All in for Ancillary Coding

Presented by:
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Consultant and Speaker

- Nationally recognized otolaryngology coding and documentation expert.
- Expert in analyzing chart documentation and in reengineering practices to enhance the reimbursement process.
- Understands the complexity of coding and reimbursement issues specific to surgeons.
- Improving the revenue cycle for practices having worked with hundreds of practices in her almost 20 years of consulting.
- Former board member of both the Society of Otorhinolaryngology and Head-Neck Nurses and the Ear, Nose and Throat Nursing Foundation.
- Recipient of the Presidential Citation from the Society of Otorhinolaryngology and Head-Neck Nurses.
- Published coding book author, multiple articles.

Agenda

- What are Ancillary Services?
- Who are Auxiliary Providers?
- Billing / Reimbursement Models
- Specific Services
  - Otolaryngic Allergy
  - Audiological Diagnostic Testing
  - Home Sleep Study
  - CPAP Management

What are Ancillary Services?

CMS Says:
ANCILLARY SERVICES are Professional services by a hospital or other inpatient health program. These may include x-ray, drug, laboratory, or other services.

an·cil·lar·y
adjective
providing necessary support to the primary activities or operation of an organization, institution, industry, or system.
"the development of ancillary services to support its products"

noun
a person whose work provides necessary support to the primary activities of an organization, institution, or industry. "the employment of specialist teachers and ancillaries"
Who are Auxiliary Providers?

CMS uses the term **Auxiliary personnel** which means any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician. Examples: RN, LVN/LPN, MA, etc.

**aux·il·ia·ry**

*adjective*
providing supplementary or additional help and support.

"auxiliary airport staff"

*noun*
a person or thing providing supplementary or additional help and support.

"a nursing auxiliary"

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CMS: Billing and Reimbursement Models

### Three Models

- Incident-to
- Direct
- Shared/Split Services

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**Tip:** Survey your other payers for their rules or assume CMS for all payors.

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### CMS: Billing and Reimbursement Models

What models are applicable to auxiliary personnel?

<table>
<thead>
<tr>
<th>Type of Personnel</th>
<th>Incident-to</th>
<th>Direct Bill</th>
<th>Split/Shared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiologist</td>
<td>-</td>
<td>X</td>
<td>-</td>
</tr>
<tr>
<td>Speech-Language Pathologist</td>
<td>X</td>
<td>X</td>
<td>-</td>
</tr>
<tr>
<td>Nurse Practitioner/Physician Assistant/</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Clinical Nurse Specialist (Non-physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>practitioners—NPP)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>X</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Licensed Vocational Nurse/Licensed</td>
<td>X</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Practical Nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Assistant (certified or not)</td>
<td>X</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

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### CMS Definition: Incident-to

- Incident-to means that the services billed are not directly performed by the billing provider.
- This is the only option for auxiliary personnel as Medicare does not allow enrollment for RN, LVN/LPN, MA, etc. (Example: RN performs cerumen removal and it is billed using the NPI of the on-site supervising physician).
- Physician may report NPP services as incident-to if all the requirements are met.
- NPPs may bill incident-to for certain services (therapeutic) but the 15% payment reduction will apply.
**CMS Definition: Incident-to**

5 Requirements

1. The service must be part of the patient’s normal course of treatment during which a physician personally performed an initial service and remains actively involved in the course of treatment.
   - The supervising/billing physician should co-sign the note or the practice have a signature log attesting to the on-site billing physician’s presence
   - Applies to an established patient with an established problem (a new patient does not already have an “initial” service or a set treatment plan.

2. Service is furnished under the physician’s direct supervision meaning the billing physician is present in the office suite and immediately available. The billing physician may be different from the patient’s attending physician/physician who set the plan of care.

3. Service is rendered without additional charge by the performing personnel (meaning included in the billing physician charge).

4. Service is of a type that are commonly furnished in the physician’s office or clinic.

5. NPP / auxiliary personnel must be an expense to the physician.

**CMS Definition: Incident-to**

- Claim filed under on-site supervising provider NPI
- Paid at 100% of the Medicare Physician Fee Schedule (MPFS)

**Decision Tree for Reporting Office Services “Incident-to”**

Assuming the other requirements for “incident to” services are met, follow this decision tree:

- Is the billing/supervising physician present?

  - NO
    - Bill service using non-physician practitioner (NPP) NPI
  
  - YES
    - 4 Scenarios

**CMS Definition: Direct**

- Service personally provided by billing provider (e.g., new patient E/M, established patient with new problem E/M, typically procedures).
- NPP reimbursed at 85% of MPFS, physician reimbursed at 100%.
- ALWAYS direct bill to Medicare assistant-at-surgery (e.g., PA, NP) services with modifier AS.
- ALWAYS direct bill to Medicare services performed by an AUDIOLOGIST.

