Building a Thriving Food Allergen Desensitization Practice

The Business Case: Billing Models, Revenue Streams & Growth

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Topics Covered:
Billing Models • CPT Codes • PCM / Remote Care • Medical Home • Marketing

Questions

1. Offering food allergen desensitization is professionally gratifying, but can it be financially viable from a practice management standpoint?

2. How can leaning into the“allergy medical home” model simultaenously optimize patient care and maximize practice revenue?

3. How do we get compensated for all the work associated with managing such complex care outside of scheduled office visits?

Agenda

01 The OIT Opportunity

02 Treat Comorbidities First: The A/I Medical Home

03 Billing Models: Insurance, Direct Care & Hybrid

04 CPT Codes & Supply Fees

05 Principal Care Management (PCM) & Remote Care

06 Marketing & Practice Growth

The OIT Opportunity: Why Now, Why Ever?

8% (1 in 13)
U.S. children with food allergies

$4,184
Annul economic cost of childhood food allergy per patient

<10%
Currently receiving desensitization care

Why Allergists/Immunologists are Uniquely Positioned

- Specialty expertise in IgE-mediated disease & immunomodulation
- Existing infrastructure for allergy testing & immunotherapy administration
- Established relationships for managing comorbidities (asthma, rhinitis, eczema)
- OIT is immunotherapy — allergists already understand dose escalation & reaction management
- Large unmet need: most food-allergic patients have never seen an allergist

Gupta R, Holdford D, Bilaver L, Dyer A, Holl JL, Meltzer D. The Economic Impact of Childhood Food Allergy in the United States. JAMA Pediatr. 2013;167(11):1026–1031. doi:10.1001/jamapediatrics.2013.2376

Gupta RS, Warren CM, Smith BM, et al. The Public Health Impact of Parent-Reported Childhood Food Allergies in the United States. *Pediatrics*. 2018;142(6):e20181235. doi:10.1542/peds.2018-1235

Treat Comorbidities First: The Gateway to Safe OIT

Poorly controlled asthma, rhinitis, or eczema are relative CONTRAINDICATIONS to initiating OIT — not afterthoughts. Addressing them first is a win-win.

Allergic Rhinitis

~40% of food-allergic patients

WHY TREAT FIRST

Should be controlled before OIT; persistent AR destabilizes baseline & may augment reaction risk

REVENUE WHILE YOU WAIT

Skin testing
Immunotherapy
Rhinoscopy

Asthma

~50% of food-allergic patients

WHY TREAT FIRST

Active asthma exacerbation/symptoms = absolute dose hold; uncontrolled asthma is a risk factor for fatal FA, and a contraindication to OIT initiation

REVENUE WHILE YOU WAIT

Skin testing
Immunotherapy
FeNO and Spirometry
Biologics

Atopic Dermatitis

>/=45% of food-allergic patients

WHY TREAT FIRST

Active/flaring AD augments systemic inflammation, may lower reaction threshold, and causes confusion during up-dosing; must be stabilized pre-OIT

REVENUE WHILE YOU WAIT

Skin testing
Immunotherapy (off-label)
Patch testing
Biologics

NIAID-Sponsored Expert Panel, Boyce JA, Assa'ad A, et al. Guidelines for the diagnosis and management of food allergy in the United States: report of the NIAID-sponsored expert panel. *J Allergy Clin Immunol.* 2010;126(6 Suppl):S1-S58. doi:10.1016/j.jaci.2010.10.007

Christensen MO, Barakji YA, Loft N, et al. Prevalence of and association between atopic dermatitis and food sensitivity, food allergy and challenge-proven food allergy: A systematic review and meta-analysis. J Eur Acad Dermatol Venereol. 2023;37(5):984-1003. doi:10.1111/jdv.18919

The A/I Medical Home: From Comorbidity Control to Lifelong Care

Every comorbidity visit is both a clinical necessity and a billable revenue event. Optimizing the patient's health before OIT builds trust, ensures safety, and generates income.

