Coding Trends for Infusions and Injections

Lynn M. Anderanin, CPC,CPC-I,COSC
AHIMA Approved ICD-10-CM Trainer

Today’s Agenda

• Infusions
• Injections
• Drugs
Infusions

3 categories of CPT codes for chemotherapy and nonchemotherapy infusions

- Hydration-96360-96361

- Therapeutic, prophylactic, and diagnostic infusions - 96365-96371

- Chemotherapy administration-96409-96417
  • Intra-Arterial and Other- 96420-96425

All Infusions

Items are included and are not separately billable:
1. Use of local anesthesia;
2. IV start;
3. Access to indwelling IV, subcutaneous catheter or port;
4. Flush at conclusion of infusion; and
5. Standard tubing, syringes and supplies.
6. Preparation of chemotherapy agent(s).

2012 CPT Professional, page 517
Hydration

- The hydration codes are used to report a hydration IV infusion which consists of a pre-packaged fluid and/or electrolytes but are not used to report infusion of drugs or other substances.
  - normal saline
  - D5-1/2 normal saline +30 mg EqKC1/liter
- Should not be used for purpose of IV fluids to “keep open” IV line

  2012 CPT Professional, page 518-519

Infusions

- Therapeutic, prophylactic, or diagnostic IV infusion.
- Fluid used to administer the drug(s) is incidental hydration and is not separately payable.

  2012 CPT Professional, page 519
What’s included in Chemotherapy?

• Chemotherapy administration codes apply to parenteral administration of non-radionuclide anti-neoplastic drugs; and also to anti-neoplastic agents provided for treatment of noncancer diagnoses (e.g., cyclophosphamide for autoimmune conditions) or to substances such as monoclonal antibody agents, and other biologic response modifiers. The following drugs are commonly considered to fall under the category of monoclonal antibodies: infliximab, rituximab, alemtuzumab, gemtuzumab, and trastuzumab. Drugs commonly considered to fall under the category of hormonal antineoplastics include leuprolide acetate and goserelin acetate.

  ➢ 2012 CPT Professional, page 520

Physician Initial Service

• Initial infusion is the key or primary reason for the encounter, regardless of the order of administration

• Only one “initial” service code is billed per day, unless the patient condition or protocol requires two IV lines per protocol. For these separately identifiable services, instruct the physician to report with modifier 59.

  ➢ 2012 CPT Professional, page 518
Facility Initial Service

- Initial service based on hierarchy
  - Chemotherapy
  - Therapeutic
  - Prophylactic
  - Diagnostic
  - Hydration

- Only one “initial” service code is billed per day, unless the patient condition or protocol requires two IV lines per protocol. For these separately identifiable services, instruct the physician to report with modifier 59.

  ➢ 2012 CPT Professional, page 518

Concurrent Infusions

- The CPT includes a code for a concurrent infusion in addition to an intravenous infusion for therapy, prophylaxis or diagnosis. Allow only one concurrent infusion per patient per encounter. Do not allow payment for the concurrent infusion billed with modifier 59 unless it is provided during a second encounter on the same day with the patient and is documented in the medical record.
Additional Hour

• The physician may report the infusion code for “each additional hour” only if the infusion interval is greater than 30 minutes beyond the 1 hour increment. For example if the patient receives an infusion of a single drug that lasts 1 hour and 45 minutes, the physician would report the “initial” code up to 1 hour and the add-on code for the additional 45 minutes.

Other Medication For Cancer Patients

• The administration of anti-anemia drugs and anti-emetic drugs by injection or infusion for cancer patients is not considered chemotherapy administration.

