

CODING & DOCUMENTATION

Cindy Hughes, CPC

Joint injection + E/M service?

Q I was taught that for injections of major joints such as the knee or shoulder, insurance companies generally will pay for an office visit or the injection (CPT code 20610) but not both. For example, if a patient comes in with impingement syndrome of the shoulder and I do a steroid injection, I customarily code 20610 plus the CPT code for the corticosteroid medication administered – omitting the office visit code because the injection code pays more. Is this the best approach?

A The joint injection codes are assigned a zero-day global period, which means that an evaluation and management (E/M) service should not be billed on the same date. This is because the procedure was valued to include the initial assessment and other pre-service work. However, when the E/M service is significant and separately identifiable from the typical pre-service work of providing the injection, the E/M service may be separately reported with modifier 25 attached. An E/M service should not be billed for a planned injection service where the patient presents with no complication or new problem.

Your Medicare Administrative Contractor and private payers may provide additional guidance on this subject. For instance, Cigna Government Services and Trailblazer Health have published guidance that says providers are allowed to bill for an appropriate E/M service if they decide to start the series of injections after evaluating the patient during the same visit and their documentation supports the level of E/M service billed.

Annual wellness visits and Part D vaccines

Q Tdap and herpes zoster vaccines are indicated for Medicare patients but are not among the elements Medicare considers part of the

annual wellness visit. What is the best approach to providing and billing for these vaccines?

A These vaccines are covered only under Medicare Part D prescription plans. You can either provide the patient with a prescription to receive these from a pharmacy that participates with the patient's Part D plan, sign up to be a provider of Part D vaccines and receive payment directly, or provide the vaccines as an out-of-pocket cost to the patient and provide the patient a claim form to submit to the Part D plan for any benefits payable for out-of-network services. (More information is available on the AAFP web site at <http://bit.ly/qPWLKC>.)

The Centers for Medicare & Medicaid Services (CMS) have developed a quick reference chart for the annual wellness visit that may be helpful: http://www.cms.gov/MLNProducts/downloads/AWV_Chart_ICN905706.pdf.

Newborn heel stick

Q What is the CPT code for a heel stick for a bilirubin and PKU on a newborn?

A It is 36416, "Collection of capillary blood specimen (e.g., finger, heel or ear stick)." This code is also often reported in conjunction with screening for lead. Medicare has assigned this code a "B" status, meaning it is always bundled with other services on the same date, but many Medicaid plans provide separate payment due to state mandates for lead screening in children. Private payers may or may not bundle this with other services on the same date; check with those you contract with.

Editor's note: While this department attempts to provide accurate information, some payers may not agree with our advice. You should refer to the current CPT and ICD-9 coding manuals and payer policies. **FPM**

About the Author

Cindy Hughes is the AAFP's coding and compliance specialist and is a contributing editor to *Family Practice Management*. Author disclosure: no relevant financial affiliations disclosed. These answers were reviewed by the FPM Coding & Documentation Review Panel, which includes Robert H. Bösl, MD, FFAFP; Marie Felger, CPC, CCS-P; Thomas A. Felger, MD, DABFP, CMC; David Filipi, MD, MBA, and the Coding and Compliance Department of Physicians Clinic; Emily Hill, PA-C; Kent Moore; Joy Newby, LPN, CPC; P. Lynn Sallings, CPC; and Susan Welsh, CPC, MHA.

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