**CMS Definition: Shared/Split Service**

- Applies only to inpatient E/M services (not office) such as initial hospital care (9922x) and subsequent hospital care (9923x).
- Both NPP and physician provide face-to-face E/M service on same date of service – may combine documentation and report under one provider (usually the physician to avoid payment reduction).
- If physician does not see patient and document, then bill E/M under NPP.
- Reimbursed at billing provider rate (100% of MPFS for physician, 85% of MPFS for NPP).
Specific Services
- Otolaryngic Allergy
- Audiological Diagnostic Testing
- Home Sleep Study
- CPAP Management

The Future of Otolaryngic Allergy

Otolaryngic Allergy ICD-10-CM Codes:

**Active Conditions**
- J30.0 Vasomotor rhinitis
- J30.1 Allergic rhinitis due to pollen (hay fever, pollinosis, allergy NOS 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) hair and dander
- J30.89 Other allergic rhinitis (Perennial allergic rhinitis)
- J30.9 Allergic rhinitis, unspecified
- J32. - Chronic sinusitis

Otolaryngic Allergy ICD-10-CM Codes:

**Testing Services**

Primary diagnosis code:
- Z01.82 Encounter for allergy testing

Secondary diagnosis codes:
- J30.0 Vasomotor rhinitis
- J30.1 Allergic rhinitis due to pollen (hay fever, pollinosis, allergy NOS 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) hair and dander
- J30.89 Other allergic rhinitis (Perennial allergic rhinitis)
- J30.9 Allergic rhinitis, unspecified
Otolaryngic Allergy ICD-10-CM Codes:

**Treatment Services**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z51.6</td>
<td>Encounter for desensitization to allergens</td>
</tr>
</tbody>
</table>

**Secondary diagnosis codes:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J30.0</td>
<td>Vasomotor rhinitis</td>
</tr>
<tr>
<td>J30.1</td>
<td>Allergic rhinitis due to pollen (hay fever, pollinosis, allergic NOS due to pollen)</td>
</tr>
<tr>
<td>J30.2</td>
<td>Other seasonal allergic rhinitis</td>
</tr>
<tr>
<td>J30.5</td>
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</tr>
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</tr>
<tr>
<td>J30.89</td>
<td>Other allergic rhinitis (Perennial allergic rhinitis)</td>
</tr>
<tr>
<td>J30.8</td>
<td>Allergic rhinitis, unspecified</td>
</tr>
</tbody>
</table>

Otolaryngic Allergy CPT Codes

- **Testing – blood, skin**
- **Treatment – injections, sublingual**

CPT Codes for Testing: Blood

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Says</th>
<th>Comments</th>
</tr>
</thead>
</table>
| 86003    | Allergen specific IgE; quantitative or semiquantitative, each allergen | • "RAST" testing  
• Report 1 unit for each allergen tested.  
• Use when you perform the blood test in your office.  
• Report only code for blood draw (e.g., 36415) when drawing blood for outside lab. Outside lab should do own billing for services provided - Medicare calls this a “purchased service” with many rules. |

CPT Codes for Testing: Skin

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Says</th>
<th>Comments</th>
</tr>
</thead>
</table>
| 95004    | Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests | • Testing for airborne allergens.  
• Report 1 unit for each antigen tested. |

CPT Codes for Testing: Skin

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Says</th>
<th>Comments</th>
</tr>
</thead>
</table>
| 95024    | Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests | • Again, testing for airborne allergens.  
• "Intradermal" testing with immediate reading.  
• Single concentration of a single antigen.  
• Report 1 unit for each antigen tested.  
• If reporting with 95004 for the same antigen, be sure the dilution for 95024 is different.  
• Do not report with 95027 for the same antigen. |

CPT Codes for Testing: Skin

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Says</th>
<th>Comments</th>
</tr>
</thead>
</table>
| 95027    | Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report, specify number of tests | • Also, testing for airborne allergens.  
• "Sequential and incremental" testing.  
• Multiple concentrations of a single antigen.  
• If reporting with 95004 for the same antigen, be sure the dilutions for 95027 are different.  
• Report 1 unit for each concentration tested.  
• Example: 3 concentrations each of 10 antigens = 30 units billed.  
• Do not report with 95024 for the same antigen.  
• Sometimes considered "experimental" or "investigational" by payors. |
Skin Testing Coding Examples

<table>
<thead>
<tr>
<th>Examples</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Prick testing of 35 different antigens</td>
<td>95004 x 35</td>
</tr>
<tr>
<td>2 Prick testing of 35 different antigens followed by intradermal testing (single concentration) of 10 prick testing positives (*Document why additional testing needed)</td>
<td>95024 x 10 95004 x 35</td>
</tr>
<tr>
<td>3 Prick testing of 30 different antigens followed by intradermal (sequential and incremental) of 10 prick testing positives (*Document why additional testing needed)</td>
<td>95027 x 30 95004 x 30</td>
</tr>
</tbody>
</table>

ALERT
Be sure the testing documentation describes the 5 W’s (who, what, when, where and why).

