Internal Medicine Coding Alert

Optimal Billing for Joint Injections: Get Paid for an E/M Service, Administration, and the Medication

Internal medicine practices often treat elderly patients, a high percentage of whom suffer from arthritis, tendinitis, or problems with their joints. Patients often present to the doctor complaining of pain in the joint and/or a limited range of motion.

For example, Mr. Smith comes into the office complaining of hip pain, the physician examines him and makes a diagnosis of arthritis (715.xx, osteoarthritis and allied disorders). The doctor then gives an injection of a glucocorticoid into the joint to reduce the inflammation.

This scenario presents several challenges to the internists coders. Is the E/M service included in the code for the administration of the injection? Can the administration be coded separately? What about billing for the injectable agent? We talked to some internal medicine practice coders about how they report these procedures.

If the patient presents to the practice complaining of joint pain, but does not specifically come into the office for the injection, then the E/M service can and should be coded separately, notes **Carol Ethridge, CPC,** coding specialist with Baptist Health Centers, Inc. which runs 70 clinics in the Birmingham, AL, area.

For example, coders would bill the above scenario with an E/M code for the evaluation of the problem (probably a 99213 in this case), plus the code for the injection into the joint (20610, drain/inject of major joint, shoulder, hip, knee, subacromial bursa), plus the J code for the supply of the drug (i.e., J1020, methylprednisolone acetate 20 mg inj, or J1040, methylprednisolone acetate 80 mg), says Ethridge.

The coder should be sure to use a -25 modifier (significant, separately identifiable procedure or service, performed on the same day) on the E/M code to indicate that a separate procedure was performed, she adds.

Medicare Carrier Policy Rejects E/M Code and Administration

Practices may want to get clarification from their Medicare carrier before billing joint injections this way, reports **Teresa Burnett, CPC,** reimbursement specialist with the Clark-Holder Clinic in LaGrange, GA.

Burnett says she has always been instructed to code an evaluation for joint pain plus a joint injection separately, but a letter from the Georgia Medicare carrier indicates that it does not consider administration of a joint injection to be separately reportable from the E/M service.

According to a letter in response to her request for clarification on billing for joint injections, the carrier representative wrote: the exam is considered to be a routine preoperative service and a visit should not be billed in addition to the procedure. Only the injection procedure and the J code for the medication should be billed to Medicare.

Code 20610, the code used for injection into a major joint, is a starred surgical code. According to CPT, this means that the code includes the procedure only, and does not include any pre- or postoperative service. However, Burnett notes, Medicare doesnt recognize starred codes.

The same may or may not be true for other, private third-party payers.

In addition, the Health Care Financing Administration, the federal agency that oversees Medicare recently clarified that

E/M services that result in performance of an unscheduled procedure can be reported with a -25 modifier, Burnett says, but she hasnt had a separate instruction from her carrier.

She has, however, been paid by Medicare for joint injections and an E/M service, despite the carriers stated position. Burnett reports that when she has submitted joint injections using the E/M code with the -25 modifier plus the administration code, they have been paid.

But, until they tell me otherwise [about billing the E/M], I am kind of nervous about reporting this way, she says, noting that overuse of the -25 modifier is one of the areas under scrutiny by the Department of Health and Human Services Office of the Inspector General (OIG).

Diagnosis Codes Must Justify Medical Necessity of the Drug

Burnett and Ethridge also note that Medicare will only pay for certain injectable drugs when used with specific diagnoses.

In the previous scenario, the diagnosis of arthritis or tendinitis or another eligible ICD-9 code would have to be used in conjunction with the J code for the methylprednisolone acetate.

Practice managers should obtain a list from their Medicare carrier of which diagnosis codes are eligible for reimbursement for which drugs.

In addition, notes Ethridge, Medicare will only reimburse for the injection of a therapeutic drug, a medication intended to treat the illness or injury. It will not pay for painkillers or other drugs used as anesthetics during the procedure.

For example, they would not pay for xylocaine or lidocaine used with the injection, she adds.