Infusion Coding
Infusions, Pushes, Injections

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Codes

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Review all codes and code descriptions for appropriate use
Agenda

- Overview of Infusions
- Initial Codes
- Infusion vs. Push vs. Injection
- Drugs
- Services – billable?
- Incident to
- Chemo Orders
- Audits

What are We Really Talking About?

- Section in the CPT®
  - Divided into sections
- Infusion
- Push
- Injection
- Know the code and what it means
Infusion Categories

- Hydration
- Therapeutic
- Chemotherapy

Initial Codes

- Each category has at least 1 initial code
- Select only 1 initial code per encounter
- Slight difference between facility and physician office
Office - Initial Code

• Answer this question –
  – Why is the patient here????

Facility – Initial Code

• Specific hierarchy
  – Chemo services before
    • Therapeutic/prophylactic/diagnostic before
      – Hydration
Facility – And More..

• Infusions before
  – Pushes before
    • Injections

Facility – Be Careful

This hierarchy may complicate the mixing and matching of codes
What’s Included?

The CPT® manual gives a list of services that are included with and infusion/push/injection

• Local anesthesia
• IV start
• Access to port/catheter
• Tubing – syringes – supplies
• Flush at conclusion

Supplies? Really?

When you can bill and when you cannot

Billable if the fluid is used as hydration or when the patient has a reaction and is used to relieve symptoms

NOT billable if it used to keep a line open, flush before or after treatment
Access

The time taken to access the port/IV/catheter is NOT billable

Time does not start until the drug starts

Flush at conclusion of infusion” is part of the service and not billable

Flush allowed only if no other service is provided on the same day?

Clear? Simple? Easy?

Not Really! (more on this later)
Subsequent vs. Concurrent

• Subsequent
  – Comes after another service

• Concurrent
  – Happens at the same time as another service

Add-on Codes

These are the procedures designated by a + sign in the CPT® that mix and match with the Initial Codes

Facilities beware!
Hydration

Consists of pre-packaged fluids and electrolytes

A very simple category

Hydration Codes

• Initial Code
  – 96360 must be over 31 minutes
    • Less than 31 – not billable!
• Add-on
  – 96361 must be over 31 minutes
Therapeutic

- Much more complicated
- Includes Prophylactic and Diagnostic services
- Several sub-categories
- Multiple initial codes
- Drugs are not pre-packaged fluids and are non-chemo

Therapeutic – Initial Codes

- 96365 - IV Infusion
- 96369 - Sub q infusion
- 96374 - Push
Therapeutic – Add Ons

• 96366 - Each additional hour
  » At least 31 minutes
• 96367 - Sequential infusion *
• 96368 - Concurrent infusion

* Once per sequential infusion of same mix

Therapeutic - Miscellaneous

• 96370 – TIME code
• Is used with 96369
Therapeutic- Injections

NOT vaccines, toxoids, anti-neoplastics, hormonal or non-hormonal agents

- 96372 - Sub-q – IM
- 96373 - Intra-arterial

Therapeutic - Push

- 96375 - Different drug
- 96376 - FACILITIES ONLY
  » Same drug but cannot be within 30 minutes of last push
Chemotherapy

• Highly complex drugs and biologic agents
• Non-radionucleid anti-neoplastics
• Anti-neoplastics for non-cancer diagnoses
• Monoclonal antibodies
• Biologic response modifiers

Chemotherapy – Initial Codes

• 96409 - Push
• 96413 - IV Infusion
Chemotherapy – Add-ons

- 96411 - Additional Push
- 96415 - Additional hour beyond 31 minutes
- 96416 - Sequential infusion*

