5101:3-4-19 **Allergy services.**

(A) Allergy testing.

(1) Providers of physician services may be reimbursed for the performance and evaluation of allergy sensitivity tests as set forth in appendix DD to rule 5101:3-1-60 of the Administrative Code.

(a) A complete medical and immunologic history and physical examination must be done prior to performing diagnostic testing and be made available to the department upon request; and

(b) The testing must be performed based on the medical and immunologic history and physical examination that documents that the antigen being used for the testing exists within a reasonable probability of exposure in the patient's environment and be documented in the patient's medical record; and

(c) Based on the information in the medical record, the testing must be limited to the minimal number of necessary tests to reach a diagnosis.

(2) The appropriate use of professional and technical modifiers and relevant place of service restrictions are set forth in rule 5101:3-4-11 of Administrative Code.

(3) Physician professional services associated with allergy testing are bundled into the code for evaluation and management services (visit).

(4) Percutaneous tests, intracutaneous/intradermal tests, photo patch tests, and patch tests, photo tests, or application tests are reimbursed on a per test basis. When billing, the provider must specify the number of tests performed.

(5) Quantitative or semi-quantitative in vitro allergen specific IgE tests (formerly referred to a RAST tests) are covered if skin testing is not possible or not reliable and they are performed by providers certified under the "Clinical Laboratory Improvement Amendment of 1988" (CLIA '88) to perform the tests and billed in accordance with Chapter 5101:3-11 of the Administrative Code.

(6) The qualitative multiallergen screen for allergen specific IgE, CPT code 86005, is not covered since it is not considered medically necessary.

~~(7) Provocative testing, CPT code 95078, is not covered since it is not considered~~

~~medically necessary.~~

~~(8)~~(7) Ophthalmic mucous membrane tests and direct nasal mucous membrane tests are allowed only when skin testing cannot test allergens.

~~(9)~~(8) Ingestion challenge tests~~, CPT code 95075,~~ are allowed once per patient encounter regardless of the number of items tested. Ingestion challenge tests include the evaluation of the patient's response to the test items.

(B) Allergen immunotherapy.

(1) "Allergen immunotherapy" is the provision of and parenteral administration of allergenic extracts as antigens at periodic intervals, usually on an increasing dosage scale to a dosage that is maintained as maintenance therapy.

(2) Providers may be reimbursed for the professional services necessary for allergen immunotherapy. Coverage and reimbursement of allergen immunotherapy is set forth in rule 5101:3-4-11 of the Administrative Code.

(3) The patient's medical record must document that allergen immunotherapy was determined by appropriate diagnostic procedures coordinated with clinical judgment and knowledge of the natural history of allergic diseases. Documentation must be made available to the department upon request.

(4) An office visit may be billed in addition to the allergen immunotherapy codes (95115, 95117, 95144-95180) only if other identifiable services are provided at that time. If an office visit code is billed with an allergen immunotherapy service, the modifier 25 must be used.

(5) Allergen immunotherapy will not be covered for the following antigens: newsprint, tobacco smoke, dandelion, orris root, phenol, formalin, alcohol, sugar, yeast, grain mill dust, goldenrod, pyrethrum, marigold, soybean dust, honeysuckle, wool, fiberglass, green tea, or chalk since they are not considered medically necessary.

(6) The department recognizes two components of allergen immunotherapy, one being the administration (injection) of the antigen, which includes all professional services associated with the administration of the antigen, and the other being the antigen itself. These two components must be billed separately, regardless of whether or not the provider who prescribes and provides the antigen is the same as the provider who administers the antigen.

(a) Injections.

For reimbursement for the administration (injection) of allergenic extract or stinging insect venom, the provider must bill CPT code 95115 or 95117. The allergenic extract may be administered by the physician or by a properly instructed employee under the general supervision of the physician in an office setting. These codes may not be billed with CPT code 95144.

(b) Antigens (excluding stinging insect venoms).

(i) When the provider prescribes and provides single or multiple antigens for allergen immunotherapy in multiple-dose vials (i.e., vials containing two or more doses of antigens), the provider must bill CPT code 95165 in the procedure/service code block and the number of doses contained in the vial in the unit(s) block on the invoice. If the provider dispenses two or more multiple-dose vials of antigen, for each vial dispensed CPT code 95165 must be billed on a separate line along with the corresponding number of doses.

For example, if a patient cannot be treated with immunotherapy by placing all antigens in one vial and two multidose vials containing ten doses each must be dispensed, the CPT code 95165 must be billed on two separate lines and a "10" (for ten doses) must be entered for the corresponding units.

(ii) CPT code 95144, the single dose vial antigen preparation code, must not be billed as one of the components of a complete service performed by a provider. The code must be billed only if the provider providing the antigen is providing it to be injected by some other entity. The number of vials prepared must be indicated.

(iii) The department does not recognize CPT codes 95120 through 95134 because they represent complete services, i.e., services that include both the injection service as well as the antigen and its preparation. Only component billing will be allowed. Providers providing both components of the service must do component billing. The provider must, as appropriate, bill one of the injection CPT codes (95115 or 95117) and one of the antigen/antigen preparation CPT codes (95145 through 95149, 95165, or 95170). The number of doses must be specified.

(c) Insect venoms in single dose vials or preparations.

(i) If the provider administers the venom(s), CPT code 95115 or 95117 must be billed for the injection(s) of the antigen(s).

(ii) When a provider prescribes and/or provides stinging insect venom antigens in single dose vials or preparations, CPT codes 95145 to 95149 must be billed.

(a) For each single dose vial or preparation provided, a unit of service of "1" must be reported.

(b) If the provider also administers the venom, CPT code 95115 or 95117 must be billed for the injection(s).

(iii) For any single dose vial or preparation of stinging insect venoms, the provider must use CPT codes 95145 to 95149 with a unit of service of "1" for each single dose vial/preparation provided.

(d) Insect venoms in multiple dose vials or preparations.

(i) When a provider prescribes and provides single or multiple stinging insect venom(s) in multiple dose vials, CPT codes 95145 to 95149 must be billed. The number reported as the unit of service must represent the total number of doses contained in the vial.

(ii) Regardless of the number of doses, the date of service reported should be:

(a) The date the vial is dispensed to the patient, if the patient takes the vial home to be administered elsewhere or at another time; or

(b) The date that the first dose is administered to the patient, if the vial is kept in the physician's office.

(iii) If the provider also administers the venom, CPT code 95115 or 95117 must be billed for the single or multiple injection(s). The correct quantity billed is one for either code.

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