

Eli's Rehab Report

Supervision Reqs Can Make or Break 90772--Here's How

If you can't meet the standards, resort to no-charge

When you report 90772, you should make sure your psychiatrist's involvement meets the requirements for direct supervision. If not, the nonphysician-performed procedure [CPT 99211](#) shouldn't be your next choice.

Depending on your payers' incident-to policies, you may have to report a no-charge.

To determine which code applies, ask yourself the following questions:

1. Is the Doctor Available During the Injection?

If you can answer, "Yes, the psychiatrist provided direct supervision throughout the subcutaneous or intramuscular injection," you can report 90772 (Therapeutic, prophylactic or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular).

CPT adds this requirement in an instruction following 90772 that indicates you should "not report 90772 for injections given without direct physician supervision."

If the injection administration encounter does not meet the direct-supervision criteria, you should instead 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), according to CPT's further instructions following 90772.

"CPT's direct-supervision example is consistent with CMS' direct-supervision guidelines as defined in the Medicare Carriers Manual 2050.1," says **Quinten A. Buechner, MS, MDiv, CPC**, president of ProActive Consultants LLC in Cumberland, Wis.

Translation: The physician must be in the office setting and immediately available.

The requirement does not mean the psychiatrist must be present in the exam room during the procedure to bill 90772, says **Babette Christofferson, CCS-P**, coding and billing specialist at Scottsbluff Psychiatry Associates and Regional Neurology Services in Scottsbluff, Neb.

Red flag: "This level is higher than the general supervision requirement [physician available by phone] that therapeutic shots required in 2005," Buechner says.

2. Does Documentation Support MD's Presence?

Without supporting documentation that shows the psychiatrist was in the office and immediately available, you should consider coding a nurse visit instead of injection administration.

Remember: The direct-supervising psychiatrist does not have to be the physician who created the standing order. But to avoid reporting 90772 incorrectly, make sure documentation can prove the physician's presence.

Best practice: "Have a stamp made that indicates 'Direct supervision by,'" says **Barbara J. Cobuzzi, MBA, CPC, CPC-H, CHBME**, president of CRN Healthcare Solutions, a coding and reimbursement consulting firm in Tinton Falls, N.J.

The nurse can then write which psychiatrist was present during the injection administration. If Medicaid or another insurer requests documentation supporting direct supervision or audits your 90772 claims, the chart note will substantiate your charge.

The scheduling record should also show which psychiatrist was present in the office suite during the injection administration.

3. Is 99211 OK With Lower-Level Supervision?

When a psychiatrist provides injection administration under general supervision, you should report 99211 instead of 90772 if the procedure meets your payers' incident-to rules. "You should check an insurance company's incident-to rules before using 99211 without direct physician supervision," Cobuzzi says.

Example: A patient presents with moderate post-procedure pain. A psychiatrist performing rounds at a rehab hospital talks to the patient over the telephone and sends the patient to his office for an injection. The office nurse administers 60 mg of Toradol, an injectable non-steroidal anti-inflammatory.

In this situation, you should use 99211 instead of 90772, according to CPT rules. The procedure does not meet the direct-supervision requirement because the physician is not present in the office suite.

But CPT's 99211 directive could contradict insurers' incident-to requirements. "Although some payers follow CPT's more liberal rules and allow 99211 without direct supervision, CMS requires the physician provide direct supervision to bill a service incident-to," Cobuzzi says.

The lowdown: Reporting 99211 for the above Toradol injection scenario hinges on the insurer's incident-to requirements. If the payer follows Medicare policies, you should treat the injection as a no-charge service, Christofferson says. You would code neither 90772 nor 99211. If your office provides the 60 mg of Toradol, assign four units of J1885 (Injection, ketorolac tromethamine, per 15 mg).