Part B Insider (Multispecialty) Coding Alert

INJECTIONS: Will CPT 2007 Include A Code For Non-Supervised Injections?

Use 59 modifier for multiple injections per day

When CPT 2006 introduced new injection code 90772, it made injection coding simpler--but it also introduced a couple of new headaches.

Throw away old injection codes G0351, 90782 and 90788. You can use the new code 90772 for all subcutaneous or intramuscular injections for therapeutic, prophylactic or diagnostic purposes. You should also use 90772 for antibiotic injections, according to a note in the CPT manual.

And you should report 90772 for non-antineoplastic hormonal injections (See Coding Coach later in this issue).

Headache #1: But that new simplicity comes with a problem. The CPT book says you can't report 90772 if a physician wasn't present in the office suite supervising whoever provided the injection. If the physician wasn't present, you should bill level one evaluation and management code 99211, the CPT book says. But Medicare won't pay for 99211 either unless a physician was present, experts note.

Proving that a physician was nearby during the injection, is a requirement you already face for other situations, including incident-to billing. The easiest thing is to point to the physician's schedule and show that he or she was seeing patients during the injection service, says **Joan Gilhooly**, president of **Medical Business Resources** in Evanston, IL.

No-win situation: In the end, you may not be able to bill Medicare for unsupervised injections by a nurse, experts say.

The relative value units (RVUs) for 90772 include the work of physician supervision, explains Gilhooly. So the **American Medical Association** isn't likely to delete the requirement for a physician's presence during injections.

Hope for new code: The best you can hope for is that the **American Medical Association** might delete the nonsensical instruction to use an E/M code for a non-E/M service when the physician isn't present, says Gilhooly. The AMA also could introduce a new code next year for unsupervised injections, she adds.

Headache #2: It's great that you only need one code for diagnostic, therapeutic, prophylactic and antibiotic injections. But this does increase the chances that you'll have to bill more than one unit of 90772 per day. It's unclear how you should do this.

Smart idea: If you're providing an antibiotic injection and a non-antibiotic injection on the same day, the best bet is to bill 90772 on two lines, says Gilhooly. Attach the 59 modifier to the second line to emphasize that this was a second injection, and the provider didn't mix the medications and inject them in one shot.

Another way: But the **Asthma & Allergy Center** in Papillion, NE has had success billing 90772 on one line, with a "2" in the units column, according to Manager **Mary Beth Wass**.

If you bill for an injection on the same day as an E/M service, you should make sure the patient received more than just the normal examination before an injection, warns coder **Pamela Eddy** with **Peace Health** in Bellingham, WA. Medicare will never pay for a level one E/M code on the same date as an injection code. You should use the 25 modifier for the separate E/M service, according to CPT instructions.