➢ 2012 CPT Professional, page 519
## Non Facility Chemotherapy Example

### Services Rendered
1. 1 hour of hydration
2. 1 hour chemotherapy infusion of Drug 1
3. 45 minutes of chemotherapy infusion of Drug 2
4. 10 minutes infusion of chemotherapy Drug 3

### CPT Codes
- 96413-Drug 1
- 96361-hydration
- 96417-Drug 2
- 96420-Drug 3
- Drugs

## Non Facility Therapeutic Infusion

### Services Rendered
1. 1 hour infusion of drugs 1 and 2
2. 45 minute infusion of drug 3
3. 1 hour and 45 minutes of hydration

### CPT Codes
- 96365
- 96361 X 2
- 96367
- 96368
- Drugs
### Infusion Table

<table>
<thead>
<tr>
<th>Infusion Type</th>
<th>Intravenous</th>
<th>Intra-arterial</th>
<th>Subcutaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>96413</td>
<td>96222</td>
<td>95420</td>
</tr>
<tr>
<td>Additional infusion</td>
<td>96445</td>
<td>96243</td>
<td></td>
</tr>
<tr>
<td>Additional prolonged drug</td>
<td>96445</td>
<td>96242</td>
<td></td>
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<tr>
<td>Single drug</td>
<td>96449</td>
<td>96221</td>
<td></td>
</tr>
<tr>
<td>Subsequent drug</td>
<td>96442</td>
<td>96222</td>
<td></td>
</tr>
<tr>
<td>Concurrent infusion</td>
<td>96221</td>
<td>96222</td>
<td></td>
</tr>
</tbody>
</table>

### Visits and Infusions

If a significant separately identifiable evaluation and management service is performed, the appropriate E & M code should be reported utilizing modifier 25 in addition to the chemotherapy administration or nonchemotherapy injection and infusion service. For an evaluation and management service provided on the same day, a different diagnosis is not required.

- 2012 CPT Professional, page 517
Venous Access Irrigation

• Pay for code 96523, “Irrigation of implanted venous access device for drug delivery systems,” if it is the only service provided that day. If there is a visit or other chemotherapy administration or nonchemotherapy injection or infusion service provided on the same day, payment for 96523 is included in the payment for the other service.

Wikipedia Says An Injection Is...........

“Infusion method of putting fluid into the body, usually with a hollow needle and a syringe which is pierced through the skin to a sufficient depth for the material to be forced into the body.”
Some Methods Of Injection

- Intra-arterial
- Intradermal
- Intramuscular
- Intraosseous
- Intraperitoneal
- Intravenous
- Joint
- Subcutaneous
Push Technique

- Intravenous or intra-arterial push is defined as:
  a) an injection in which the healthcare professional who administers the substance/drug is continuously present to administer the injection and observe the patient, or
  b) an infusion of 15 minutes or less.

Injections

- 96372 Therapeutic, prophylactic, diagnostic, subcutaneous or intramuscular
  - 96373- intra-arterial
- 96374 Intravenous push, single or initial
  - 96375- each additional sequential push of new substance/drug
  - 96376- each additional sequential push of same substance/drug
- 96379- Unlisted Therapeutic, prophylactic, diagnostic, intravenous or intra-arterial injection or infusion
Chemotherapy Injections

• 96401- subcutaneous or intramuscular; non-hormonal anti-neoplastic
  – 96402- hormonal anti-neoplastic
• 96405- intralesional, up to and including 7 lesions
  – 96406- intralesional, more than 7 lesions
• 96409- intravenous push, single or initial
  – 96411- intravenous push, each additional

Vaccines and Toxoids

• Administration- 90460-90474

• Vaccines/Toxoids- 90476-90749
  – New codes released January 1, July 1
  – AMA website publishes new codes
Administration

• 90460- patient up to 18 years of age, physician or other qualified healthcare professional counseling, first or only vaccine or toxoid
  – 90461- each additional component
• 90471- Immunization, 1 vaccine
  – 90472- each additional vaccine
• 90473- Immunization by intranasal or oral route
  – 90474- each additional vaccine

Carpal Tunnel

Diagnosis 354.0

20526 - Injection, therapeutic (e.g., local anesthetic, corticosteroid), carpal tunnel

If imaging guidance is performed, see 76942, 77002, 77021
Dupuytren’s Contracture 2012

Diagnosis-728.6

**Day 1**
- 20527- Injection enzyme (eg, collagenase), palmar fascial cord
- J0775- Xiaflex™ (collagenase clostridium histolyticum)

