Internal Medicine Coding Alert

3 Injection-Coding Tips That All IM Coders Must Master

Know the difference between 90782 and 90471 - or face denials

Internists often give injections, and that means you should understand when and how to report a number of injection codes. Follow this expert advice to code shots for B12 vitamins, vaccinations and pain.

1. **B12 Injections: Understand Tricky Coding Policies**

Although coding a B12 injection may seem simple, the different carrier guidelines make reporting this service - and getting paid for it - frustrating for many IM practices.

Most Medicare payers, such as Noridian Administrative Services, accept 90782 (Therapeutic, prophylactic or diagnostic injection [specify material injected]; subcutaneous or intramuscular]) for the B12 administration, and J3420 (Injection, vitamin B-12 cyanocobalamin, up to 1,000 mcg) for the drug.

But nearly all Medicare and private carriers will not pay for the injection code if you report an E/M code, such as established patient code 99211, on the same day. This applies even if you attach modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the E/M.

"I would not recommend reporting an E/M with a B12 shot," says **Lisa Center, CPC,** quality review coordinator for Freeman Health System in Joplin, Mo. "If the nurse gives only a shot, I would bill only for the administration (90782) and drug code (J3420)."

Remember that CMS includes the same number of RVUs that 99211 carries with 90782, effectively bundling the two codes. In addition, Medicare generally reimburses for 90782 only if the physician bills for no other payable service on the same day. **Exception:** You can also report the drug code J3420.

Caution: "On rare occasions when the patient brought in the drug, and we billed only 90782 without the J code, Medicare as well as other carriers occasionally rejected the claim," says **Kathy Pride, CPC, CCS-P,** a coding consultant for QuadraMed in Port St. Lucie, Fla. But Medicare paid after an appeal, she adds.

"I am sure that they thought we wouldn't appeal such a small dollar amount, but we appealed everything based on principal," Pride says. "If we deserved to get paid, no matter how big or small the amount, we fought for it."

Good news: If you're able to report 90782, you should expect more payment than in previous years. Reimbursement for the code ranges from $25 to $40, depending on location. This price is up from the $3 or $4 most insurers once paid.

2. **Know Which Vaccine Codes Payers Accept**

If the physician administers a vaccination, make sure you know whether the patient has a private or Medicare insurer before you assign a code.

Typically, Medicare pays only for flu, pneumonia and hepatitis B vaccine codes:

1. G0008 - Administration of influenza virus vaccine

2.   G0009 - Administration of pneumococcal vaccine

3.   G0010 - Administration of hepatitis B vaccine.

Scenario: Your internist administers both flu and pneumonia vaccinations to a Medicare patient. You report G0008 and G0009 for the shots, Center says. You also list supply codes 90658 (Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use) and 90732 (Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use). And link V04.81 (Need for prophylactic vaccination ...; influenza) to G0008 and 90658, and V03.82 (Need for prophylactic vaccination ...; streptococcus pneumoniae [pneumococcus]) to G0009 and 90732, she adds.

Exception: Medicare will reimburse physicians for other vaccines or inoculations, such as the anti-rabies treatment or tetanus anti-toxin, when the provider administers the vaccine to treat an injury or direct exposure to a disease.

Therefore, if you report vaccine administration for injury or exposure, or if the patient has a private insurer that doesn't follow Medicare guidelines, you should use the following codes:

4.   90471 - Immunization administration (includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections); one vaccine (single or combination vaccine/toxoid)

5.   +90472 - ... each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure).

You should assign 90471 for the first administration, such as a hepatitis B vaccine. Use add-on code 90472 for any additional shots, like a tetanus or diphtheria injection.

3. Muscles Count When Coding Trigger Points

If the internist provides trigger point injections to treat a patient's pain, select the correct code based on the number of muscles the physician treated, not the number of injections he gave.

For instance, if the physician administers a single injection to a patient's back muscle, you should assign 20552 (Injection[s]; single or multiple trigger point[s], one or two muscle[s]). This code represents any number of shots, so you should report the code only once.

On the other hand, 20552 describes only "one or two" muscles. If the internist treated three or more muscles, make sure you list 20553 (... single or multiple trigger point[s], three or more muscles).

When - and When Not - to Report an E/M

An office visit often determines whether a patient needs a trigger point injection. This means you may report the appropriate E/M code (99201-99215), because the visit's primary purpose wasn't giving the shot, Center says.

Tip: Be sure you attach modifier -25 to the code, Center says. The modifier shows that the E/M was separate from the injection.

Prevent denials: If the patient's encounter is principally for the injection, you should not bill an E/M unless the physician treats an additional problem during the visit. For instance, the patient complains of recent dizziness (780.4) that may be related to his high blood pressure (401.x, Essential hypertension).