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Internal Medicine Coding Alert

What the New G Codes Mean For Your Bottom Line

Bonus: Here's how to get paid for same-day injections and E/M services

This year, you can prevent denials for your internist's injections if you know which new G codes to report instead of 90782-90784, and if you know how to code sequential push injections.

On Jan. 1, Medicare introduced temporary codes G0351-G0354 to represent therapeutic and sequential injections.

These new codes replace CPT's 90782-90784, according to the Nov. 15, 2004, Federal Register. Check with your commercial carrier to find out if it will accept the G codes. Some private payers may still accept 90782-90784, but you should not report the codes to Medicare for any injection service in 2005.

"However, CPT 90783 (Therapeutic, prophylactic or diagnostic injection [specify material injected]; intra-arterial) and 90788 (Intramuscular injection of antibiotic [specify]) remain in effect" for this year, says **Laura Siniscalchi, RHIA, CCS, CCS-P, CPC**, manager of Deloitte & Touche's Healthcare & Life Sciences Regulatory in Boston.

For example, suppose the internist or nurse administers a B-12 injection (J3420, Injection, vitamin B-12 cyanocobalamin, up to 1,000 mcg) to a Medicare patient. You would list G0351 (Therapeutic or diagnostic injection; subcutaneous or intramuscular), not CPT's 90782 (... subcutaneous or intramuscular), which G0351 replaces.

Note: Don't get too attached to these codes. CPT will release new injection codes in 2006, which means Medicare will likely delete the G codes after 2005, coding experts say.

Get Your Reimbursement Update

Because the Medicare Modernization Act reduced the transitional payment adjustment to 3 percent in 2005, the new injection codes will offer less reimbursement than their CPT counterparts did last year.

For example, G0351 pays $19, whereas 90782 paid $25 in 2004.

Even so, the new G codes are supposed to increase reimbursement, says **Kristi White, CPC,** a coding and reimbursement specialist at the Rockford Clinic in Illinois.

How? Prior to 2005, Medicare would pay for codes 90782-90788 only when the physician did not bill any other services on the same day, Siniscalchi says. But now you can report G0351-G0354 and 90783 and 90788 in addition to another payable service, such as an E/M visit.

Remember the 99211 Exception

"Evaluation and management codes other than 99211 may be separately paid when reported with a -25 modifier, but documentation will have to support an evaluation and management service over and above the injection and/or infusion," Siniscalchi says.

You can't report 99211 in addition to the injection codes because Medicare includes 99211's relative value units with injection-code payment.

Coding tip: You should report an additional E/M code only when the patient sees the physician, not when the patient presents to the nurse just for an injection, White says.

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How it works: Your internist bills for an intravenous push injection of Demerol (J2175) and a level-three established-patient office visit. In this case, you would report G0353 (Intravenous push, single or initial substance/drug), drug code J2175 (Injection, meperidine HCl, per 100 mg) and 99213-25 (Office or other outpatient visit for the E/M of an established patient...; significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service).

Be sure the documentation supports the physician billing a separate, distinct office visit.

When the physician bills an additional intravenous push of a nonchemotherapy drug, you should use new code G0354 (... each additional sequential intravenous push) in addition to G0353. Previously, CPT had no code to reflect sequential pushes.

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