Internal Medicine Coding Alert

Reader Question ~ Count on 36415 Payment for Venipuncture

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Question: When billing 36415 x 7 (Collection of venous blood by venipuncture) for V77.1 (Special screening for diabetes mellitus), we also report 99211 for the office visit. However, insurance will only pay for 36415. Why is this? We can't bill for the lab because we aren't doing the test on-site and none of the insurances pay for 99000 (Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory). Is there anything else we can do to recoup more payment for diabetes screening?

Colorado Subscriber

Answer: If the only service your office provides is the venipuncture, the simple answer is no. The only billable service you mention is the venipuncture.

However, you could report 99211 (Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician) if the nurse or lab technician were to perform a significant and separately identifiable E/M service above and beyond just the venipuncture. And for ancillary staff members to report E/M services, you must meet the incident-to guidelines.

For example, an established patient who is performing glucose monitoring comes for a visit to assess the accuracy of his continuing glucose monitoring system (CGMS) by checking it against his laboratory glucose readings. If the nurse or technician helps to check the accuracy and functioning of the patient's CGMS, documents an E/M service and meets the incident-to requirements, you would report 99211 in addition to 36415. A modifier would not be required to report these two codes together.