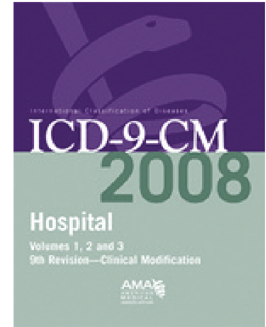
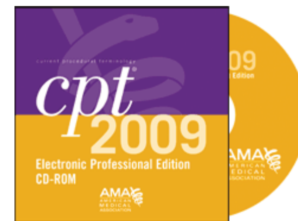
PATCH TEST CODING AND REIMBURSEMENT GUIDE



Accurate coding and documentation is essential for appropriate reimbursement for medical services, including dermatology. Coding is intended to transform a physician's verbal descriptions of diseases and procedures into standardized numeric designations, facilitating patient care documentation and billing.

Currently, the three major coding systems include the American Medical Association's Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). These systems are used by both government and private health care payers for health care reimbursement. They can change frequently and vary by geographic location and payer. Always refer to current versions of these coding guides.



In addition to understanding these coding systems used in health care, physicians and staff should know the policies and procedures for their primary payers or contracted health plans. This includes information about patient coverage, anticipated and contracted reimbursement rates, definition of complete claims, claims appeal processes, as well as appropriate contact numbers, email and addresses.

Disclaimer: *The brief information included here about coding and reimbursement is for educational purposes only. It should not replace current Medicare or specific payer policies, state or federal regulations, medico-legal practice guidelines, or consultation with coding experts or attorneys. Users should always consult payers for final guidance and about changes in coding and reimbursement practices. Allerderm, a SmartPractice® Affiliate, and Mekos Laboratories assume no liability from the use of this manual.*

Coding For Evaluation and Management (E/M) Services

A generalized summary of E/M service coding is shown below. For complete information about these procedures, refer to current versions of the *American Academy of Dermatology Coding and Documentation Manual* and the *American Medical Association's CPT* and *ICD-9-CM* guidance manuals.

New Patients (i.e., no professional services within previous 3 years)*:

CPT CODE	History[1]	Physical exam[2]	Medical desicion process	Time[3] (minutes)
99201	Problem-focused	Problem-focused	Straight forward	10
99202	Expanded problem-focused	Expanded problem-focused	Straight forward	20
99203	Detailed	Detailed	Low complexity	30
99204	Comprehensive	Comprehensive	Moderate complexity	45
99205	Comprehensive	Comprehensive	High complexity	60

* Although dermatologists may receive patients by referral, these are usually coded as new patients not consultations. Consultation codes are used when advice is formally requested by another physician currently providing care for that patient, and influences that patient care. Strict criteria, including extensive documentation, must now be met for billing consultation services.

Established Patients:

CPT code	History of current illness[1]	Physical exam[2]	Medical decision process	Time[3] (minutes)
99211	Minimal	Minimal	Minimal	5
99212	Problem-focused	Problem-focused	Straight forward	10
99213	Expanded problem-focused	Expanded problem-focused	Low complexity	15
99214	Detailed	Detailed	Moderate complexity	25
99215	Comprehensive	Comprehensive	High complexity	40

[1] Per Medicare, "history" is often defined based on the chief complaint, history of present illness, a review of systems, and any relevant history (e.g., past, family or social).

[2] Per Medicare, 1) a "problem-focused" exam means the affected body area or organ system; 2) an "expanded problem focused" exam means the affected body area or organ system and other related systems; 3) a "detailed" exam means a more extensive exam of the affected body area or organ system and other related organ systems and 4) a "comprehensive" exam means an extensive exam of 12 organ systems or complete exam of a single organ system.

[3] Per Medicare, the length of time spent with a patient does not primarily control the level of service billed, unless it constitutes more than 50% of the face-to-face time such as when providing counseling or coordinating care.

PATCH TEST CODING

- For each patch test(s), use **CPT code 95044** (or 95052 for photo patch tests). According to Medicare guidelines, the number of tests (i.e., allergen patches) must be specified. For T.R.U.E. TEST® panels 1.1, 2.1 and 3.1 the total number of patches is 29. This number (29) is the multiplier used for the 95044 reimbersement fee.