TIP: Make sure your testing and treatment forms can be interpreted by an independent third-party (e.g., auditor) without clinical allergy background.

CPT Codes for Treatment: “Unbundled” Services

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Says</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Injection Only Codes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>95115</td>
<td>Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection</td>
<td>*Report 95117 once regardless of the number of injections greater than 1.</td>
</tr>
<tr>
<td>95117</td>
<td>2 or more injections</td>
<td></td>
</tr>
</tbody>
</table>

Note: Most payors do not recognize the “bundled” codes 95120/95125.

CPT Codes for Treatment: “Unbundled” Services

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Says</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>95144</td>
<td>Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single dose vial(s) (specify number of vials)</td>
<td>• Code 95144 (single dose vials of antigen) should be billed only if the physician providing the antigen is different from the physician providing the injection.  • Medicare/most payors want providers to use 95165 when providing the injection and antigen to the patient.</td>
</tr>
<tr>
<td>95165</td>
<td>Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)</td>
<td>• Use 95165 for services delivered from treatment boards.  • Report the number of doses as units on the CMS-1500 claim form. More information to follow on definition of “dose”  • Date of service on claim is date vial is mixed</td>
</tr>
</tbody>
</table>

Note: Most payors do not recognize the “bundled” codes 95120/95125.

What is a Billable Dose for 95165? CPT vs. Medicare

<table>
<thead>
<tr>
<th>Scenario</th>
<th>CPT Says</th>
<th>Medicare Says</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 5cc multi-dose vial</td>
<td>Report the number of doses/units, or injections, the patient will receive from this vial. 5 doses/units</td>
<td>A “dose” is the number of “units” reported on the CMS-1500 claim form. A dose, for reporting purposes, is the amount contained in a single injection. The number of doses = the number of units on the CMS-1500 claim form.</td>
</tr>
<tr>
<td>5 cc multi-dose vial delivered in ten ½ cc aliquots</td>
<td>10 doses/units 5 doses/units</td>
<td>• Use 95165 for services delivered from treatment boards.  • Report the number of doses as units on the CMS-1500 claim form.</td>
</tr>
<tr>
<td>½ cc aliquots from a 10cc multi-dose vial for a total of 20 doses from one vial</td>
<td>20 doses/units 10 doses/units</td>
<td></td>
</tr>
<tr>
<td>Two 10 cc multi-dose vials—administering 1/2 cc aliquot from one vial and 5 cc aliquots from the other vial</td>
<td>30 doses/units 20 doses/units</td>
<td></td>
</tr>
</tbody>
</table>

TIP: There is no CPT code, or charge, for a “vial test”. This is part of the vial provision code/activity (e.g., 95165) and not separately reported.

CPT Codes for Treatment: Sublingual

<table>
<thead>
<tr>
<th>CPT Says</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Obtain prior authorization, preferably in writing.  • Typically coded as 95199 (Unlisted allergy/clinical immunologic service or procedure).  • Request written policy if payor says to use a code such as 95165 as these codes are typically for injectable substances.</td>
<td>• Collect $ CASH $ from the patient.  • Record in practice management system as dummy code (e.g., SLIT) to differentiate from other services provided using 95199.</td>
</tr>
</tbody>
</table>
Medicare’s Physician Supervision Rules: Otolaryngic Allergy Testing

- Services do not fall under Incident-to billing.
- CMS has specific rule for Physician Supervision of Diagnostic Tests: Requires diagnostic tests payable under the Medicare physician fee schedule be performed under the supervision of an individual meeting the definition of a physician.
- Services must be billed using the on-site supervising physician’s name/NPI. Payment will be 100% of the allowable if performed by auxiliary personnel (e.g., RN, MA) and billed by on-site supervising physician.
- NPPs may not bill for supervised testing. NPPs may bill for testing personally performed (15% payment reduction applies).

