Message	Response Message
What does CHONC stand for?	Certified Hematology Oncology Coder
Would hydration with cal/mag be coded as hydration or iv drug infuse?	It gets covered in a bit but when you add something it becomes therapeutic
At this time audio appears to be working properly. Long-term outages are not occuring at this time. Please try refreshing your browser or calling the dial-in number at the bottom of the slides. Also, the on-demand version of this presentation will be available immediately following the presentation. We apologize for the difficulties.	Audio issue
Great I had a couple of questions that someone gave me yesterday. First,When a patient is in the hospital as "Observation Status" and receives the same drug, IV every 6 hours, for two days. (i.e. ancef IV q6hrs) Each ancef runs for one hour and is in the same IV access site. Would you code the infusions as A) total time as an initial infusion for ancef infused over the two day period or B) one initial followed by total time for all the others as a sequential.	Initial followed by the extra time
What constitutes hydration?	Pre-packaged fluids with documented need for the service
So, patient is in for headache, found to be dehydrated by UA, IV started with a push of pain med. What would be initial...96360 - initial hydration or 96374 - initial push	Push would be the initial code followed by the hydration dd on code
Is there a certain amount of fluids required to qualify for hydration billing?	No - quantity does not count - time does
As a reminder, a transcript of the questions and answers will be available 48 hours from the conclusion of this presentation in the online account of the purchaser.	No response needed
What do you use for drug admin for 16-30 min?	If it is an initial code then you would bill for the code. If it is for an add-on - there is no code for time less than 31 min
Can the add-on push 96375 be added with an initial code 96360?Patient is in for dehyrdation, IV is ran for 1 hour then provider decides to add an antinausea, would we add the 96375.	No - the initial hydration cannot be used with add ons from "higher level" services. If the anitemetic is a push, use 96374 or infusion 96365 and the hydration add on 96361

Chemo nurse infuses two meds sequentially, but since we are on an EMR their note is timed per their entry, not the actual infusion. The note states infused med A 9:00-10:00 infused med B 10:00-12:00. Stop time of med A is within the same minute as the start time of med B. Does this support sequential or would it be interpreted as concurrent due to sharing the stop/start minute?	It would be considered sequential since the full times do not overlap
How do you record Infusion time for a BID patient. Do you add the times together or treat them as separate infusions- please explain you reasoning	Please explain bid - same encounter or 2 separate encounters
oops, you missed 96375 to the initial 96374 on the Confused table	Slide corrected (changes in bold)
If a patient comes in for chemo and has a reaction or is in need of other services, can the facility charge an established visit code with a modifier?	Documentation would dictate this answer. If it is a separately identifiable service - then yes. If you can document the need for the stop and the re-start of service and what happened, then absolutely yes.
Please correct me if I am wrong, but just because a drug suggests that you do hydration therapy and you have no medical necessity to back you up, you should NOT administer hydration therapy?	Medical necessity is always the foundation of any service.
Just want to make it clear, 96367 is for sequential IV push same substance in facility only, correct?	96376 if the facility code for push of the same drug
can a 99211 be billed with a flush if no other service for the day	No - 99211 is a low level visit and should not be billed with another service since it would hard to show it as a truly separate service which the modifier would need
patient has vanco and maxipime in the am and in the pm. am does vanco 1.15, maxipime 1 hr, pm dose vanco 2hrs and max 48 minutes	If the same encounter is used, you would add the times. If a separate encounter is used, then you would have additional time. ASCO and CPT have given examples doing this time calculation
There is an error on page 14 of the printed slide. 96416-sequential infusion should be 96417.	In reviewing the slide I do not see 96416 listed. Am I not understanding where this reference is?
Would a general practice protocol when using a specific med states to administer IV hydration therapy for one hour be supportive of using hydration for every patient on this drug, or should each patient have an order based on their particular need?	Each patient needs an order or a DIRECT reference to a specific protocol. All orders need to be patient specific. If a standing order is used, it must be reviewed, dated, signed and placed in the patient's chart.
I thought you could not bill hydration if it was part of chemo treatment?	Hydration is only billed if it is necessary and not just to keep lines open etc. If the order calls for it and there is medically necessary, it is billable. Don't get hydration confused with fluids.

