Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Brace Yourself For 2006 Injection And Flu Shot Coding With 4 Need-to-Know Tips

Warning: You may be over-reporting 99211 and sending up a red flag to Medicare

A long-standing source of coding confusion--injections, vaccines and nurse visits--is about to get thornier.

If you haven't mastered new 2006 injection coding changes, checked the medical necessity on your nurse visit claims or taken the time to understand flu shot coding, there's still time to get prepared. Review the following expert advice.

Tip #1: Cozy Up To Code 90772

Starting Jan. 1 you'll have just one code to report all subcutaneous and intramuscular injections to Medicare and your other payers: 90772 (Therapeutic, prophylactic or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular), says **Patricia Trites, MPA, CPC, CHCC**, founder and CEO of **Healthcare Compliance Resources** in Augusta, MI.

Retired codes: CPT 2006 will delete 90782 (Therapeutic, prophylactic or diagnostic injection [specify material injected]; subcutaneous or intramuscular) and 90788 (Intramuscular injection of antibiotic [specify]). HCPCS 2006 will delete code G0351 (Therapeutic or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular).

What this means for you: For all your payors, you will now use 90772 for injections such as B-12 shots and therapeutic injections like intramuscular (IM) steroids. You will also report 90772 for antibiotic injections.

Action: Be sure to delete 90782, 90788 and G0351 from your encounter sheets and super bills--and add 90772 in their place.

Tip #2: Watch For A Coding 'Catch-22'

If you want to report an injection using 90772 when there is no supervising physician present in the office suite, you will find yourself between a rock and a hard place. Under the descriptor for 90772, CPT instructs, "Do not report 90772 for injections given without direct physician supervision. To report, use 99211."

Problem: According to Medicare, you can't report **CPT 99211** (for an established patient nurse visit) without direct physician supervision either. "It's like a Catch-22," observes **Barbara J. Cobuzzi, MBA, CPC, CPC-H, CHBME** of **CRN Healthcare Solutions** in Tinton Falls, NJ.

Example: A Medicare patient receives a B-12 shot while your physician is out doing hospital rounds. CPT states you shouldn't report 90772, and Medicare instructs you shouldn't use 99211. In this sticky situation, some consultants advise that the injection service is simply unbillable. Hopefully Medicare will offer clarification on this issue before Jan. 1, Trites says. And if the clarification doesn't come directly from CMS, local Medicare carriers will probably offer information. Keep your eyes and ears open on this, she advises.

Temporary solution: Avoid getting stuck in this no-bill situation by ensuring you schedule patients for injections when the physician is in the office, says **Catherine Brink, CMM, CPC**, president of **HealthCare Resource Management** in Spring Lake, NJ.

Tip #3: Verify Medical Necessity, Before Reporting 99211 With An Injection

Important: Don't report both 99211 and 90772 if the documentation doesn't support medical necessity for the E/M service, Brink warns. When a patient comes in specifically for a therapeutic injection, for example, many practices believe they can report 99211 in addition to 90772 because the nurse spent time administering the injection. This is incorrect, she says.

Note: You can only code for a nurse visit if it consists of patient interaction significant enough to document. For example, if during a routine blood pressure check the nurse asks the patient about his physical status, diet and exercise regimen, and how new medications have been working, there is enough for the nurse to document and subsequently report 99211 for the visit, Brink says.

However, with most visits for the express purpose of an injection, there is no such interaction. For example, a nurse usually only asks the patient if he's feeling well before administering a B-12 shot.

If the patient does have symptoms requiring attention, the visit will likely turn into a doctor visit that you can bill with a higher-level E/M code such as 99212 or 99213, Brink says. Just remember that you may need to append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) order to recoup payment for this service and 90772 during the same visit.

Bottom line: Unless you see solid documentation of nurse-patient interaction, you should only report 90772 for an injection visit.

Tip #4: Know 4 Basic Flu Shot Coding Steps

With so many flu shots administered this time of year, you have the power to make or break your office's payment--and avoid denials hassles--based your coding know-how.

1. Select the correct code for the vaccine administered. See 3 Steps Pinpoint the Right Flu Shot Code contained in the next article to sharpen your code-selecting skills.

2. Determine the appropriate administration code. Reporting a flu shot encounter is a two-code process, and you need to choose one of the following administration codes to complement your vaccine code:

• When the flu shot is the primary vaccine, bill private carriers using 90471--Immunization administration [includes percutaneous, intradermal, subcutaneous, or intramuscular injections]; one vaccine [single or combination vaccine/toxoid].

• When the patient receives a flu shot in addition to another primary vaccine, bill private payors with +90472--each additional vaccine [single or combination vaccine/toxoid] [list separately in addition to code for primary procedure].

• Use the following code to bill Medicare for flu shot administration--but only when there are no other rendered services during the visit: G0008--Administration of influenza virus vaccine when no physician fee schedule service on the same day.

• When the patient receives an intranasal vaccine, bill private payors using 90473--Immunization administration by intranasal or oral route; one vaccination [single or combination vaccine/toxoid] or +90474 (...each addition vaccine...).

3. Don't forget the diagnosis. You must link V04.81 (Need for prophylactic vaccination against certain viral diseases; other viral diseases; influenza) to both the vaccine code and the administration code to show medical necessity for both services.

4. Remember to report any separate E/M service with modifier 25. Example: A 68-year-old Medicare patient comes in for a flu shot and examination of a sprained ankle. The nurse administers an intramuscular, preservative-free vaccine, and the doctor renders a level-two established patient E/M service to evaluate and treat the ankle. Report 90656 linked to V04.81 for the flu shot, and 99212 linked to the appropriate diagnosis code for the E/M visit. Then

append modifier 25 to 99212 to ensure payment of both services. You do not need to report an administration code because you may only report G0008 to Medicare when there is no other billable service rendered during the encounter.