CODING Q&A

Consult Codes, Injection Codes, and Coding for Diabetes Education and In-House Dispensing

DAVID STERN, MD, CPC

Q. My codes for consults seem to suddenly be getting denied as invalid. I checked my CPT book, and the codes are still listed as valid. What's going on?

– *Question submitted by multiple urgent care billers*

A. Yes, you are right that the consultation codes (99241-99245, 99251-99255) are still valid per CPT, as published by the AMA. CMS, however, has decided to no longer reimburse for these codes and has now changed the status indicator to an "I" (invalid for Medicare). Some other payors have decided to follow suit. Instead of billing consult codes, physicians should code either a new patient visit code (99201-99205) if the patient visit meets new patient criteria or an established patient visit code (99211-99215) if the patient visit does not meet new patient criteria. Medicare will not convert a consultation code to a standard physician office E/M code. Instead, Medicare will simply deny the code.

This change will result in a significant loss of revenue for specialist physicians, many of whom have frequently coded consult codes in the past. In the urgent care setting, however, these codes have rarely been used. When used in urgent care, these codes were usually coded for preoperative clearance exams.

You may ask individual payors if they plan to follow suit. Even if payors tell you that you may continue to bill these codes, if you decide to continue billing them to non-government payors, you should watch closely for denials. Individual payors have a tendency to follow Medicare's lead, especially when it can result in savings to the payor. Many payors that are currently reimbursing for consult codes may discontinue this reimbursement without warning to providers.

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Q. How is it legal for Medicare to deny these codes when these codes remain perfectly valid CPT codes.

– *Question submitted by multiple urgent care billers*

A. You are right; at least for now, the consultation codes do remain in the CPT book. Any specific payor, however, may make an individual decision to discontinue payment for certain valid CPT codes. Unlike non-government payors, however, Medicare has a very public and complicated process to change reimbursement. Even so, Medicare, may unilaterally decide (without appealing to or waiting for a corresponding change in CPT by the AMA) to eliminate payment for any existing CPT codes.

Q. I was reading through a previous issue of *JUCM* and read a statement that when charging J2550 (phenergan) it is also appropriate to bill the injection code 96372. Does this apply to all J codes that are injections? I assume we can charge this code if no other services were billed and the visit was for a therapeutic injection only. I have been told, however, that if you bill an E/M to insurance, then the injection is included in the E/M. Is this true?

– *Question submitted by Jennifer Smith, CPC, Sisters of Mercy Urgent Care, Asheville, NC*

A. You may use the injection code (96372) for any injection that meets the definition—i.e., "Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular."

In general, payors do not include the injection code in the E/M. It should be separately coded and separately payable. For Medicare (and some other payors), however, you must add modifier -25 to the E/M code when you code an injection

code on a claim. Missing modifier -25 will cause denials, so these denials have caused some coders to mistakenly assume that the injection code is bundled into the E/M.

Q. Our practice runs a program for diabetes patients. The patients see the nurse and fill out a diabetes questionnaire. Can we bill a 99211? The documentation has a brief history, a medication list, and some education (if needed). Is this sufficient to code a 99211?

– *Question submitted by Marianela C., Community Health Centers, Inc, Apopka, FL*

A. Some of the visits that you describe may meet the criteria to code a 99211. If the nurse documents a history, vital signs, specific diabetes education, and a plan for treatment and follow-up, this may be adequate for coding a 99211. Remember, in order to code the 99211 compliantly, the patient must have previously had a face-to-face encounter with a provider in the practice to be an established patient, and the rendering physician must be on site at the time this visit occurs.

Q. We just opened an urgent care facility in Florida. We dispense medication if the patient chooses to purchase meds here instead of at the pharmacy. My biller is having trouble finding the correct G or J codes to correspond to the meds to show on the claim form it was purchased by the pt. So far, we've found J0456 for Z-Pak and G0778 for ciprofloxacin. Can you tell us where we can find the rest of the codes for oral medications?

– *Name withheld*

A. Oral meds do *not*, generally, have corresponding HCPCS codes and are generally *not* coded nor billed to private health insurance. For billing these medications to third parties, which is mainly done for worker compensation cases, you should use the appropriate NDC code. The NDC code is unique for each medication for each manufacturer. Thus, you need to watch the code used carefully, as penicillin from one manufacturer will have a different NDC code than penicillin from another manufacturer, and some suppliers may change manufacturers without notice.

Many patients have separate pharmaceutical insurance, but billing to this insurance generally is done only by pharmacies. There are a few pre-packaged medication companies that will set you up as a pharmacy and bill these medications to the patient's pharmaceutical insurance. In many cases, this is not cost effective, as it takes much labor to enter the patient's information, and reimbursement by insurance payors for these medications is quite is typically quite low. There are no CPT or HCPCS codes for pre-packaged medications. The two codes that you have found are *not* billing codes for pre-packaged medications.

J0456 is the code for injectable azithromycin, not oral Z-Pack (azithromycin). Using this code for a Z-Pack would be incorrect and noncompliant.

G0778 looks like it is an HCPCS code, but it is not. It is a proprietary identification code used by some pre-packaging companies for internal identification of ciprofloxacin bottle, containing 20 tablets of ciprofloxacin. This code should not be billed to a payor, as it is not a valid code for billing.

I encourage you to attend specialized coding classes or obtain the services of an expert coder/biller. Errors in billing and coding are among the most frequent causes for financial difficulties in opening a new urgent care center. ■

terial infection, with four separate types of errors. Other studies are needed to assess the potential avoidability of this type of death. ■

Effect of Pneumococcal Conjugate Vaccine on Incidence of Empyema

***Key point:** The annual empyema-associated hospitalization rates increased almost 70% between 1997 and 2006.*

Citation: Li ST, Tancredi DJ. Empyema hospitalizations increased in U.S. children despite pneumococcal conjugate vaccine. *Pediatrics*. 2010;125(1):26-33.

The purpose of this study was to determine if the incidence of empyema among children in the United States has changed since the introduction of the pneumococcal conjugate vaccine in 2000.

During 2006, an estimated total of 2,898 hospitalizations of children ≤18 years of age in the United States were associated with empyema.

The empyema-associated hospitalization rate was estimated at 3.7 per 100,000 children, an increase of almost 70% from the 1997 empyema hospitalization rate of 2.2 per 100,000.

The rate of complicated pneumonia (empyema, pleural effusion, or bacterial pneumonia requiring a chest tube or decortication) increased 44%, to 5.5 per 100,000.

Among children ≤18 years of age, the annual empyema-associated hospitalization rates increased almost 70% between 1997 and 2006, despite decreases in the bacterial pneumonia and invasive pneumococcal disease rates. ■