Eli's Rehab Report

NCCI 11.3 Update: Tap Into New Injection Edits or Face a Denial

Reporting a sub-q injection with an office visit? Think again

If you're reporting diagnostic/therapeutic injections and destruction/chemodenervation services, you'll want to pay extra attention to the latest batch of National Correct Coding Initiative (NCCI) edits.

These new injection edits, which took effect Oct. 1, are sure to have you changing your daily coding regimen.

Heed These Diagnostic/Therapeutic Injection Edits

Be careful when you're reporting diagnostic/ therapeutic injection codes (644xx and 645xx) because NCCI version 11.3 throws these codes into the work involved with destruction and chemodenervation codes. This edit doesn't come wholly unexpected because the CPT manual states, "Codes 64600-64681 include the injection of other therapeutic agents (e.g., corticosteroids)."

"Makes sense to me that it would be inappropriate to bill for basically numbing the nerve and then destroying it," says **Chris Felthauser, CPC, CPC-H, ASC-OH,** coding consultant at Orion Medical Services in Portland, Ore.

Keep in mind: All of these edits have a modifier indicator "1," which means you can separate this edit with a modifier as long as your documentation supports these services as being separate and distinct.

Example: If you physiatrist performs 64640 (Destruction by neurolytic agent; other peripheral nerve or branch) and also 64450 (Injection, anesthetic agent; other peripheral nerve or branch), you can append modifier 59 (Distinct procedural service) to 64450, given that your documentation proves that the physiatrist injected the anesthetic in a different peripheral nerve. The "two separate locations" mean you can make an argument for bypassing an edit, says **Ann K. Silvia, BS, CPC, EMS,** director of billing services, group one, at the American Health Network of Indiana LLC in Indianapolis.

No Modifier for IM injections and Nurse Visits

If your physiatrist administers intramuscular (IM) injections, you'll no longer be able to report the nurse visit separately. In one of the few edits with a "0" modifier indicator, you'll have to include the work involved with 99211 (Office or other outpatient visit for the E/M of an established patient ...) in the IM injection (90788, Intramuscular injection of antibiotic [specify]). There's no way to report a modifier to get around this edit. This may not affect your coding practice. For example, "we charge the injection code only when the patient is seen by a nurse and not a doctor," says **Sue Lodding,** office manager of Drs. Lorenzini, Senica & Bruneau Ltd. in Downers Grove, Ill.

Heads up: Depending on your provider's documentation, you may also report just G0351 (Therapeutic or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular) instead of E/M codes **CPT 99201** - **99205** (New patient visit ...) or 99212-99215 (Established patient visit ...). Code G0351 now contains the work involved with the E/M visit.

In the past: "Many times our physician would bill an office visit as well as a sub-q or IM injection," Silvia says. "It didn't matter if the E/M service was for the same or different problem ...quot; either case seemed to require an appeal for payment."

As of Oct. 1: If your provider did not provide a significant and separately identifiable E/M service and document it, you'll

only be able to report G0351. If the E/M visit is for a different problem than what the injection was given for, you may be able to override this edit with modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) on the E/M code because NCCI has given this pairing a modifier indicator of "1."

Eye the IDET Edit

NCCI has landed IDET code 0062T (Percutaneous intradiscal annuloplasty, any method, unilateral or bilateral including fluoroscopic guidance; single level) with a Medicare-specific edit. You'll have to consider G0351 and intravenous push codes G0353-G0354 already included--but most Medicare carriers consider the IDET procedure to be not medically reasonable and necessary in any case.

"We currently do not have any carriers covering the IDET procedure," Felthauser says. "Patients pay out of pocket for this service."