* Once per drug

Chemotherapy - Injections

- 96401 - Non-hormonal
- 96402 - Hormonal
Intralesionals

- 96405 - 1 to 7 lesions
- 96406 - 7+ lesions

Confused? Try This

<table>
<thead>
<tr>
<th>Initial</th>
<th>Add-On</th>
</tr>
</thead>
<tbody>
<tr>
<td>96360</td>
<td>96361</td>
</tr>
<tr>
<td>96365</td>
<td>96366, 96367, 96368, 96361, <strong>96375</strong></td>
</tr>
<tr>
<td>96369</td>
<td>96370, 96371</td>
</tr>
<tr>
<td>96374</td>
<td>96367, 96361, <strong>96375</strong></td>
</tr>
<tr>
<td>96409</td>
<td>96411, 96367, 96361, <strong>96375</strong></td>
</tr>
<tr>
<td>96413</td>
<td>96417, 96415, 96361, 96366, 96367, 96375, 96411, 96368</td>
</tr>
</tbody>
</table>
Time – Not Always on Your Side

- Begins when the drug starts
- 31 minutes is the magic number
- Pushes have no minimum or maximum time
- Infusions less than 15 minutes are a PUSH
- Mixing, accessing, starting IV – doesn’t count

Prolonged Infusion

- Not an initial and not an add-on
- 96416 - An infusion lasting greater than 8 hours through a pump
Port Flush

- 96521 96522 96523
- CPT® states that you cannot report the code if any other service is performed the same day
- Part of the infusion service

But Then…

- What about after a prolonged infusion?
- Major confusion
  - CPT® states no other service same day
    - But also states that
  - Part of the infusion service
Let’s Review

Look at this sample administration record and see how it could be coded!

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydration</td>
<td>9:00 – 9:35</td>
</tr>
<tr>
<td>Antiemetic</td>
<td>9:35 – 10:15</td>
</tr>
</tbody>
</table>
| Chemo 1     | 10:15 – 11:15| 96413
| Chemo 2     | 11:15 – 12:50| 96417, 96415
| Antiemetic  | 12:50 – 1:05 | 96375

How Did You Do?

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Time</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydration</td>
<td>9:00 – 9:35</td>
<td>96361</td>
</tr>
<tr>
<td>Antiemetic</td>
<td>9:35 – 10:15</td>
<td>96367</td>
</tr>
<tr>
<td>Chemo 1</td>
<td>10:15 – 11:15</td>
<td>96413</td>
</tr>
<tr>
<td>Chemo 2</td>
<td>11:15 – 12:50</td>
<td>96417, 96415</td>
</tr>
<tr>
<td>Antiemetic</td>
<td>12:50 – 1:05</td>
<td>96375</td>
</tr>
</tbody>
</table>
Explanation

• The first chemo drug is considered the primary reason for the treatment so it becomes the initial service (96413).
• The hydration code for additional hour is used since it is beyond 31 minutes (96361).
• The first antiemetic is coded with an additional/sequential therapeutic code (96367).
• The second chemo drug is reported as an additional sequential and the additional hour code for the 35 minutes (96417, 96415).
• The second antiemetic is only 15 minutes so it has to be a therapeutic push (96375).

Let’s Try Another

Here is another sample administration and see how it should be coded.

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:30 – 9:50</td>
<td>Antiemetic</td>
</tr>
<tr>
<td>9:50 – 10:35</td>
<td>Antiemetic</td>
</tr>
<tr>
<td>10:35 – 11:05</td>
<td>Chemo 1</td>
</tr>
<tr>
<td>11:05 – 12:05</td>
<td>Chemo 2</td>
</tr>
</tbody>
</table>
Here are the Codes

<table>
<thead>
<tr>
<th>Time</th>
<th>Service</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:30 – 9:50</td>
<td>Antiemetic</td>
<td>96367</td>
</tr>
<tr>
<td>9:50 – 10:35</td>
<td>Antiemetic</td>
<td>96367</td>
</tr>
<tr>
<td>10:35 – 11:05</td>
<td>Chemo 1</td>
<td>96413</td>
</tr>
<tr>
<td>11:05 – 12:05</td>
<td>Chemo 2</td>
<td>96417</td>
</tr>
</tbody>
</table>

Explanation

- The first chemo drug is considered the primary reason for the treatment so it becomes the initial service (96413).
- The first antiemetic is coded with an additional/sequential therapeutic code (96367).
- The second antiemetic was infused sequentially after the first and is also reported with (96367).
- The second chemo drug is reported as an additional sequential (96417).
Drugs!

