Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Reader Questions: Check Rules for Injection + E/M

Question: A payer denied our claim for an established patient office visit in addition to 96372. We appended modifier 25 and appealed but were denied again. What are we doing wrong?

Answer: If you're billing a payer that follows the Correct Coding Initiative (CCI), the edits bundle office visit codes 99212-99215 (Office or other outpatient visit for the evaluation and management of an established patient ...) into therapeutic injection code 96372 (Therapeutic, prophylactic, or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular).

Good news: If your documentation supports the office visit as significant and separately identifiable from the E/M associated with the procedure code 96372, you are allowed to override the edit with a modifier, such as modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service), as you did. Be sure you append modifier 25 to the E/M code, not the procedure code.

The payer may want to see the documentation supporting each separate service. Separate diagnosis codes aren't required, but coders report that separate diagnoses for each reported service can help to justify the claim.

Caution: The edit does not allow you to report 99211 (Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician ...) with 96372 under any circumstances. Medicare considers the 99211 service part of the relative value units included in 96372. Private payers may similarly bundle 99211 into 96372 and not allow you to report a 99211 service separately.

Also, be sure that 96372 is the most appropriate code for the injection. If you're providing a flu vaccine, for example, CPT provides more appropriate codes than 96372.

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