**Day 2**
- 26341- Manipulation

Tendon Sheath Injections

20550 - Injection(s); single tendon sheath, or ligament, aponeurosis (e.g., plantar "fascia")

20551 - Injection(s); single tendon origin/insertion
Trigger Point Injections

20552 - Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)

20553 - Injection(s); single or multiple trigger point(s), 3 or more muscle(s)

Joint Injections

20600 - Arthrocentesis, aspiration and/or injection; small joint or bursa (e.g., fingers, toes)

20605 - Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)

20610 - Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa)
Other Musculoskeletal Injections

20612 - Aspiration and/or injection of ganglion cyst(s) any location

20615 - Aspiration and injection for treatment of bone cyst

Neurolytic Substance
Subarachnoid and Epidural Injections

62280 - Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; subarachnoid

62281 - epidural, cervical or thoracic

62282 - epidural, lumbar, sacral (caudal)
**Epidural or Subarachnoid Injections**

62310 - Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic

62311 - lumbar, sacral (caudal)

**Injection with Catheter**

62318 - Injection(s), including catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic

62319 - lumbar, sacral (caudal)
Nerve Blocks

64400-64455-Injection of anesthetic agent

• Specific nerves
• Continuous infusion by catheter
• Can be reported bilateral, when appropriate

Transforaminal Epidural with Guidance

64479 - Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level

64480 - cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transforminal Epidural with Ultrasound Guidance</td>
<td>0228T</td>
</tr>
<tr>
<td>0228T - Injection(s), anesthetic agent and/or steroid, transformaminal epidural, with ultrasound guidance, cervical or thoracic; single level</td>
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</tr>
<tr>
<td>0229T – cervical or thoracic, each additional level (List separately in addition to code for primary procedure)</td>
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</tr>
<tr>
<td>Transforminal Epidural with Guidance</td>
<td>64483</td>
</tr>
<tr>
<td>64483 - Injection(s), anesthetic agent and/or steroid, transformaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level</td>
<td></td>
</tr>
<tr>
<td>64484 – lumbar or sacral, each additional level (List separately in addition to code for primary procedure)</td>
<td></td>
</tr>
</tbody>
</table>
Transforminal Epidural with Ultrasound Guidance

0230T - Injection(s), anesthetic agent and/or steroid, transformaminal epidural, with ultrasound guidance, lumbar or sacral; single level

0231T - lumbar or sacral, each additional level (List separately in addition to code for primary procedure)

Paravertebral Facet with Guidance

64490 - Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level

64491 – cervical or thoracic, second level (List separately in addition to code for primary procedure)

64492 – cervical or thoracic, third and any additional level(s) (List separately in addition to code for primary procedure)
Paravertebral Facet with Ultrasound Guidance

0213T - Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; single level

0214T – cervical or thoracic, second level (List separately in addition to code for primary procedure)

0215T – cervical or thoracic, third and any additional level(s) (List separately in addition to code for primary procedure)

Paravertebral Facet with Guidance

64493 - Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level

64494 – lumbar or sacral, second level (List separately in addition to code for primary procedure)

64495 – lumbar or sacral, third and any additional level(s) (List separately in addition to code for primary procedure)
**Paravertebral Facet with Ultrasound Guidance**

0216T - Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; single level

0217T – lumbar or sacral, second level (List separately in addition to code for primary procedure)

0218T – lumbar or sacral, third and any additional level(s) (List separately in addition to code for primary procedure)

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**Sympathetic Nerve Blocks**

64505-64530

- Control Body Functions

- Specific Nerves

- Anesthetic Agent
Allergy Immunotherapy

• 95115-95199-Professional services:
  – Number of injections
  – Inclusion of allergenic extracts
  – Use of stinging insect venom
  – Preparation

Injections for Testing or Procedures

• Intermingled in every body area within the surgery section of CPT

• Some sections injections will be found under Introduction

• Usually reference other codes to report
HCPCS Changes

• An updated list of the HCPCS codes for Durable Medical Equipment Medicare Administrative Contractors (DME MAC) and Part B local carrier/Medicare Administrative Contractor (MAC) jurisdictions is updated annually.

