Codify
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Eli's Rehab Report

Keep Infusion Coding Accurate With G Codes

Use G0345-G0354 for therapeutic/diagnostic injections

For this year only, Medicare requires that you submit **HCPCS G codes** when reporting IV infusions and injections - a change that you'll notice when your reimbursement drops and your National Correct Coding Initiative hassles go up.

We've got the scoop on how you can navigate this coding annoyance without letting it get the better of you.

You'll see slightly less reimbursement from the G codes than you did from the CPT codes, but you will be able to bill them with some E/M services "with the expectation of full payment for both," says **Michael A. Ferragamo, MD, FACS**, clinical assistant professor at State University of New York, Stony Brook, New York.

According to Medicare, you have to use the G0347-G0354 series if your physician provides a therapeutic/diagnostic injection into:

1. subcutaneous or intramuscular tissue or
2. the vein or artery via an IV set-up (including saline with the drug, either as an additive or injected into the IV line).

The G codes do not, however, describe therapeutic or diagnostic drug administrations, applicable to non-chemotherapy agents.

Note: You can expect reimbursement from only one "initial" code per day, so you should choose the best code to describe the key service - regardless of the order in which the physiatrist performs the infusions or injections.

(Editor's note: Want to know more? For a chart listing the new HCPCS codes versus the existing CPT codes, e-mail me at suzannel@eliresearch.com.)

Don't Overlook Edits for These Codes

The new codes, G0345-G0354, may help your physical medicine and rehab practice obtain fair reimbursement for tough medications, but NCCI version 11.0 may make it hard for you to report them alongside other procedures - unless you can justify using a modifier.

For example, G0345 (Intravenous infusion, hydration; initial, up to one hour) and G0347 (Intravenous infusion, for therapeutic/diagnostic [specify substance or drug]; initial, up to one hour) will each become components of a shocking 5,687 codes. Luckily, NCCI assigns a status indicator of "1" to most of these edits, so you should be able to override them, when appropriate, with the correct modifier and suitable documentation. Exception: Be careful not to unbundled these codes from stereotactic lesion treatment code 77432 and lesion destruction code 67221.

Fifteen other codes, including E/M codes **CPT 99201** - **99215**, are now considered components of G0345 and G0347. Of those, only 99211 will be immune to modifiers.

It makes sense that you can't override edits governing 99211, because Medicare will only pay for "significant, separately identifiable" physician visits with chemotherapy or infusion, says **Cindy Parman, CPC, CPC-H, RCC**, co-owner of Coding Strategies in Atlanta.

Also, G0351 (Therapeutic or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular) will become a component of 560 codes, including 161 surgery codes, 101 radiology codes and 33 medicine codes. Code 90788 (Intramuscular injection of antibiotic [specify]) will become a component of G0351.

And code G0353 (IV push, single or initial substance/drug) will become a component of a startling 705 codes, including many from the surgery, radiology and medicine areas. You will be able to use a modifier to override these edits.

Bundling the injection/infusion codes with surgery and radiology codes also makes sense because the administration of contrast or other agents isn't separately payable, Parman says.