

Internal Medicine Coding Alert

READER QUESTIONS: Beware--CPT Now Requires Modifier 25 With 90772

Question: An internist performs a significant, separately identifiable E/M service for a 62-year-old patient with an upper respiratory infection. Based on the history, examination and medical decision-making, he orders a nurse to give the patient a penicillin injection. Should I append modifier 25 to the office visit code?

Ohio Subscriber

Answer: Yes. On claims after Jan. 1, you should attach modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the office visit code (such as 99213, Office or other outpatient visit for the evaluation and management of an established patient ...).

CPT 2006 clarifies that you need modifier 25 when a physician performs a significant, separately identifiable E/M service in addition to new injection administration code 90772 (Therapeutic, prophylactic or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular).

Link both the office visit and the injection code to the upper respiratory infection diagnosis, such as 465.8 (Acute upper respiratory infections of multiple or unspecified sites; other multiple sites).

You should also report the penicillin supply. For Bicillin C-R, use J0530 (Injection, penicillin G benzathine and penicillin G procaine, up to 600,000 units), J0540 (... up to 1,200,000 units) or J0550 (... up to 2,400,000 units).

Code Bicillin L-A with J0560 (Injection, penicillin G benzathine, up to 600,000 units), J0570 (... up to 1,200,000 units) or J0580 (... up to 2,400,000 units).

Although some payers previously required modifier 25 on 99201-99215 with deleted code 90782 (Therapeutic, prophylactic or diagnostic injection [specify material injected]; subcutaneous or intramuscular), CPT 2005 did not contain this requirement.

The introductory notes for "Hydration, Therapeutic, Prophylactic, and Diagnostic Injections and Infusions (Excludes Chemotherapy)" now make this directive clear. "If a significant separately identifiable evaluation and management service is performed, the appropriate E/M service code should be reported using modifier 25 in addition to 90760-90779. For same-day E/M service, a different diagnosis is not required," CPT 2006 states.

Tip: If you're experiencing insurer E/M service-administration bundles, use modifier 25 on 2006 claims and include CPT's instructions in your appeal letter. The insurance company, however, may include the edit as part of its policy. In this case, the added language probably won't affect payment.

Answers to You Be the Coder and Reader Questions reviewed by **Kathy Pride, CPC, CCS-P**, a coding consultant for QuadraMed in Port St. Lucie, Fla.; and **Bruce Rappoport, MD, CPC**, a board-certified internist who works with physicians on compliance, documentation, coding and quality issues for Rachlin, Cohen & Holtz LLP, a Fort Lauderdale, Fla.-based accounting firm with healthcare expertise.