- Supply vs. Billable (again!)
- SDV vs. MDV
- Chemo and non-chemo
- Hormonal and non-hormonal
- Billable units
- Other issues

Supplies - Billables

Remember – fluids running to facilitate treatment are supplies

Adding additional medications to the bag may make them therapeutic
SDV - MDV

- Single Dose Vials
  - Single patient treatment

- Multi-Dose Vials
  - Multiple patient treatments

Examples

**Single Dose Vials**
- Zometa
- Gemzar
- Abraxane
- Emend
- Rituxan

**Multi-Dose Vials**
- Doxorubicin
- Herceptin
- Dexamethasone
- B-12
- Paclitaxel
Drug Waste

- MDVs never have waste
- SDVs may not be shared

Reporting Waste

Rules will vary by carrier –

Make sure you know how the major carriers in your area want to see it on the claim!

Make sure you document the waste in the chart and can easily find it if asked!
You Will Need …

• NDC number
• Name of the drug
• Amount administered
• Amount wasted
• Method of administration

A Carrier May Want …

• One service line with the full vial size and a note with the NDC
• A service line with the actual amount administered and another with the waste amount and $0.00
• Some want a JW modifier, others do not
HCPCS codes

- Index under chemotherapy list of drugs
- Some exceptions to the chemotherapy rule
  - Leucovorin is an example
    - Non-chemo drug but some carriers treat it as if it were

Hormonal or not?

- Lupron
- Bleomycin
- Fulvestrant
- Azacitidine
Billable Units

- Each code is assigned a unit value
- Bill in multiples of that value
- Critical in correct coding and reimbursement

Rounding

- ASCO printed guidelines
- No official rule
- MDVs – round up to nearest whole unit
‘Tweeners

• Some drugs have multiple codes for various amounts or specific drugs.
• When this happens, use the one closest in multiple units.

Cytoxan

• Here is an example – Cyclophosphamide
• Has five J codes with different billable units and naming specific drugs
• What do you do for 350 mgs – there is not a specific code for that amount
• One for 200 mgs then 500 mgs
• It is not a single dose vial, so no waste
Minimums

If less than lowest billable unit administered – bill unit of 1

Let’s Review…

• SDV? MDV?
• How much?
• Waste?
• What is billable unit?
• How many billable units administered?
Let’s Try an Example

Let’s take a look at some examples.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Billable Unit</th>
<th>Administered</th>
<th>Waste?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Herceptin (mdv)</td>
<td>10 mg</td>
<td>100</td>
<td>No</td>
</tr>
<tr>
<td>Alimta (sdv)</td>
<td>10 mg</td>
<td>7</td>
<td>Yes</td>
</tr>
<tr>
<td>Paclitaxel (mdv)</td>
<td>30 mg</td>
<td>90</td>
<td>No</td>
</tr>
<tr>
<td>Gemzar (sdv)</td>
<td>200 mg</td>
<td>450</td>
<td>Yes</td>
</tr>
</tbody>
</table>

How Do You Code the Units?

Let’s see how our examples coded . .

<table>
<thead>
<tr>
<th>Drug</th>
<th>Billable Unit</th>
<th>Administered</th>
<th>Waste?</th>
<th>Billed Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Herceptin (mdv)</td>
<td>10 mg</td>
<td>100 mg</td>
<td>No</td>
<td>10</td>
</tr>
<tr>
<td>Alimta (sdv)</td>
<td>10 mg</td>
<td>7 mg</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>Paclitaxel (mdv)</td>
<td>30 mg</td>
<td>90 mg</td>
<td>No</td>
<td>3</td>
</tr>
<tr>
<td>Gemzar (sdv)</td>
<td>200 mg</td>
<td>450 mg</td>
<td>Yes</td>
<td>3</td>
</tr>
</tbody>
</table>
Yeah, but….