• CMS also updates HCPCS codes quarterly to reflect additional changes or corrections that are emergency in nature. Quarterly changes are issued by letter or memorandum for local implementation.

CMS Claims Processing Manual Chapter 23, 20.3

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### New Drug Codes 2012

<table>
<thead>
<tr>
<th>Code</th>
<th>Brand Name</th>
<th>Chemical Name</th>
<th>Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0561</td>
<td>AFINITOR</td>
<td>Everolimus, oral</td>
<td>0.25mg</td>
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<tr>
<td>J7665</td>
<td>ARIDOL</td>
<td>Mannitol through inhaler</td>
<td>5mg</td>
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<tr>
<td>J0490</td>
<td>Benlysta</td>
<td>Belimumab</td>
<td>10mg</td>
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<tr>
<td>J7180</td>
<td>Corifact</td>
<td>Factor XIII (antihemophilic factor)</td>
<td>1IU</td>
</tr>
<tr>
<td>J0840</td>
<td>CroFab</td>
<td>Crotalidae polyvalent immune fab</td>
<td>1g</td>
</tr>
<tr>
<td>J0840</td>
<td>FabAV</td>
<td>Crotalidae polyvalent immune fab</td>
<td>1g</td>
</tr>
<tr>
<td>J1557</td>
<td>Gammalex</td>
<td>Immune globulin IV, nonlyophilized</td>
<td>500mg</td>
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<tr>
<td>J7326</td>
<td>Gel-One</td>
<td>Hyaluronan of derivative</td>
<td>per dose</td>
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<tr>
<td>J0257</td>
<td>Glassia</td>
<td>Alpha 1 proteinase inhibitor</td>
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<tr>
<td>J9179</td>
<td>HALAVEN</td>
<td>Eribulin mesylate</td>
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<tr>
<td>J9043</td>
<td>Jevtana</td>
<td>Cabazitaxel</td>
<td>1mg</td>
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<tr>
<td>J2507</td>
<td>KRYSSEXKA</td>
<td>Pegloticase</td>
<td>1mg</td>
</tr>
<tr>
<td>J0221</td>
<td>Lumizyme</td>
<td>Alglicosidase alpha</td>
<td>10mg</td>
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<tr>
<td>J1725</td>
<td>Makena</td>
<td>Hydroxyprogesterone caproate</td>
<td>1mg</td>
</tr>
<tr>
<td>J2265</td>
<td>MINULIN</td>
<td>Minocycline HCl</td>
<td>1mg</td>
</tr>
<tr>
<td>J0131</td>
<td>Ofirmev</td>
<td>Acetaminophen</td>
<td>10mg</td>
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<tr>
<td>J0897</td>
<td>Prolia</td>
<td>Denosumab</td>
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<tr>
<td>J0712</td>
<td>Teflaro</td>
<td>Ceftaroline fosamil</td>
<td>10mg</td>
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<tr>
<td>J0588</td>
<td>Xeomin</td>
<td>IncobotulinumtoxinA</td>
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<td>J0897</td>
<td>XGEVA</td>
<td>Denosumab</td>
<td>1mg</td>
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<td>J9228</td>
<td>YERVOY</td>
<td>Ipilimumab</td>
<td>1mg</td>
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<tr>
<td>J8561</td>
<td>Zortress</td>
<td>Everolimus, oral</td>
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<tr>
<td>J7131</td>
<td>Hypertonic saline solution</td>
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<tr>
<td>J7183</td>
<td>VonWillebrand factor complex</td>
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ASP Drug Files

http://www.cms.gov/McrPartBDrugAvgSalesPrice/01a18_2011ASPFiles.asp#TopOfPage

- NDC-HCPCS
- ASP Pricing file
- NOC pricing file

ASP

Payment Allowance Limits for Medicare Part D Drugs
Effective January 1, 2011 through March 31, 2011

