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Internal Medicine Coding Alert

E-Prescribing: G8553: Techniques for Solid Claims Success

Check filing dates and charge guidelines to smooth processing every time.

HCPCS doesn't include specific guidelines for reporting G8553, which makes some coders wonder if they're using it correctly. Here's how to know that you're filing correctly, including charging the correct amount and adding the most pertinent details to your claim.

Step 1: Verify G8553 Applies to the Patient

You'll turn to code G8553 (Prescription[s] generated and transmitted via a qualified erx system) when reporting e-prescriptions. Don't automatically report it for any patient your physician orders an e-prescription for, however. Code G8553 only applies to Medicare patients. Add it to your claim anytime the physician e-prescribes a medication for a Medicare patient during a visit with that patient.

Step 2: Include G8553 With Encounter Code

Code G8553 only applies to e-prescriptions ordered during an encounter with the patient. Typically, this is an office visit. Include G8553 with office codes such as 99202-99205 (Office or other outpatient visit for the evaluation and management of a new patient ...) or 99212-99215 (Office or other outpatient visit for the evaluation and management of an established patient ...). Report the same diagnoses with G8553 that you use for the office visit.

"The medication you report with G8553 must be e-prescribed the same day as the office visit," says **Sharron Thomas,** business office manager for The Family Doctors in Shreveport, La. "The provider has to see the patient -- you cannot use G8553 for your call-in refills for the day."

Tip: You don't have to list the specific medication prescribed when you submit G8553. If an audit occurs later, your backup documentation will be in the patient's medical record.

Step 3: Watch the Timing and Charges

The G code needs to be on the claim with any other charges for that day, Thomas adds. "You can't go back and bill for G8553 after the claim has been sent in," she says.

Although Medicare views G8553 as a "reporting purposes" code, you may still need to submit a minimal charge, depending on your clearinghouse requirements.

Example: "Our clearinghouse says we have to charge $0.01 or the claim will not be processed," says **Barbara Suchon,** office manager for Dr. Richard Andolsen in Healdsburg, Ca. In other cases, your billing software might require a monetary value on the charge line before the claim can leave the clearinghouse.

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