Internal Medicine Coding Alert

Dont Get Pinched by the Wrong Injection Code

Many coders are stuck on 90782 as a catchall code for injections, but this is the wrong choice for some types of shots, and it often pays less than the correct code.

CPT notes that you should use 90782 for a "therapeutic, prophylactic or diagnostic injection (specify material injected); subcutaneous or intramuscular."Examples of shots that meet this criteria include a B-12 injection, a Demerol shot for a migraine headache, or the injection of an anti-nausea drug. Reimbursement for 90782 is low, just $3.98 nationally, not adjusted for region, in 2002.

If the patient receives an injection of an antibiotic, use another code in this same series, 90788 (Intramuscular injection of antibiotic [specify]), which pays a few pennies more on a national basis at $4.34.

Don't use 90782 for infusion therapy, allergy shots, vaccine administration, trigger point injections or arthro-centesis/joint injections.

Infusion Is Not Injection

Coders sometimes have difficulty distinguishing between infusion and injection, and the error can be costly. Use the infusion codes 90780 (Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour) and +90781 (each additional hour, up to eight [8] hours [list separately in addition to code for primary procedure]) when a patient receives drugs intravenously for a prolonged period.

If you're unsure whether the internist is infusing the patient, check the documentation.

"Look for terms such as 'rehydration,' 'fluid challenge' or 'nitroglycerin drip' in the chart as clues that the drug was infused, not injected," says **Charol Spaulding, CPC, CPC-H,** vice president of Coding Continuum Inc., a healthcare consulting firm in Tucson, Ariz., and a licensed Professional Medical Coding Curriculum (PMCC) instructor for the American Academy of Professional Coders (AAPC).

Code 90780 pays $40.54 nationally, while 90781 pays $20.27. Bill 90781 for each additional hour of infusion after the first hour, up to eight hours. Make sure to note your units for all subsequent hours.

When you give a patient an injection directly into a vein rather than through an infusion use a code from the injection series, 90784 (intravenous). Code 90784 pays $17.37 nationally, not adjusted for region.

Take the Sting out of Allergy Shots

Allergy shots have their own series of codes, and they pay better than 90782. Use 95115 (Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection) when your office administers a single allergy shot and 95117 (two or more injections) when you give the patient two or more shots. Often, an allergist will supply the antigen, but if the physician mixes it, also use 95165 (Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens [specify number of doses]), Spaulding says.

Code 95115 pays $14.11, and 95117 pays $18.09 nationally, not adjusted for region.

Vaccinate Your Office Against Denials

One of the most common injection mistakes is using 90782 to code the administration of a vaccination. Both CPT and Medicare have special codes for vaccine administration, and you should use those codes instead. They pay the same amount as 90782.

For private payers, use 90471 (Immunization administration [includes percutaneous, intradermal, subcutaneous, intramuscular and jet injections]; one vaccine [single or combination vaccine/toxoid]) for administration of one vaccine and +90472 (each additional vaccine [single or combination vaccine/toxoid] [list separately in addition to code for primary procedure]) for each additional vaccine given.

Medicare specifies codes for administration of flu, pneumonia and hepatitis B vaccines: G0008 (Administration of influenza virus vaccine), G0009 (Administration of pneumococcal vaccine), and G0010 (Administration of hepatitis B vaccine).

Many coders who are familiar with 90471 are unaware of Medicare's G0008 code, says **Karen Jeghers, PA-C, CPC,** manager of Compliant Billing Services, a Carver, Mass.-based firm that provides coding, billing and consulting services. "If you use 90471, Medicare will deny the claim," Jeghers says.

Offices that receive a denial of 90471 often write off the cost under the mistaken impression that Medicare doesn't pay for vaccinations, Jeghers adds. If you make this mistake, she advises that you resubmit with the proper G code.

Also, remember to code for all required doses of a vaccine. For example, Spaulding says, the hepatitis B vaccine often requires additional doses.

Shoot Payers the Right Trigger Point Code

Physicians sometimes give patients trigger point injections to ease pain in various muscles. Choose 20552 (Injection; single or multiple trigger point[s], one or two muscle group[s]) or 20553 (... single or multiple trigger point[s], three or more muscle groups) depending on the number of muscles receiving treatment.

Be sure to note that CPT has made slight changes in these codes for clarity in 2003, changing "muscle group(s)" to "muscle(s)." This helps resolve questions coders raised about what constitutes a muscle group. Report these codes one time per session, regardless of the number of injections given. These codes pay significantly more than the general injection codes with both codes reimbursed at $61.53 nationally, not adjusted for region.

Keep Arthrocentesis Coding in Joint

Physicians sometimes give patients joint injections for pain. Code these with the 20600 series (Arthrocentesis, aspiration and/or injection). Use 20600 for small joints, 20605 for intermediate joints, and 20610 for major joints.

One of the trickiest aspects of using this series is choosing the right code for the joint size, Jeghers says. "A lot of people think of a wrist as a small joint, but it actually is intermediate," Jeghers says.

Finger and toe joints are considered small, while wrists, elbows and ankles are intermediate, Jeghers says. Major joints are shoulder, hip and knee, she adds.

New for 2003 is 20612 (Aspiration and/or injection of ganglion cyst[s] any location). To report multiple ganglion cyst aspirations/injections, use 20612 for each procedure performed and append modifier -59 (Distinct procedural service) to all but the first aspiration/injection to show that you are coding more than one of these procedures.

Medicare's national payment, unadjusted for region, is $50.31 for 20600, $55.02 for 20605 and $66.24 for 20610. Because 20612 is a new code in 2003, reimbursement information is not available yet.

Some physicians try to use the arthrocentesis codes for acupuncture-like treatments for pain, but "you cannot use these codes for dry needling," Spaulding says.

The correct code for insertion of dry needles is 97780 (Acupuncture, one or more needles; without electrical stimulation) or 97781 (with electrical stimulation), but most payers will not cover them, Spaulding says.

Note: In addition to the proper CPT code for the injection, don't forget to also use the J code for the drug or substance that the internist administers. Remember, though, that lidocaine is considered to be an inherent part of any procedure, so you can't bill for it separately.