- The patient brought the medicine
- The clinical trial provided some of the medicine
- The medication is listed as self administered
- The medication is off label
- The medication is oral

Patient provided med

- Can bill for administration
- Need to document
  - NDC
  - Drug Name
  - Amount administered
  - Method of administration
  - Source of drug
Clinical Trials

- Pretty much the same
- QV modifier
- Trial information

Self Administered

- Each carrier decides list
- Rough guidelines
  - Not IV drugs
  - Not IM drugs
  - Usually Sub-Q drugs
Off Label

• New indications
• Successful trials
• Not yet in Compendia

Oral Meds

• Check to see local and state rules on dispensing
• Not billed through regular claim processing - usually
Scenario

<table>
<thead>
<tr>
<th>Time</th>
<th>Route</th>
<th>Drug</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00 – 9:15</td>
<td>IV</td>
<td>Dexamethasone</td>
<td>20 mg</td>
</tr>
<tr>
<td>9:15 – 9:50</td>
<td>IV</td>
<td>Gemzar</td>
<td>1430 mg</td>
</tr>
<tr>
<td>10:00 – 10:05</td>
<td>SC</td>
<td>Procrit</td>
<td>40,000 units</td>
</tr>
</tbody>
</table>

Here are a few hints on the drugs -

Dexamethasone is a mdv and is billed in units of 1 mg
Gemzar is a sdv that is 1600 mgs and billed in 200 mg increments
Procrit is a single 40,000 unit pre-filled syringe billed in 1000 mg increments

How Did You Do?

First the drugs:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Quantity</th>
<th>Billed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dexamethasone</td>
<td>20 mgs given</td>
<td>20 units billed</td>
</tr>
<tr>
<td>Gemzar</td>
<td>1430 mg given</td>
<td>8 units billed with 170 mg wasted</td>
</tr>
<tr>
<td>Procrit</td>
<td>40,000 units given</td>
<td>40 units billed</td>
</tr>
</tbody>
</table>

Now the administration:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>96413</td>
<td>Chemo infusion is the primary service</td>
</tr>
<tr>
<td><strong>96375</strong></td>
<td>The sequential therapeutic <strong>PUSH</strong></td>
</tr>
<tr>
<td>96372 – 59</td>
<td>The injection using the modifier</td>
</tr>
</tbody>
</table>
This Is a Bit Harder

<table>
<thead>
<tr>
<th>Time</th>
<th>Drug</th>
<th>Dose</th>
<th>Route</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 – 8:05</td>
<td>Aloxi pre filled</td>
<td>.25 mgs</td>
<td>IM</td>
</tr>
<tr>
<td>8:05 – 8:40</td>
<td>Dexamethasone mdv</td>
<td>20 mgs</td>
<td>IV</td>
</tr>
<tr>
<td>8:40 – 11:45</td>
<td>Avastin sdv</td>
<td>830 mgs</td>
<td>IV</td>
</tr>
<tr>
<td>11:45 – 1:00</td>
<td>Camptosar sdv</td>
<td>240 mgs</td>
<td>IV</td>
</tr>
<tr>
<td>1:00 – 1:05</td>
<td>Emend sdv</td>
<td>115 mgs</td>
<td>IM</td>
</tr>
<tr>
<td>8:00 – 1:00</td>
<td>Normal saline</td>
<td>1000 cc</td>
<td>IV</td>
</tr>
</tbody>
</table>

Aloxi is billed in 25 mcg units
Dexamethasone is billed in 1 mg units
Avastin is a 900 mg vial and billed in 10 mg units
Camptosar is a 250 mg vial and billed in 20 mg units
Saline comes in a series of bags and is billed in 200 cc units