Food Allergy Evaluation

Diagnosis & extended workup

Services:

E/M (NP + FU)
SPT
Baseline FeNO/PFT
OFCs

Comorbidity Control Phase

Asthma, AD, AR
(Optimize before OIT)

Services:

E/M
SPT/IDT
Aeroallergen IT
FeNO/PFT monitoring
Biologics

OIT / SLIT Desensitization

Build-up + remote monitoring

Services:

OFC vs Rapid Desensitization
Supply Fees
E/M for up-doses
G2211 vs PCM vs Program Fee
OFCs

Maintenance & Medical Home

Long-term follow-up and comorbidity management

Services:

E/M
Aeroallergen IT
FeNO/PFT monitoring
Biologics

Billing Models: Choosing Your Approach

Insurance-Based

- Bill CPT codes for all covered services rendered
- Works with commercial & government payers
- Maximize reimbursement with proper coding
- Requires robust documentation

Direct / Cash Pay

- Flat all-inclusive program fee (upfront or installment)
- Monthly subscription during build-up phase
- Fee-for-service with self-pay rates
- Patients may self-submit to OON insurance

Hybrid Model

- Bill insurance for covered services (E&M, testing, PCM)
- Separate supply fee for allergen preparations
- Advance Beneficiary Notice for non-covered items
- Optimizes revenue across payer mix

💡 Many practices find the Hybrid model maximizes revenue while preserving access for insured patients.

Access Considerations: A small pro-bono or sliding-scale tier demonstrates community commitment, generates goodwill referrals, and supports practice mission alignment. Even 2–3 cases/year can yield outsized marketing and morale benefits.

Key CPT Codes during Food Allergen Desensitization

CPT Code	Service	Typical Use	Insurance Coverage
95076, 95079	Ingestion challenge	OFC / Initial dose escalation / up-dose visits	Yes (get ABN)
95180 (per hour)	Rapid desensitization	Initial dose escalation	Yes (get ABN)
99213–99215	E&M – established patient	Up-dose & follow-up visits	Yes
99417	Prolonged service (q15 min beyond 99215)	Extended time add-on	Yes
95012, A4617	Fractional Exhaled NO (FeNO)	Asthma monitoring	Yes (get ABN)
94010, 94060	Pulmonary function testing	Asthma monitoring	Yes
95004, 95024	Skin testing	Identification of allergic triggers	Yes
G2211	Complex care add-on code	Complex care add-on code to E/M	Yes (CMS, +/- others)
99424–99427	Principal Care Management	Remote care monitoring (monthly)	Yes (some, get ABN)
Supply Fee	OIT allergen preparation	OIT suspensions, bottles, syringes	No

Sample Revenue per OIT Patient During Build-up (YMMV)

Initial Dose Escalation: ($123.15 x1 [95076] + $84.84 x2 [95079]) OR ($137.61 x4) [95180]	$292.83 - 550.56
Up-dose +/- G2211: $135.61 [99214] ×20 visits	$2,712.20
Complex Care Add-On: $17.37 ×20 visits	$347.40
Principal Care Management: ($67.80 - $87.51) ×12 months	$813.60 - 1050.12
Supply fees (variable)	$200 - 1,000

~$3,500 - 5,300+/patient

https://www.cms.gov/medicare/physician-fee-schedule/

Principal Care Management (PCM): The Remote Care Engine

What Is PCM?

PCM provides continuous, between-visit care management for one complex high-risk chronic condition — in this case, IgE-mediated food allergy requiring desensitization therapy.

Eligibility Criteria

- ✓ One complex condition expected to last ≥3 months
- ✓ Significant risk of hospitalization or recent hospitalization
- ✓ Requires disease-specific care plan development/revision
- ✓ Frequent medication/management adjustments needed
- ✓ Unusually complex due to comorbidities

PCM Billing Codes

99424	Physician/QHP First 30 min/month
99425	Physician/QHP Each add'l 30 min
99426	Clinical staff First 30 min/month
99427	Clinical staff Each add'l 30 min

