Internal Medicine Coding Alert

Reader Question: Nurse Injections

Question: When a nurse gives an injection, should we bill 99211 or the injection code 90782? We would prefer to bill 99211 because it is the higher-paying code.

Illinois Subscriber

Answer: You are correct that 99211 (office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem[s] are minimal. Typically, five minutes are spent performing or supervising these services) is the higher-paying code with a transitioned, non-facility relative value unit of .52 compared to .12 for 90782 (therapeutic, prophylactic or diagnostic injection [specify material injected]; subcutaneous or intramuscular). Which code you report, however, will depend on whether the nurse just gave the injection or whether some evaluation and management (E/M) took place.

Missing from the 99211 definition are the history, examination and medical decision-making components that are required of most other E/M codes. Because the CPT manual states that the presence of a physician is not necessary, the code is often used to bill services by a nonphysician practitioner, such as a registered nurse.

There is also a clinical example for 99211 in the back of CPT 2001, which indicates that this is an appropriate code to use for billing only the administration of an injection. The example reads as follows:

Office visit for 82-year-old female, established patient, for a monthly B12 injection with documented Vitamin B12 deficiency.

On the other hand, what Medicare says about injections indicates that it is looking for some E/M services to be provided in addition to the injection. The Medicare Carriers Manual (MCM) section 15502(D) states, CPT code 99211 cannot be used to report a visit solely for the purpose of receiving an injection which meets the definition of CPT codes 90782, 90783, 90784, or 90788.

An additional requirement for billing 99211 is that the internist must be in the office while the injection is being administered. Services such as injections that are provided by a nurse and are covered by Medicare are billed incident to a physicians professional services. The MCM section 2050.1(B) has stipulated that to bill as incident to, there must be direct supervision of the service by the internist. While direct personal supervision in the office does not mean that the internist must be present in the room when the service is administered, it does mean that he or she must be in the office and immediately available to provide assistance and direction if needed.

Clearly there are two sets of rules on this, says **Pat Stout, CMT, CPC,** an independent coding consultant in Knoxville, Tenn. The clinical examples in CPT state that you can use 99211 to report the administration of an injection, even one that is administered on a weekly basis. Medicare has a more stringent set of requirements. In the end, the payer has discretion over which code it is willing to reimburse.

Stout suggests that internists contact their local Medicare and private insurance payers to obtain specific instructions on how to code for this service. Some local Medicare carriers have already issued instructions that state they will not reimburse for any E/M services provided by a nurse. For example, a March 1997 special bulletin issued by Blue Cross and Blue Shield of Alabama, the Part B carrier for the state, says, Although the Physicians Current Procedural Terminology (CPT) book specifies that office visit code 99211 may be used for visits that may not require the presence of a physician, a physician should not bill for an office visit if only the assistant or nurse actually sees the patient. This is true whether or not the physician is in the office at the time.

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