Follow these tips for compliant injection documentation

Anyone who has perused the 1995 or 1997 evaluation and management (E&M) guidelines knows that the rules for appropriately documenting E&M visits are extensive. But there are also rules you shouldn’t overlook for documenting procedures — even minor office procedures, such as injections.

With the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) and local carriers on the lookout for improper billing of these services, it’s a good idea for you and your providers to brush up on the requirements for injection billing.

A good place to start is with your carrier or Medicare administrative contractor (MAC) local coverage determination (LCD). Most of these policies include documentation requirements. For example, here are the documentation requirements from a CIGNA LCD for joint injections (L15602):

“Office records including procedure notes should be maintained. Medical necessity of the procedure(s) must be clearly documented and provided to Medicare upon request. The records must clearly indicate the specific anatomical site injected, the drug(s) used in the injections and, if appropriate, the number of injections given. Records must clearly state the medical necessity for repeat injections.”

Make sure you are following procedure-specific carrier documentation rules. Trailblazer, for example, requires the following in its pain management LCD (L26743):

“Preprocedural evaluation leading to suspicion of the presence of facet joint pathology must be explicitly documented in the patient’s medical records, along with postprocedural conclusions.

“When using code 729.1 with [current procedural terminology] codes 20552 and 20553 for trigger point injection, medical documentation must be clearly maintained noting the anatomic location of the injection site(s).”

In addition to LCDs, payers sometimes publish articles on the subject of documentation.

For example, a 2008 article on the National Government Services (NGS) Web site warns against illegible documentation and “cookie cutter” physician notes “where all patients are getting the same procedure, with the same complaint, the same findings and the provider is treating them all with the same exact plan of care” — a typical pitfall of some electronic medical records systems.

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As for injections, the NGS article suggests that your injection documentation answer the following questions:

- What was the medication and how much was injected?
- How was the medication administered?
- Where was it administered?
- Who administered the medication?
- Did the patient have a reaction to the medication?
- Was any medication discarded?
- Was it medically necessary?

see Code of Conduct, page 14

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Questions from MGMA members, answers from CustomCoder

Q: One of our doctors references “easy bruising” as a diagnosis and mentions that the patient has no memory of injury for her multiple bruises. I lean toward coding this diagnosis as 782.7, spontaneous ecchymosis. Am I correct?

A: Spontaneous bruising is different than easy bruising. Unless the note clearly states these bruises are appearing out of nowhere, you may want to clarify with the physician that he or she believes they are spontaneous.

People can get bruises without remembering a trauma, but that is different from getting them spontaneously. If not spontaneous this will be a generic code like 782.9, other symptoms involving skin and integumentary tissues.

Q: Can diagnosis code V70.0 (routine general medical examination at a health care facility) be the only diagnosis with 99318 (annual nursing facility evaluation) or should we use the reason(s) the patient is in the nursing facility?

A: Typically, the reason(s) co-morbidities and chronic conditions are listed is they are the focus of the exam. V70.0 implies more or less that the patient is healthy and just getting a screening.

Q: Can you bill for a repair of a dural tear during a lumbar surgery? For example, when the physician does a lumbar laminectomy, facetectomy and foraminotomy (63047) and then repairs a dural tear (63707)?

A: Not if done through the same incision/anatomical site or caused during performance of the original procedure. The 63707 is bundled with the 63047.

Q: What is the correct CPT code for a sternocostal joint block? The patient received bilateral injections into each sternocostal joint between the third and fifth.

A: This is most commonly reported with CPT 20600 (arthrocentesis, aspiration and/or injection; small joint or bursa, fingers, toes) unless clearly documented that this is a nerve block.