~$68–88/patient/month
billed monthly during active therapy

Implementing PCM: Workflow & Documentation

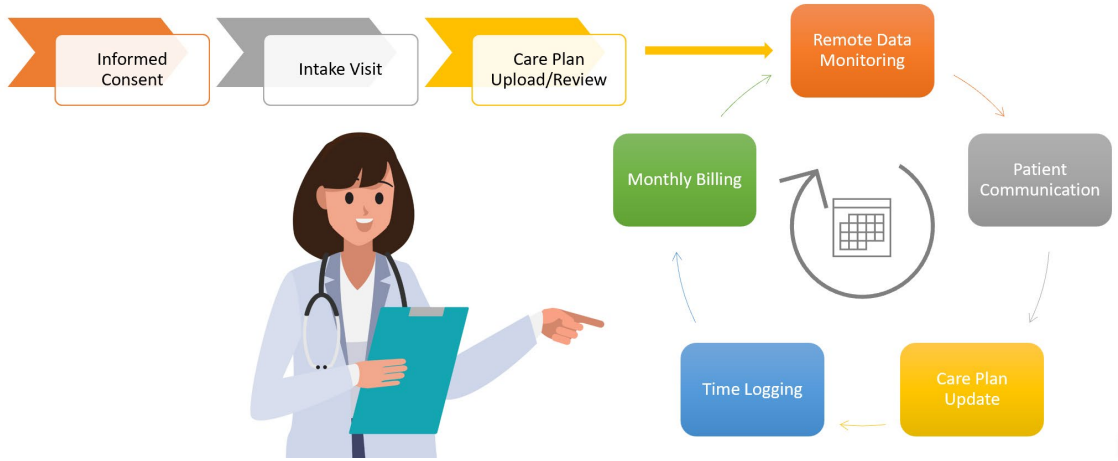
PCM Services Provided to OIT Patients

- 24/7 access to clinical team for dosing questions, reactions, illness
- Remote review of dosing/reaction log data
- Guidance on comorbid conditions: asthma, rhinitis, eczema
- Safe hybrid care: remote monitoring reduces in-person clinic visits
- Disease-specific electronic care plan w/ real-time adjustments

Documentation Best Practices

- Identify a Practice PCM Champion for oversight
- Include PCM eligibility checklist in every chart
- Track time separately: physician vs. clinical staff
- Use dedicated EMR template for PCM billing
- Conduct periodic internal audits of documentation

Scan to watch my 2023 AAAAI talk on Remote Care Management in Food Allergy



Marketing Your OIT Program: Reaching Patients & Referrers

Digital & Online

- Dedicated OIT/food allergy page on website
- SEO: 'food allergy treatment [city]', 'peanut OIT near me'
- Patient testimonials & FAQ videos
- Google Business profile with OIT keyword tags
- Active social media: Instagram, Facebook groups

Referral Network

- Pediatrician & family practice outreach (lunch-and-learn)
- School nurse education programs
- ER/urgent care relationships (post-reaction referral path)
- GI physicians (EoE, food-protein enterocolitis overlap)
- Dietician referral partnerships

Patient Community

- Sponsor/attend local food allergy support groups
- Partner with food allergy summer camps
- Patient ambassador program
- Email newsletter: dosing tips, OIT milestones

📣 The best marketing is a patient who ate their allergen safely at Thanksgiving. Make every patient outcome a story worth sharing.

Operationalizing OIT: Staffing & Infrastructure

Clinical Staff

- RN/LPN for updose monitoring & PCM documentation
- Medical assistant for prep & observation timing
- PA/NP for independent updose visits
- PCM Champion: oversees workflow & billing audits
- Medical Director

Technology

- Telemedicine visits
- Digital dose/reaction logging for home monitoring
- EMR templates for PCM billing documentation
- Patient portal for 24/7 communication

Space & Supplies

- Dedicated dosing and observation areas (post-dose wait ~30-60 min)
- Anaphylaxis response kit (epinephrine, O2, IV access)
- Allergen preparation & storage (per local regulations)
- Spirometer & FeNO device for co-morbidity management

Key Takeaways

01 OIT is a high-value, high-impact service — but comorbidity control is a prerequisite, not an afterthought.

02 Poorly controlled asthma, rhinitis, or AD are contraindications to OIT initiation: treat them first, bill while you do.

03 The Hybrid billing model (insurance + supply fees) typically maximizes revenue across payer mixes.

04 PCM codes (99424–99427) properly compensate the real work of between-visit monitoring — use them.

05 Allergen immunotherapy (+/- biologics) are drivers of both disease control and practice revenue — not secondary services.

06 Marketing works best when it combines digital presence, referral relationships, and patient community engagement.

Questions & Discussion

"The best time to start offering OIT was 10 years ago. The second-best time is now."