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Psychiatry Coding & Reimbursement Alert

Reader Question: Avoid Confusion Over Drug Administration and Management

Question: When our psychiatrist provides a psychotropic injection in our facility, what codes do I have to report for the procedure? Should I use 90862 or 96372? Also, should the drug that was used for the administration be reported separately?

Colorado Subscriber

Answer: For patients covered by Medicare and other commercial providers, you will have to report administration of any psychotropic drugs with 96372 (Therapeutic, prophylactic, or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular), assuming the route of administration was subcutaneous or intramuscular.

If a significant and separately identifiable E/M service was provided, you can also report the appropriate code for the E/M service, although you will need to append the modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the E/M code that you are reporting. This is necessary because Correct Coding Initiative (CCI) edits prevent you from reporting an office visit E/M code (99201-99205 and 99212-99215) with 96372 unless a suitable modifier is appended to the E/M code. The CCI edits do no permit 99211 to be reported with 96372, even with a modifier.

The CPT® code 90862 (Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy) is concerned with the pharmacological management of psychotropic medications, which means that it has to be used when your psychiatrist is trying to review the effects of a prescribed drug. It is also used when your psychiatrist studies the efficacy of the medication, any adverse effects, and determining dosage adjustments during subsequent visits rather than for the actual administration of a drug. So, to cover the drug administration, you will need to use 96372 and not 90862.

Along with reporting the drug administration with 96372, you also have to report the code for the drug. So you will have to use the appropriate J code to report the drug. If the drug is being provided from elsewhere and is not coming from your facility (i.e., the drug itself does not represent an expense to you), you will need to append the modifier FB (Item provided without cost to provider, supplier or practitioner, or full credit received for replaced device [examples, but not limited to, covered under warranty, replaced due to defect, free samples]) to the J code to indicate to the payer that you are not incurring any cost for the drug that needs to be reported and would otherwise be separately reimbursed.

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