CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 504 **Date: MARCH 11, 2005**

CHANGE REQUEST 3732

SUBJECT: Update to Pub 100-04, Chapter 12, Section 200 of the Internet Only Manual

I. SUMMARY OF CHANGES: Information contained in the MCM section 15050, transmittal 1725 was inadvertently omitted during the conversion to the Internet-only manual. This instruction manualizes the omitted material.

MANUALIZATION/CLARIFICATION – EFFECTIVE/IMPLEMENTATION DATES: Not Applicable.

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	12/200/Allergy Testing and Immunotherapy

III. FUNDING: No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 20xx operating budgets.

IV. ATTACHMENTS:

	Business Requirements
x	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

200 - Allergy Testing and Immunotherapy

(Rev. 504, Issued: 03-11-05, Effective/Implementation: N/A)

B3-15050

A - Allergy Testing

The MPFSDB fee amounts for allergy testing services billed under codes 95004-95078 are established for single tests. Therefore, the number of tests must be shown on the claim.

EXAMPLE

If a physician performs 25 percutaneous tests (scratch, puncture, or prick) with allergenic extract, the physician must bill code 95004 and specify 25 in the units field of Form CMS-1500 (paper claims or electronic format). To compute payment, the Medicare carrier multiplies the payment for one test (i.e., the payment listed in the fee schedule) by the quantity listed in the units field.

B - Allergy Immunotherapy

For services rendered on or after January 1, 1995, all antigen/allergy immunotherapy services are paid for under the Medicare physician fee schedule. Prior to that date, only the antigen injection services, i.e., only codes 95115 and 95117, were paid for under the fee schedule. Codes representing antigens and their preparation and single codes representing both the antigens and their injection were paid for under the Medicare reasonable charge system. A legislative change brought all of these services under the fee schedule at the beginning of 1995 and the following policies are effective as of January 1, 1995:

1 - CPT codes 95120 through 95134 are not valid for Medicare. Codes 95120 through 95134 represent complete services, i.e., services that include both the injection service as well as the antigen and its preparation.

2 - Separate coding for injection only codes (i.e., codes 95115 and 95117) and/or the codes representing antigens and their preparation (i.e., codes 95144 through 95170) must be used.

If both services are provided both codes are billed.

This includes allergists who provide both services through the use of treatment boards.

3 - If a physician bills both an injection code plus either codes 95165 or 95144, carriers pay the appropriate injection code (i.e., code 95115 or code 95117) plus the code 95165 rate. When a provider bills for codes 95115 or 95117 plus code 95144, carriers change 95144 to 95165 and pay accordingly. Code 95144 (single dose vials of antigen) should be billed only if the physician providing the antigen is providing it to be injected by some other entity. Single dose vials, which should be used only as a means of insuring proper dosage amounts for injections, are more costly than multiple dose vials (i.e., code 95165) and therefore their payment rate is higher. Allergists who prepare antigens are assumed to be able to administer proper doses from the less costly multiple dose vials. Thus, regardless

of whether they use or bill for single or multiple dose vials at the same time that they are billing for an injection service, they are paid at the multiple dose vial rate.

4 - The fee schedule amounts for the antigen codes (95144 through 95170) are for a single dose. When billing those codes, physicians are to specify the number of doses provided. When making payment, carriers multiply the fee schedule amount by the number of doses specified in the units field.

5 - If a patient's doses are adjusted, e.g., because of patient reaction, and the antigen provided is actually more or fewer doses than originally anticipated, the physician is to make no change in the number of doses for which he or she bills. The number of doses anticipated at the time of the antigen preparation is the number of doses to be billed. This is consistent with the notes on page 30 of the Spring 1994 issue of the American Medical Association's CPT Assistant. Those notes indicate that the antigen codes mean that the physician is to identify the number of doses "prospectively planned to be provided." The physician is to "identify the number of doses scheduled when the vial is provided." This means that in cases where the patient actually gets more doses than originally anticipated (because dose amounts were decreased during treatment) and in cases where the patient gets fewer doses (because dose amounts were increased), no change is to be made in the billing. In the first case, carriers are not to pay more because the number of doses provided in the original vial(s) increased. In the second case, carriers are not to seek recoupment (if carriers have already made payment) because the number of doses is less than originally planned. This is the case for both venom and nonvenom antigen codes.

6 - Venom Doses and Catch-Up Billing - 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). A dose of code 95146 (the two-venom code) means getting some of two venoms. Similarly, a dose of code 95147 means getting some of three venoms; a dose of code 95148 means getting some of four venoms; and a dose of 95149 means getting some of five venoms. Some amount of each of the venoms must be provided. Questions arise when the administration of these venoms does not remain synchronized because of dosage adjustments due to patient reaction. For example, a physician prepares ten doses of code 95148 (the four venom code) in two vials - one containing 10 doses of three vespid mix and another containing 10 doses of wasp venom. Because of dose adjustment, the three vespid mix doses last longer, i.e., they last for 15 doses. Consequently, questions arise regarding the amount of "replacement" wasp venom antigen that should be prepared and how it should be billed. Medicare pricing amounts have savings built into the use of the higher venom codes. Therefore, if a patient is in two venom, three venom, four venom or five venom therapy, the carrier objective is to pay at the highest venom level possible. This means that, to the greatest extent possible, code 95146 is to be billed for a patient in two venom therapy, code 95147 is to be billed for a patient in three venom therapy, code 95148 is to be billed for a patient in four venom therapy, and code 95149 is to be billed for a patient in five venom therapy. Thus, physicians are to be instructed that the

venom antigen preparation, after dose adjustment, must be done in a manner that, as soon as possible, synchronizes the preparation back to the highest venom code possible. In the above example, the physician should prepare and bill for only 5 doses of "replacement" wasp venom - billing five doses of code 95145 (the one venom code). This will permit the physician to get back to preparing the four venoms at one time and therefore billing the doses of the "cheaper" four venom code. Use of a code below the venom treatment number for the particular patient should occur only for the purpose of "catching up."

