Internal Medicine Coding Alert

NCCI Update: Override Injection Administration Edits Using Simple Tactic

Version 11.3 reinforces 90788 as separately payable from E/M

Despite CMS' latest round of edits, modifier 25 will keep reimbursement rolling for therapeutic or antibiotic injection services with an office visit.

The National Correct Coding Initiative (NCCI), version 11.3, effective Oct. 1, bundles office visit codes (99201-99215, Office or other outpatient visit for the evaluation and management of a new or established patient ...) with injection administration codes:

• 90788--Intramuscular injection of antibiotic (specify)

• G0351--Therapeutic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular.

When appropriate, you may break the E/M service-injection edit with modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service). The edits allow a modifier to bypass all 99201-99215 and 90788/G0351 bundles, except for claims containing 99211.

The lowdown: This edit doesn't come as a big surprise to **Mary Falbo, MBA**, **CPC,** president of Millennium Healthcare Consulting Inc., a healthcare consulting firm based in Landsdale, Pa. Many carriers already require modifier 25 when you report an office visit with a therapeutic or antibiotic injection.

Why: To charge 99201-99205 or 99212-99215 in addition to 90788 or G0351, the visit must be significant and separate from the injection administration. Payers often expect you to append modifier 25 to the E/M code to indicate the service's significant, separately identifiable nature, Falbo says. "The edits solidify this principle."

For instance, Cigna of Tennessee allows 90788 with 99201-99205 or 99212-99215. Practices may bill office visits "on the same day as a drug administration service with modifier 25 indicating that a separately identifiable evaluation and management service was provided," states the carrier's February 2004 newsletter.

Consider Medicare's Stance

Many coders, however, are surprised to hear that Medicare permits an E/M service on the same day as a drug administration. The 2005 National Physician Fee Schedule changes the status indicator for 90788 and G0351 from "T" (Injections) to "A" (Active). The new designation means Medicare will pay separately for injection services even if you bill another physician service that day, Falbo says. "Previously, the administration codes had a 'T' status, which meant you were not allowed to bill 90788 in addition to an E/M service."

Good idea: Check when your carrier adopted the fee schedule change. Arkansas' Medicare carrier started accepting 90788 with a significant and separate E/M service Jan. 1, 2005, says **Lisa Marie Barnes, CPC**, coding specialist at Fayetteville Diagnostic Clinic in Arkansas. Tennessee Medicare permitted the code pair a year earlier (Jan. 1, 2004).

Because the edits reinforce the E/M's separately billable nature, Barnes thinks the edits are excellent. "Insurance carriers, especially Medicare, should have been covering injection administration all along," she says.

Rejoice Over Modifier Regulation

Coders also welcome the modifier clarification that the edits provide. "CPT's medicine section is very vague on using modifier 25," says **Carol Hall, CPC**, a coding and reimbursement specialist at California Family Health Council in San Diego.

While the "Vaccine/Toxoids" subsection offers modifier guidance, the AMA is silent on E/M service reporting with therapeutic or diagnostic infusions. "Significant, separately identifiable E/M services should also be reported," states the AMA in the "Vaccine/Toxoids" subsection introductory notes. CPT's "Therapeutic or Diagnostic Infusions (Excludes Chemotherapy)" subsection notes do not address the topic.

Best practice: You have to know each insurer's requirement. "Some of our commercial carriers have been covering 90788 and an E/M service without using modifier 25," Barnes says. "Medicare now reimburses the injection service with modifier 25 on the E/M service."

Bottom line: The new edits clarify that you need to use modifier 25 with 90788 Medicare claims involving an office visit.