Internal Medicine Coding Alert

Optimize Payment for Vitamin B-12 Injections

"Although coding for vitamin B-12 injections is not complicated, internists may have difficulty getting reimbursed for the treatment because the patient has exceeded the frequency limits for the injection or because a noncovered diagnosis code was used to establish the medical necessity of the injection. Under certain circumstances, internists may be able to bill a higher-valued evaluation and management (E/M) service instead of billing for the administration of the vitamins injection.

Vitamin B-12 injections are used to treat conditions such as certain types of anemia or intestinal malabsorption. Patients without these conditions, however, often will request an injection from their internist because they have an unspecified feeling of fatigue or sluggishness conditions that generally are not covered by Medicare.

There are a lot of patients who request a vitamin
B-12 injection because theyre feeling tired or just not feeling very well, says **Sandi Scott, CPC,** director of coding at the Mission Internal Medicine Group in Mission Viejo, Calif. Those arent approved diagnoses for the vitamin B-12 treatment, however, and will probably be denied by Medicare.

Medicare Limits to Once a Month

A news brief in the June 2000 California Medicare Bulletin also points to another source of reimbursement trouble for internists the frequency limitation of one vitamin B-12 injection per month for maintenance treatment that has been established by Medicares national policy. After recently processing many claims for vitamin B-12 injections, the Medicare carrier in California referred to the national policy set forth in the Medicare Carriers Manual (MCM) that states, The accepted standard of medical practice in the maintenance treatment of pernicious anemia is one vitamin B-12 injection per month. The carrier then went on to emphasize that, Physicians and practitioners should be prepared to submit documentation with the claim when more than one vitamin B-12 injection is billed for the same patient per month.

When Medicare denies the service because its for a noncovered diagnosis or because the patient has already had a vitamin B-12 injection that month, Scott suggests that internists get the patient to sign a waiver before treatment is given. The waiver says that the patient agrees to pay for the service if it is denied by Medicare, she explains.

When coding for vitamin B-12 injections, the internist may bill for both the administration of the vitamin and the vitamin itself, according to Scott. HCPCS code J3420 (injection, vitamin B-12 cyanocobalamin, up to 1,000 mcg) should be used to report the vitamin dosage given to the patient. Code 90782 (therapeutic, prophylactic or diagnostic injection; subcutaneous or intramuscular) should be used to report the administration of the injection.

When the patient signs a waiver, modifier -GA (waiver of liability statement on file) should be attached to code 90782 to indicate to the carrier that the patient was advised that this service might be denied, Scott says.

When the internist bills the patient for the service, the Medicare fee schedule does not apply, and the internist can bill the customary fee for the injection. The internist also can bill the patient for the administration of the injection and any materials used.

Specify Type of Anemia in ICD-9 Code

Another reimbursement problem arises when the internist does not specify an anemia or other vitamin
B-12-related condition that is covered by the local carrier. The internist has to state in the patients medical record what type of anemia he or she has, Scott notes, because there are many types of anemia that are not covered by Medicare.

What is covered will vary significantly from carrier to carrier. Nationwide Medicare of Ohio and West Virginia lists the following as some of the covered ICD-9 codes in its local medical review policy: dietary deficiency (281.1), regional enteritis (555.0-555.9) and pancreatic steatorrhea (579.4). None of these codes, however, are covered in the local medical review policy of Empire Medicare Services of New Jersey, which additionally lists seven ICD-9 codes not included in the Ohio and West Virginia policy.

Report E/M Visit if Other Services Are Performed

Internists may be able to report an E/M visit with the vitamin B-12 injection if those services are in addition to the administration of the vitamin B-12. If the patient is only coming in for an injection, you can only bill for the administration of the injection with code 90782, Scott says. If the patient comes in to discuss his or her anemia or some other condition such as diabetes, the internist can bill for an E/M visit instead of the administration of the injection, which then becomes a part of the E/M service.

The level of E/M service billed will depend on the level of history, examination and medical decision-making that the internist performs with the patient. Code J3420 still can be reported in addition to the E/M service, says Scott. If a waiver for the injection has been obtained from the patient, the -GA modifier should be attached to the code for the vitamin and not the E/M visit, she notes. Medicare should reimburse for the E/M visit even if it denies the injection.

Editors note: Some payers may require the use of modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) with an E/M code in this situation.

Medicare Requirements for Code 99211

Because of a vignette published in the CPT manual that cites an office visit for a 73-year-old female, established patient with pernicious anemia for weekly
B-12 injection as a clinical example of E/M code 99211 (established patient office or other outpatient visit), internal medicine practices may try to report 99211 instead of 90782 when a nurse administers the injection. Even though code 99211 is the lowest level of E/M service, it has a higher relative value unit (RVU) than 90782.

There seems to be some disagreement, however, between CPT and Medicare regarding the appropriateness of using code 99211 to report injections. The MCM section 15502(D) states, CPT code 99211 cannot be used to report a visit solely for the purpose of receiving an injection which meets the definition of CPT codes 90782, 90783, 90784 or 90788. In addition, Medicare has established the following documentation requirements that must be met before code 99211 can be used:

The patients record needs to show medical necessity. A standing order to give the injection is not enough. The nurse needs to evaluate the patient for a specific problem. The internists involvement must be documented. Although the internist does not need to see the patient for a 99211 visit, the documentation must indicate that he or she provided some direction to the nurses service.

The nurse needs to document fully the office visit and have the internist sign off on it. Simply making a notation as to the lot number of the medication and the site where the injection was given is not enough documentation.

Because some private insurance companies adhere strictly to CPT coding principles, internists should check with their local payers to obtain specific instructions regarding how to code for this service."