# Eli's Rehab Report

## Reader Question: E/M With Injection

**Question:** When billing for an evaluation and management (E/M) service along with an injection code (20610), should the diagnosis for the injection be a pain code? Do we need to have two different diagnoses? Is this payer-specific?

California Subscriber

**Answer:** This might be carrier specific because some dictate that a single diagnosis garners one payment for the combination of an E/M service and a procedure, with no exceptions. Juggling the diagnosis e.g., designating knee pain (719.4) for the E/M and effusion (719.06) for the injection would not be appropriate and could create audit liability.

Other carriers strictly follow CPT guidelines. And according to CPT, you should be able to bill the E/M service in addition to the injection by using modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service). In this case, the diagnosis could be the same, for example, knee effusion. Proving that there is a significant enough difference between the E/M and the injection usually involves showing the carrier a new problem or a major exacerbation of an existing problem.

Carrier specificity, however, must be emphasized. For example, in Southern California, Medicare and most local carriers honor modifier -25 and do not require two diagnoses. They reject, however, when the medical record documentation indicates that the patient had been previously scheduled to return for an injection, but the doctor instead performed it with the E/M.