*7 - **Code 95165 Doses**. - Code 95165 represents preparation of vials of non-venom antigens. As in the case of venoms, some non-venom antigens cannot be mixed together, i.e., they must be prepared in separate vials. An example of this is mold and pollen. Therefore, some patients will be injected at one time from one vial – containing in one mixture all of the appropriate antigens – while other patients will be injected at one time from more than one vial. In establishing the practice expense component for mixing a multidose vial of antigens, we observed that the most common practice was to prepare a 10 cc vial; we also observed that the most common use was to remove aliquots with a volume of 1 cc. Our PE computations were based on those facts. Therefore, a physician's removing 10 1cc aliquot doses captures the entire PE component for the service.*

This does not mean that the physician must remove 1 cc aliquot doses from a multidose vial. It means that the practice expenses payable for the preparation of a 10cc vial remain the same irrespective of the size or number of aliquots removed from the vial. Therefore, a physician may not bill this vial preparation code for more than 10 doses per vial; paying more than 10 doses per multidose vial would significantly overpay the practice expense component attributable to this service. (Note that this code does not include the injection of antigen(s); injection of antigen(s) is separately billable.)

When a multidose vial contains less than 10cc, physicians should bill Medicare for the number of 1 cc aliquots that may be removed from the vial. That is, a physician may bill Medicare up to a maximum of 10 doses per multidose vial, but should bill Medicare for fewer than 10 doses per vial when there is less than 10cc in the vial.

If it is medically necessary, physicians may bill Medicare for preparation of more than one multidose vial.

EXAMPLES:

(1) If a 10cc multidose vial is filled to 6cc with antigen, the physician may bill Medicare for 6 doses since six 1cc aliquots may be removed from the vial.

(2) If a 5cc multidose vial is filled completely, the physician may bill Medicare for 5 doses for this vial.

(3) If a physician removes ½ cc aliquots from a 10cc multidose vial for a total of 20 doses from one vial, he/she may only bill Medicare for 10 doses. Billing for more than 10 doses would mean that Medicare is overpaying for the practice expense of making the vial.

(4) If a physician prepares two 10cc multidose vials, he/she may bill Medicare for 20 doses. However, he/she may remove aliquots of any amount from those vials. For example, the physician may remove ½ aliquots from one vial, and 1cc aliquots from the other vial, but may bill no more than a total of 20 doses.

(5) If a physician prepares a 20cc multidose vial, he/she may bill Medicare for 20 doses, since the practice expense is calculated based on the physician's removing 1cc aliquots from a vial. If a physician removes 2cc aliquots from this vial, thus getting only 10 doses, he/she may nonetheless bill Medicare for 20 doses because the PE for 20 doses reflects the actual practice expense of preparing the vial.

(6) If a physician prepares a 5cc multidose vial, he may bill Medicare for 5 doses, based on the way that the practice expense component is calculated. However, if the physician removes ten ½ cc aliquots from the vial, he/she may still bill only 5 doses because the practice expense of preparing the vial is the same, without regard to the number of additional doses that are removed from the vial.

C - Allergy Shots and Visit Services on the Same Day

At the outset of the physician fee schedule, the question was posed as to whether visits should be billed on the same day as an allergy injection (CPT codes 95115-95117), since these codes have status indicators of A rather than T. Visits should not be billed with allergy injection services 95115 or 95117 unless the visit represents another separately identifiable service. This language parallels CPT editorial language that accompanies the allergen immunotherapy codes, which include codes 9515 and 95117. Prior to January 1, 1995, you appeared to be enforcing this policy through three (3) different means:

- *Advising physician to use modifier 25 with the visit service;*
- *Denying payment for the visit unless documentation has been provided; and*
- *Paying for both the visit and the allergy shot if both are billed for.*

For services rendered on or after January 1, 1995, you are to enforce the requirement that visits not be billed and paid for on the same day as an allergy injection through the following means. Effective for services rendered on or after that date, the global surgery policies will apply to all codes in the allergen immunotherapy series, including the allergy shot codes 95115 and 95117. To accomplish this, CMS changed the global surgery indicator for allergen immunotherapy codes from XXX, which meant that the global surgery concept did not apply to those codes, to 000, which means that the global surgery concept applies, but that there are no days in the postoperative global period. Now that the global surgery policies apply to these services, you are to rely on the use of modifier 25 as the only means through which you can make payment for visit services provided on the same day as allergen immunotherapy services. In order for a physician to receive payment for a visit service provided on the same day that the physician also provides a service in the allergen immunotherapy series (i.e., any service in the series from 95115 through 95199), the physician is to bill a modifier 25 with the visit code, indicating that the patient's condition required a significant, separately identifiable visit service above and beyond the allergen immunotherapy service provided.

D - Reasonable Supply of Antigens

See CMS Manual System, Internet Only Manual, Medicare Benefits Policy Manual, CMS Pub. 100-02 Chapter 15, section 50.4.4, regarding the coverage of antigens, including what constitutes a reasonable supply of antigens.