Part B Insider (Multispecialty) Coding Alert

Injection Coding: Study These 5 Injection FAQs to Perfect Your Accuracy

From pain management injections to TB testing, we've got your answers.

Although performing injections might take place several times a day at your practice, there's still a good chance that your practitioners are selecting the wrong codes for these confusing services. Check out the following frequently-asked questions about different injection coding situations for various specialties so you can ensure you're coding properly.

1. How Many Codes for One Lesion Injection?

Question: Our doctor recently performed removal of a plantar wart approximately 5mm in diameter. He initially shaved the lesion and then cauterized it with silver nitrate. He finally injected it with .01 ml of Candida skin test antigen. What CPT® code(s) should I report for the procedure? I am thinking of reporting 11305, 11900 and 17110. Is this appropriate?

Answer: Even though your physician performed three different procedures (shaving, cautery, and intralesional injection), you cannot report three CPT® codes for the removal of a single lesion. For this reason, you cannot report 11305 (Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less), 11900 (Injection, intralesional; up to and including 7 lesions) and 17110 (Destruction [e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement], of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions) together for this service.

Also, Correct Coding Initiative (CCI) edits bundle the CPT® codes 11305 and 11900 into 17110. Even though the modifier indicator is '1,' you should not unbundle these codes using a modifier, because your doctor is removing a single lesion via three different methods and not three different lesions by these separate techniques.

So, in your case, you will only report 17110 as this represents the most extensive service and accurately describes the service; it forms the column 1 code in the edits, and the other two codes get bundled into 17110.

2. Unsuccessful Injection Makes Coding Confusing

Question: The physician attempted to inject a patient at spinal level L4 and was unsuccessful, but then successfully injected L5. Do we code both levels? If so, would the correct codes be 64483 and 64484, and do we need a modifier?

Answer: The correct reporting depends on how the physician documented his original plan of care, and upon the payer.

For Medicare, the physician should only bill for the successful procedure -- 64483 (Injection[s], anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance [fluoroscopy or CT]; lumbar or sacral, single level) once for the L5 selective nerve root block, regardless of the number of injections he planned. You might be compliant in appending modifier 52 (Reduced services), but it depends somewhat on the documentation.

Take note: Your coding will change if the provider had not planned both level injections. If he first attempted L4 (which failed) and then successfully administered the injection at L5, you can only bill a single level injection code (64483).

3. Does TB Test Automatically Require E/M?

Question: A patient visited our provider for a PPD (TB test).Should I include an office visit code?

Answer: No. There is no actual E/M service done during a visit where the sole purpose is the administration of PPD. Instead, you should report these:

- V74.1 -- Special screening examination for bacterial and spirochetal diseases; pulmonary tuberculosis
- 86580 -- Skin test; tuberculosis, intradermal.

Typically, PPD testing results are read 48-72 hours after administering the skin test. This means another office visit and evaluation of the results to determine whether it is negative or positive.

Quick fact: Because a patient does not always return for the reading, 86580's relative value units do not include the work of reading the test, according to Medicare.

Therefore, when a nurse does the reading, you should bill these codes:

- 99211 -- Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, five minutes are spent performing or supervising these services
- 795.5x -- Nonspecific reaction to test for tuberculosis)
- V74.1, if the results are negative.

Note: Most offices choose not to charge an office visit for PPD readings since the patient may have to pay a copay, and the resources needed to perform a reading are very limited.

4. Know Your Terminology to Select Codes

Question: Our provider does a sympathetic block for two different patients on the same day. However, the documentation mentions different terminologies for the two procedures. In one, he documented administering a lumbar sympathetic chain block and the other a lumbar sympathetic block. Are these two procedures different? What code(s) can we use to report these procedures?

Answer: A lumbar sympathetic block or lumbar sympathetic chain block are essentially the same procedures. Your physician isn't doing anything different in the two patients. You report the service with 64520 (Injection, anesthetic agent; lumbar or thoracic [paravertebral sympathetic]).

What are sympathetic nerves? Anatomically, the sympathetic nerves are a chain of nerves that run on the front side of the spinal vertebrae.

What is a lumbar sympathetic block? Providers typically inject about 10cc per level injected, which is a much larger volume of medication than with epidural steroid injections (ESI) or facet injections. The increased volume allows the medication to spread up and down the sympathetic chain, producing an improved sympathetic block.

5. ER Can Report Trigger Point Injection

Question: A patient reported to the emergency department (ED) complaining of severe neck pain. He reported that two days ago he sustained an injury when he picked up a lawn mower to move it in his back yard. In addition to the neck pain, he also reported some numbness and tingling in his right arm. The patient said the pain had been constant since the injury and over-the-counter medications had not helped.

The physician performed a history and physical exam and expressed concern that the patient may have had a herniated cervical disc in addition to muscle strain. He ordered an MRI of the cervical spine and prescription pain killers. In his exam, he also found several trigger points in the trapezius and scalene muscles. He injected the trigger points to give the patient more immediate relief. Final diagnosis was "torticollis NOS." In this situation, are the injections separately reportable, or is the TPI part of the E/M service?

Answer: When the ED physician performs TPIs, you can report them with procedure codes; unlike therapeutic injections and infusions, you can code for ED TPIs. On the claim, report the following:

- 20552 (Injection[s], single or multiple trigger point[s], 1 or 2 muscle[s]) for the TPI
- The appropriate level ED E/M code (99281-99285, Emergency department visit for the evaluation and

management of a patient, which requires these 3 key components ...) depending on encounter notes
- Modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) appended to the E/M to show that the E/M and the TPIs were separate services
- 723.5 (Other disorders of cervical region; torticollis, unspecified) appended to 20552 and the E/M code.