Note: Patch test CPT code (95044) does not include a professional or E/M service component.

- Medicare and third party payers can have different patch testing policies, including different maximum allowable tests (i.e., 95044) per beneficiary per year. Carefully review any limitations in payer policies that may impact office procedures and patient care.
- The level of **evaluation and management (E/M) service** reported should be based on *current history, exam and decision-making criteria*, and not solely on time spent with the patient. Support E/M service reporting with clear documentation in the medical record.
- Depending on patient care provided, it may be appropriate to bill for a separately identifiable E/M service that occurs on the same day as patch testing. If this is the case, it should be reported using **modifier 25**, recognized by most payers.
- The **ICD-9-CM codes** for a diagnosis of allergic contact dermatitis vary (e.g., 692.0 for detergent-based to 692.9 for an unspecified cause). Use appropriate ICD-9-CM codes (including V codes) to identify diagnoses, symptoms, other conditions, problems and complaints.

For complete information about coding procedures, physicians are referred to current versions of the *American Academy of Dermatology Coding and Documentation Manual,* and the *American Medical Association's CPT* and *ICD-9-CM* guidance manuals.

Patch Test Reimbursement

To optimize practice reimbursement, it is important to code patch testing correctly, provide accurate and sufficient documentation, and bill for all services provided. The level of service reported and billed for all patient visits must be justified by medical necessity and supported by appropriate documentation in the patient's medical record. Because coding practices are complex and change frequently, it can be valuable for physicians to implement one or more of the following in their practice:

- Regular staff instruction about proper coding, documentation and billing procedures.
- A standardized coding and practice management software that is well documented.
- A reference sheet for commonly used allergy and dermatology-based codes for your practice, including CPT 95044 and ICD-9-CM 692 examples.
- The use of an independent, audited coding and billing agency familiar with local federal and private payers.

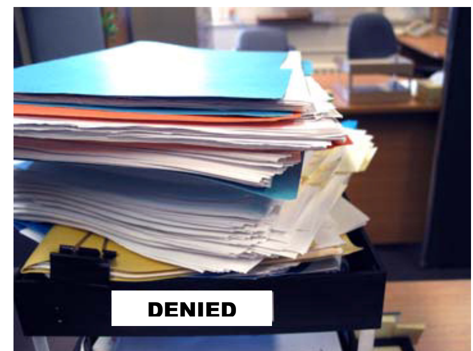
Like other health care services, patch test reimbursement can:

- Vary by payer and geographic location.
- Range from under $4 to over $8 per CPT 95044, which does not include a professional component.
- Include E/M service codes, that for new patients (99201 to 99205) range from $36.22 to $172.13 based on the 2005 Medicare reimbursement base (excluding geographic and other adjustments).

In today's health care, accurate coding is considered the ethical and legal responsibility of the physician and their practice. Recurring procedural errors can lead to reimbursement delays, unpaid claims, loss of revenue, and even disciplinary action and legal sanctions.

Claim Denials and Appeals

Claim or coverage denials are best avoided by being as proactive as possible. Understanding the coverage limitations of various health care plans and obtaining preauthorization is likely to reduce unwanted and unexpected denials.



However, claim denials do occur and the American Medical Association has reported that a significant proportion of physician revenue can be associated with underpaid or denied claims.

Moreover, the majority of claim denial or underpayment can arise from errors attributable to health care providers and payers. Therefore, it is important that physicians and staff learn to analyze rejected claims, manage claim denials effectively, and implement appeal strategies.

Tips for improving claims management overall:

- Understand the claims appeal process applicable to your local, regional and national payers.
- Review claims before submission. Use a reference sheet to crosscheck for common coding errors and proper payer procedures.
- Regularly evaluate payers' explanation of benefits (EOB) for potential errors or underpayments.
- Record claim follow-up including a summary of payer information, source(s) and reasons for denial, as well as any actions taken.
- Using standardized professional claims appeal letters may facilitate the process, and payers may be more likely to respond quickly. Clearly state the rationale for the appeal, date of service, patient information, and appropriate documentation for all patient care provided.
- For payers unfamiliar with T.R.U.E. TEST, it may be helpful to note that it is the only allergen patch test approved for marketing and sale in the United States.