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Eli's Rehab Report

NCCI 11.2 Update: Maintain Steady Cash Flow With 4,000 G Code Edits

Warning: Edits could be a result of widespread abuse

Rehab coders everywhere: Tread carefully when reporting G codes for infusion. The National Correct Coding Initiative, version 11.2, has dropped thousands of new bundles on your doorstep, and your claims should already be incorporating them.

According to NCCI, injection code G0351 (Therapeutic or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular) is a component of 4,531 codes, and intravenous push codes G0353-G0354 are components of 4,833 codes.

What this means for you: Don't expect payment for the G codes along with most of CPT's injection and destruction procedures. All of the G code edits have a modifier indicator of "1," meaning that only in certain circumstances you may override these edits - just as long as the injection procedure is not related to the surgical procedure and you have the documentation to prove it.

For example, if your physiatrist gives a Medicare patient an IM injection of steroids , you would report code G0351.

Heads up: As you probably know by now, you should avoid using G0351 (or the CPT equivalent, 90782, Therapeutic, prophylactic or diagnostic injection [specify material injected]; subcutaneous or intramuscular) as a catchall injection code. "We don't usually report this code anyway because most of the time, it's denied or bundled," says **Alfred Anderson, MD**, a pain management specialist at Pain Assessment & Rehabilitation Center Ltd. in Edina, Minn. "We do charge for medication though."

As for the reason NCCI has lashed edits onto these G codes, payers are considering an injection to be an inherent part of most procedures, says **Dawn Hopkins,** senior manager for reimbursement with the Society for Interventional Radiology. Either CMS is seeing "widespread abuse" of the new injection G codes by physicians trying to bill for them with many procedures, or this is a precaution.

CMS may simply be trying to block all of the code combinations that haven't been commonly used so far, because they assume nobody ever bills them together, she says. NCCI gave these edits a modifier indicator of "1," so if the situation warrants it, you may be able to use a modifier to override those edits.

Experts warn: Some manufacturers and vendors insist that you may report G codes in addition to the procedural codes for their products, but your payer may not agree, says **Cindy Parman, CPC, CPC-H, RCC**, co-owner of Coding Strategies Inc. in Powder Springs, Ga., and president of the AAPC National Advisory Board. **Best bet:** Keep track of each payer's preferences.

Don't miss: Codes G0351 and G0353 (Intravenous push, single or initial substance/drug) are now components of the lowest established patient visit (99211). You won't be able to use a modifier to override those edits, because NCCI gave these a modifier indicator of "0."

For example, if a Medicare patient presents to your office and requires a tetanus shot, you should not report G0351 separately from 99211. You should simply report 99211.

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