Medicare’s Physician Supervision Rules: Otolaryngic Allergy Treatment

- Services do fall under "incident-to" billing.
- Medicare requires direct physician or other qualified healthcare provider supervision of allergy immunotherapy including injections and vial preparation: the service is reported using the on-site supervising provider’s name and NPI.
- Date of service for vial charge (e.g., 95165) is the date the vial was mixed. Bill using the on-site supervising provider’s name and NPI.
- Payment will be 100% of the allowable if the on-site supervising provider is a physician. Payment will be 85% of the allowable if the on-site supervising provider is a PA or NP.

Specific Services
- Audiologic Diagnostic Testing

Audiologic Diagnostic Testing
- Audiology services must be personally furnished by an audiologist or NPP.
- Physicians may personally furnish audiology services, and technicians or other qualified staff may furnish those parts of a service that do not require professional skills under the direct supervision of physicians.

What audiologic diagnostic testing does NOT require "professional skills" and may be performed by a technician?

- Tympanogram
  
Tympanogram
The technical component (modifier TC) of codes that have both professional and technical components such as an ENG.

Electronystagmography

Step 1: Choose code for basic vestibular evaluation (92540 = 92541 + 92542 + 92544 + 92545)
Step 2: Code for caloric testing, if performed
  - 92537 bilateral and bithermal
  - 92538 bilateral and monothermal
Step 3: Code for use of vertical electrodes, if used
  - +92547
**CMS Billing Guidelines for ENGs**

- **When performed by the audiologist:** report ENG code(s) without modifier 26 or TC. Claim is submitted with the audiologist NPI as rendering and billing provider.
- **When performed by a technician and supervised by a physician:** Claim is submitted with the physician’s NPI. The technical component only may be performed by the technician – the interpretation must be performed by the billing physician. Remember, only certain services may be billed in this manner.
- **When performed by a technician and supervised by a PA/NP:** this scenario is not allowed by CMS.

**Audiologist & E/M Codes**

**Q: Can audiologists bill E/M codes?**

That depends – Medicare says no. Query your non-Medicare payors or play it safe and follow Medicare’s guidelines.

**Hearing Aids**

- Covered benefit?
- Are you contracted for that benefit?
- ABN
- Fee options
- Codes

**Coding Issues**

- CPT codes?
- HCPCS II codes?
- Dummy codes?
- Which entity is paying what amount?

**Home Sleep Study**

**Most Common Codes**

<table>
<thead>
<tr>
<th>CPT Says:</th>
<th>Medicare Says:</th>
</tr>
</thead>
<tbody>
<tr>
<td>95806</td>
<td>G0399</td>
</tr>
<tr>
<td>Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (e.g., thoracoabdominal movement)</td>
<td>Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation</td>
</tr>
</tbody>
</table>
**Home Sleep Study Example:**

A Medicare patient was given a type III sleep study monitor and a home study was completed. The patient’s monitor was attached on 1/20/2017. The physician’s interpretation and report was completed on 1/23/2017 (the physician is in private practice).

- 1/19/2017 99211 POS 11 (physician office) for MA to get patient neck and chest measurements as well as to instruct patient on how to use the machine and how take their vital signs. Remember to follow Incident-to-billing guidelines (previously discussed).
- 1/20/2017 G0399 POS 12 (home)
- 1/23/2017 95806-26 POS 11 (physician office)

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**Specific Services**

- **CPAP Management**

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**CPAP Management**

- **94660 Continuous positive airway pressure ventilation (CPAP), initiation and management**

  Code 94660 includes reviewing medical history, performing a physical examination, and reviewing diagnostic test results, all focused on the management of PAP and the underlying disorder. Discussions with the patient may include various device options and masks available; prior experiences with PAP devices; desensitization therapy to manage side effects such as claustrophobia or facial lesions; ordering durable medical equipment (DME); and addressing any related health care needs. A brief chart note to document the service is included in code 94660.

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**CPT Assistant, October 2014 Q&As**

**Question:**

May I report both an evaluation and management code (99201-99499) and code 94660 on the same day?

**Answer:**

Typically, no. The services of code 94660 are included in National Correct Coding Initiative edits in every evaluation and management code (99201-99499).

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**Question:**

May I report an evaluation and management code (99201-99499) instead of code 94660?

**Answer:**

Yes. If addressing other issues or diagnoses in addition to sleep disorders in the same patient encounter, an evaluation and management service may be the appropriate code to select. However, even if only instructing on CPAP initiation, an evaluation and management code (at the proper code level, based upon the Documentation Guidelines) can be appropriate to select. Remember an evaluation and management code may be selected in this circumstance based on time spent counseling the patient and coordinating his or her care for sleep-disordered breathing.

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Questions

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