Here are the Drugs…

<table>
<thead>
<tr>
<th>Time</th>
<th>Drug</th>
<th>Dose</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 – 8:05</td>
<td>Aloxi pre filled</td>
<td>.25 mgs</td>
<td>250</td>
</tr>
<tr>
<td>8:05 – 8:40</td>
<td>Dexamethasone mdv</td>
<td>20 mgs</td>
<td>20</td>
</tr>
<tr>
<td>8:40 – 11:45</td>
<td>Avastin sdv</td>
<td>830 mgs</td>
<td>90 with 70 mg waste</td>
</tr>
<tr>
<td>11:45 – 1:00</td>
<td>Camptosar sdv</td>
<td>240 mgs</td>
<td>13 with 10 mg waste</td>
</tr>
<tr>
<td>1:00 – 1:05</td>
<td>Emend sdv</td>
<td>115 mgs</td>
<td>115</td>
</tr>
<tr>
<td>8:00 – 1:00</td>
<td>Normal saline</td>
<td>1000 cc</td>
<td>Supply</td>
</tr>
</tbody>
</table>
The Administration…

<table>
<thead>
<tr>
<th>Time</th>
<th>Drug Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 – 8:05</td>
<td>Aloi pre-filled</td>
<td>96372</td>
</tr>
<tr>
<td>8:05 – 8:40</td>
<td>Dexamethasone mdv</td>
<td>96367</td>
</tr>
<tr>
<td>8:40 – 11:45</td>
<td>Avastin sdv</td>
<td>96413 and 96415 times 2</td>
</tr>
<tr>
<td>11:45 – 1:00</td>
<td>Camptosar sdv</td>
<td>96417</td>
</tr>
<tr>
<td>1:00 – 1:05</td>
<td>Emend sdv</td>
<td>96372</td>
</tr>
<tr>
<td>8:00 – 1:00</td>
<td>Normal saline</td>
<td>Not billable</td>
</tr>
</tbody>
</table>

Incident To

• Applies to physician practices
• Requires physician to be available
• Claims bill under supervising physician
Available??

- Supervising Physician …
  - Must be physically in the suite
  - Can’t be at hospital doing rounds
  - Can’t be out of the office but available by phone
  - Exception for rural areas

Claims?

- Billed under the Supervising Physician
- Not the ordering physician
- Not the patient’s usual physician
It All Begins with an Order

- Medication
- Dose
- Route
- Frequency
- Length of treatment
- Date
- Physician Signature

Changes

If the order changes make sure that the documentation changes with it!

Verbal orders have to be added to the documentation and be verified/signed by the physician.
Documentation

- Must be complete
- Start/stop times must be detailed
- Changes to the order must be noted and signed
- All drugs and their administration must be included

Audits

- Self audit and carrier audit
- Self audit
  - Makes sure all services are captured and claims match documentation
Audits

• Self Audit
  – Make sure all services are billed
  – Make sure documentation matches claim

• Carrier Audit
  – Makes sure that claims are supported by documentation
  – Makes sure that payment was accurate

Audits Continued

• Pre-claim Audit
  – Allows you to verify services against orders
  – Allows you to correct codes before a claim is created

• Post-claim Audit
  – Allows you to verify that claim lines match orders/documentation
  – May have to return paid services that are inaccurate
How Do You Audit?

• Select several encounters from a day or date range
• If a claim has been created, get a hardcopy
• Print the drug inventory or pull report, the orders, the flowsheet and any nurse notes from the day
• Match the orders to the flowsheet to the drug list to the notes to the claim.

Another Option

• Select patients that have had several treatments
• Check the account and make sure that all the claims are the same
• Match the claims to the orders
• If they don’t match – was there a documented change to the order
**Final Notes**

- Make sure those performing the service and documenting it understand what is needed
- Make sure that the orders can handle scrutiny
- Make sure you stay informed on coding regulations for all your carriers
- If you find a mistake and received payment send a refund

**Let’s Review**

- Only one initial code for an encounter
- Primary reason for visit – hierarchy
- Fluids are not always a supply
- Drug units and amount administered may not be in the same measurement units
- There is no waste on MDV
- Orders must be in the chart and signed by the physician
- Orders must match the treatment matching the claim
Common Resources

- www.aapc.com
- www.cms.hhs.gov
- www.asco.org
- www.accc-cancer.org
- www.clinicaltrials.gov
- www.fda.gov
- www.oig.hhs.gov

Thank you!