Note 1: Payment allowance limits subject to the ASP methodology are based on 2010 ASP data.
Note 2: The absence or presence of a HCPCS code and the payment allowance limits in this table does not indicate Medicare coverage of the drug. Similarly, the inclusion of a payment allowance limit within a specific column does not indicate Medicare coverage of the drug in that specific category. These determinations shall be made by the local Medicare contractor processing the claim.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
<th>HCPCS Scale Target</th>
<th>Payment Limit</th>
<th>Vaccine AMPS</th>
<th>Vaccine Limit</th>
<th>Infusion AMPS</th>
<th>DBE Infusion Limit</th>
<th>Blood AMPS</th>
<th>Blood Limit</th>
<th>Costing Factor</th>
<th>Notes</th>
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<tbody>
<tr>
<td>J0000</td>
<td>Desacralize hot 15 mg</td>
<td>12.945</td>
<td>4.297</td>
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<td>J0211</td>
<td>Desacralize hot 30 mg</td>
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<td>5.591.12</td>
<td>25</td>
<td>350.40</td>
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</tr>
<tr>
<td>J0220</td>
<td>Amiodarone 100 mg</td>
<td>12.945</td>
<td>598.822</td>
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</tr>
</tbody>
</table>
FDA approval of a drug is necessary in order to be reimbursed by insurance carriers.
Discarded Drugs

July 30, 2010 - Policy: Publication 100-04, Medicare Claims Processing Manual, Chapter 17, section 40, provides policy on the appropriate use of the JW modifier for discarded drugs.

MLN Matters® Number: MM6711
Related CR Transmittal #: R1962CP
Related Change Request (CR) #: 6711

Discarded Drug Example

For example, a single use vial labeled to contain 100 units of a drug, where 95 units are used and billed and paid on one line, the remaining 5 units will be billed and paid on another line using the JW modifier. The JW modifier is only applied to units not used.

➢ NOTE: Multi-use vials are not subject to payment for discarded amounts of drug or biological.
HCPCS Dosage

- The JW modifier is only applied to the amount of drug or biological that is discarded. A situation in which the JW modifier is not permitted is when the actual dose of the drug or biological administered is less than the billing unit. For example, one billing unit for a drug is equal to 10mg of the drug in a single use vial. A 7mg dose is administered to a patient while 3mg of the remaining drug is discarded. The 7mg dose is billed using one billing unit that represents 10mg on a single line item. The single line item of 1 unit would be processed for payment of the total 10mg of drug administered and discarded. Billing another unit on a separate line item with the JW modifier for the discarded 3mg of drug is not permitted because it would result in overpayment. Therefore, when the billing unit is equal to or greater than the total actual dose and the amount discarded, the use of the JW modifier is not permitted.

ACCC
Association of Community Cancer Centers

- http://www.accc-cancer.org/druginfo/

Monthly update of chemotherapy and the appropriate cancers treated by the drugs
RAC Audits Injections and Infusions

• Medicare Quarterly Provider Compliance Newsletter Volume 1, Issue 2 February 2011


Platelet Rich Plasma (PRP)

• July 1, 2010
  – AMA assigned 0232T
  – Most carriers are considering it experimental
Autologous Platelet Rich Plasma

- Effective March 19, 2008, CMS is maintaining its current non-coverage determination for autologous PRP for the treatment of chronic, non-healing cutaneous wounds, and issuing a non-coverage determination for acute surgical wounds when the autologous PRP is applied directly to the closed incision and for dehiscent wounds. Effective for claims with dates of service on or after March 19, 2008, the use of autologous PRP for the treatment of acute surgical wounds where the PRP is applied directly to the closed incision, or dehiscent wounds, will be denied by Medicare contractors.

MLN Matters Number: MM6043

PRP CMS Update

Decision Memo for Autologous Blood-Derived Products for Chronic Non-Healing Wounds (CAG-00190R3) Decision Summary-Published August, 2012

- CMS covers autologous platelet-rich plasma (PRP) only for patients who have chronic non-healing diabetic, pressure, and/or venous wounds and when all the following conditions are met:
  - The patient is enrolled in a clinical research study that addresses the following questions using validated and reliable methods of evaluation. Clinical study applications for coverage pursuant to this National Coverage Determination (NCD) must be received by August 2, 2014.