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Internal Medicine Coding Alert

CPT® Coding Strategies: Injection Coding Techniques: Follow These 3 Simple Steps

Don't forget to identify scenarios that can be reported with separate E/M codes.

When reporting an injection administration, you will need to focus on the route of administration, the number of drugs injected, and the dosage of the medications provided. You will also need to check if it is appropriate to report a separate E/M code for the encounter.

Step 1: Choose the Proper Administration Code

The first step when coding an injection service is to determine the proper administration code you should be reporting. You might think that all injections are the same, but CPT® offers several administration codes to choose from. You'll have to figure out which type of drug therapy your physician ordered to get to the right code. You'll select from the following codes depending on the route of administration:

- 96372 (Therapeutic, prophylactic, or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular)
- 96373 (...intra-arterial)
- 96374 (...intravenous push, single or initial substance/drug)

Coding tip: If the injection administered is a vaccine, you will have to choose from other CPT® codes, namely, 90460 (Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered), +90461 (...each additional vaccine or toxoid component administered [List separately in addition to code for primary procedure]) or 90471 (Immunization administration [includes percutaneous, intradermal, subcutaneous, or intramuscular injections]; 1 vaccine [single or combination vaccine/toxoid]) and +90472 (...each additional vaccine [single or combination vaccine/toxoid] [List separately in addition to code for primary procedure]) depending on the age of the patient. The above described codes should not be used when the purpose of the injection is for immunization.

Don't forget: If your physician is administering more than one drug through the intravenous route, you need to capture this administration using an add-on code. You have to report this with +96375 (...each additional sequential intravenous push of a new substance/drug [List separately in addition to code for primary procedure]).

Caveat: The intravenous administration codes, 96374 and +96375 are to be used only when any drug has been pushed intravenously and not when your clinician is performing an intravenous infusion. When an intravenous infusion is provided, you have to report this with other CPT® codes for the procedure. These are time based codes and depending on the time spent and the number of drugs your clinician administers, you will have to report from the following four codes:

- 96365 (Intravenous infusion, for therapy, prophylaxis, or diagnosis [specify substance or drug]; initial, up to 1 hour)
- +96366 (...each additional hour [List separately in addition to code for primary procedure])
- +96367 (...additional sequential infusion of a new drug/substance, up to 1 hour [List separately in addition to code for primary procedure])
- +96368 (...concurrent infusion [List separately in addition to code for primary procedure])

When your clinician performs intravenous infusion for hydration, report 96360 (Intravenous infusion, hydration; initial, 31 minutes to 1 hour) for the first hour and +96361 (...each additional hour [List separately in addition to code for primary

procedure]) for each additional hour of infusion. "Be aware that code +96361 can only be reported when you have spent more than 30 minutes after the previous hour in providing the infusion," observes an expert. "Just as 96360 can only be reported when you have passed the midpoint of the first hour, +96361 can only be reported when you have passed themidpoint of each subsequent hour," he says.

Step 2: Know When You Can Report a Separate E/M Code

If your internal medicine specialist performs a separately identifiable service at the same time as the injection, such as an office visit, you can report that service separately using an appropriate E/M code with the modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) appended.

When reviewing the service, you should be able to identify a 'stand-alone' combination of examination, medical decision making, andhistory to support the E/M service. You need to make sure that it truly is a 'separately identifiable service' as there is a degree of evaluation and management inherent to the injection.

Tip: If your physician provides two separate diagnoses -- one for the reason the patient is receiving the drug therapy and one for another unrelated problem -- then you should dig deeper to see if reporting a separate E/M service is warranted.

Caveat: Two different diagnoses are not always necessary, however; and having two diagnoses doesn't always make both services billable. Your provider has to document at least two (for established patients) or three (for new) of the required elements (history, exam, and medical decision-making) to report an E/M code.

Example: An established patient comes to your office for a B12 injection. Your internist sees the patient prior to the injection and performs an exam as the patient brings some allergic skin reaction to your clinician's notice. Your physician examines the patient and prescribes an antihistamine. Since the patient's skin problem was in no way connected to the prescribed B12 injection that was provided, you may clearly report this encounter separately.

You can use established patient office visit codes 99212-99215 (Office or other outpatient visit for the evaluation and management of an established patient ...) to report your physician's E/M service, depending on the level of work your physician performed. You would append modifier 25 to 99212-99215 to ensure payment when you bill them with 96372.

Therefore, if your physician provided a level-two E/M service in the example above, report 99212-25 for the clinical assessment and 96372 for the B12 administration.

Pointer: When a nurse or medical technician administers a drug/substance via a route that is subcutaneous, intramuscular,intra-arterial, or intravenous push, you cannot bill for a nurse's E/M visit with 99211 as this code is included in all drug administration codes, such as 96372-96374. "In each case, the Correct Coding Initiative edits make 99211 a column 2 code for 96372-96374 in column 1 and do not allow a modifier to override the bundle," Moore points out. "Ironically, per CPT® guidelines, if a nurse or medical technician administers a drug/substance subcutaneously or intramuscularly without direct physician or other qualified health care professional supervision, you do not report 96372 for the injection. Instead, you report 99211," Moore adds.

Step 3: Don't Forget the Drug Supply Code

Once you've determined the CPT® code(s) you will be reporting, you need to select the proper HCPCS code to represent the actual drug your internal medicine specialist administered. Typically, you'll use the drug supply J codes to do this.

Note the drug HCPCS code as well as the dosage or units generally administered. When you submit a claim for drug payments, in many cases it is now necessary to also include the full drug name, the total dosage or units administered, method of administration, and the National Drug Code (NDC) number.

In the example described previously, your claim for the injection will not be complete if you forget to report the appropriate J code for the B12 injection. You will have to report this with J3420 (Injection, vitamin B-12 cyanocobalamin, up to 1000 mcg).

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