.81	Atopic neurodermatitis
L20.82	Flexural eczema
L20.84	Intrinsic (allergic) eczema
L20.89	Other atopic dermatitis
L30.8	Other specified dermatitis
L50.0	Allergic urticaria

2019 Allergy and Immunotherapy billing update example
for practices that bill for services based on IN-NETWORK contracts with their insurance payors

** You will need to check with your payors in your area.

If you bill OUT OF NETWORK - ignore the protocol below. Simply bill all 180 units at whatever multiple of Medicare allowable you normally bill for services.

*For IMMUNOTHERAPY, when setting up your practice's billing schedule, is is important to note that IMMUNOTHERAPY billing should begin AT LEAST 3 DAYS AFTER TESTING (CPT 95004) billing is sent out. The below days referenced then would be AFTER these original 3 days have passed.

BCBS - 30 units with code 95165, billed each month

United - code 95165 for 75 units Day 1 and Day 2 then 30 units on Day 3

Cigna - Day 1 code 95165 for 5 units, Days 2-6 code 95144 for 30 units and Day 7 code 95144 for 25 units.

Aetna - 120 units of 95165 a year. Can bill out at one time. They also have a 75 unit max of 95144 that can also be billed out at one time.

Medicare Example - No Change: First day use 95165 for 5 units. For days 2-6 use code 95144 for 30 units each day. On
day 7, use code 95144 for 25 units.

Medicaid - 160 units of 95165. No daily limits

TRICARE - Code 95165 at 75 units for day one and two. On day three, 30 units of 95165.

General Information

Documentation Requirements

Adequate documentation is essential for high-quality patient care and to demonstrate the reasonableness and medical necessity of the testing. Documentation must support the criteria for coverage as described in the Coverage Indications, Limitations, and/or Medical Necessity section of this LCD.

There should be a permanent record of the allergy test and its interpretation including the test methodology and either the measurement (in mm) of reaction size of both the wheal and erythema response. or blood test result. An official interpretation (final report) of the testing should be included in the patient's medical record. Retention of the allergy test(s) should be consistent both with clinical need and with relevant legal and local health care facility requirements.

The medical record must document the elements of the medical and immunologic history including but not limited to:

correlation of symptoms occurrence of symptoms exposure profile

documentation of allergic sensitization by accepted means

where attempts at avoidance have proven unsuccessful (or the impracticality of avoidance exists copy of the sensitivity results

the physical examination

The history should support that attempts to narrow the area of investigation were taken so that the minimal number of necessary skin tests might deliver a diagnosis.

Testing results need to justify the diagnosis and code on each claim form. The clinical condition that is claimed to justify this test must be clearly documented in the record.

Note: A payable diagnosis alone does not support medical necessity of ANY service. The interpretation of the test results and how the results of the test will be used in the patient's plan of care for treatment and the

management of the patient's medical condition (s) must be documented.

Claims submitted without such evidence will be denied as not medically necessary. When the documentation does not meet the criteria for the service rendered or the documentation does not establish the medical necessity for the services, such services will be denied as not reasonable and necessary under Section 1862(a)(1) of the Social Security Act.

Utilization Guidelines

It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

It would not be expected that all patients would receive the same tests or the same number of sensitivity tests. The number of tests performed must be judicious and related to the history, physical findings and clinical judgment specific to each individual patient.

The selection of antigens should be individualized, based on the history and physical examination. Retesting with the same antigen(s) should rarely be necessary within a three-year period.

Skin Testing: young children with negative skin tests or older children and adults with negative skin tests, but persistent symptoms suggestive of allergic disease where skin tests may be repeated one year later. Claims for retesting within a three-year period should be submitted with documentation of the medical necessity.

Testing done on separate days for different antigens is acceptable as long as the total number of tests done within any three-year period is not excessive.

In vitro testing is covered when medically reasonable and necessary as a substitute for skin testing; it is not usually necessary in addition to skin testing. If in vitro testing is inconclusive, and contraindications for skin testing have been resolved, then skin testing may be done and is covered. The medical record must document this rationale. In vitro IgE testing will be limited to 30 allergens/beneficiary over a 12 month period. If more tests are performed, medical records may be requested.

A maximum of 55 allergy patch tests for diagnose of allergic contact dermatitis per beneficiary per year is allowed without the submission of documentation with the claim to support medical necessity. Greater than 55 patch tests per patient per year may result in a request of medical records.

It would not be expected that more than forty (40) units be reported for intracutaneous (intradermal) testing per year for a patient. If more than 40 units are reported, medical records may be requested.