Where can I find a list of drugs considered Highly Complex Drugs or Highly Complex Biologic Agents	In the CPT index under chemotherapy is a list of these meds
Are lab tests considered bundled with a port flush? Medicare is paying but other carriers eg BC are not.	Good question! Medicare has lab services in a separate fee screen. Other carriers have them on the same fee screen (BC). You can append the 59 modifier on the flush since it truly is separate and distinct
If saline is given for hydration when adminstering cfhemo drugs is it billable?	Be careful - saline MUST be documented as hydration and not just as a mixer. Saline just running is not necessarily hydration.
please direct me where the asco and cpt give examples	ASCO - Practical Tips book. CPT had a FAQ in the coding change book
What about the use of botox, which is sometimes in a single dose vials, but you never use all of it, how would you suggest billing this?	If it is an SDV, you would have to use the full vial size. It would be like paying for the drug once (SDV) but charging the carrier each time. Make sense?
If hydration done 1st hr, then antiemetic is bld as sequential, then chemo as initial & finally the same antiemetic is pushed - should antiemetic time be combined or separately billed?	Is the 1st an infusion or a push? Is this facility? Your example would be an initial chemo, sequential therapeutic, hydration add-on and antiemetic push.
In an outpatient clinic setting, if a patient sees the physician on the clinic side then reports for chemo in the infusion center, then a reaction occurs and the physician is called over by the infusion nurse to see the patient, can the infusion center charge an additional clinic visit with modifier?	Difficult question! If the first visit will be billed by the same entity as the second, then no. If it is 2 separate entities, then yes.

Annalynn, these questions just came in Via e-mail: We often have waste when using multi dose vials. Can I roll the amount administered and the amount wasted into the unit amount on the encounter form as one total? If a non-chemo drug is administered as a sequential infusion (for example J1100) for 20 minutesâ€"can I code it as 96367? If a push is indicated on the super bill and it takes 20 minutes is it coded as a push? Some carriers do not accept the JW modifier. How would you indicate waste on the claim form? Sometimes there are five pushes indicated on our superbill. Is there a limit to the amount of pushes you can bill on a claim form? (96375)	1) Technically, MDVs should not have waste. But there may be exceptions but I would have to know the specific drug and circumstance. For example, if it is an MDV and must be reconstitued with a limited shelf life, then the person getting the last of the drug would have the waste noted like a SDV does. But if the drug does not have the limited shelf life then no - there is no waste. Limited shelf life does not mean expiration date - it means that after so long in a reconstituted state it is no longer stable and cannot be used. 2) Yes, the additional drug code 96367 needs more than 15 minutes to be used or it is a push. 3) Yes, a push has no set administration time - it can take a minute or many minutes - as long as the nurse is in constant attendance it is a push. 4) Our carriers do not accept the JW modifer either. We must document the laste as noted on slide 47 in the note section of the claim. 5) I have not seen anything published that limits the number of different drug pushes.
what do you code when your push is going through a PICC line. DO you code 96374 or is it not codable?	96374 is an initial code and I have not seen anything not allowing it to be used in conjunction with a PICC line.
For hydration, if fluids are ordered is there a certain cc/hr that is considered TKO?	This is more of a clinical issue than a coding one. The answer is what the treatment/physician requires.
Can a drug ever be available in both a single does and multi-dose vial forms?	Drugs are packaged and labeled as either SDV or MDV. The only exception is a pre-filled syringe which is SDV and the same drug in MDVs. Other than this instance, I have not seen the same drug in both vial forms.
What are the billable charges if the treatment is stopped due to a patient's reaction to a specific drug?	If the treatment is stopped completely, then bill all the meds and whatever administration time has been given. You would also have good reason for a visit code as well. If treatment re-starts, then so does the administration time.

For oral medication if patient has to be observed for 6 hours after the first dose to monitor for signs and symptoms of bradycardia what CPT code would be billed? pt would be observed in fusion room	This is a hard question. The only observation codes are for hospital use (does not have to be in an observation area) but the service require the elements of an E&M code. An E&M code needs to be performed by the physician, PA, NP and documentation would be required. Since I cannot give you a specific way to handle this, contact one of your insurance carrier representatives or your State Medical Society to see how it should be reported.
Can you give specific examples of when hydration would be medically necessary to bill?	Hydration on its own would be necessary if a patient has symptoms of dehydration or if the physician feels the patient's volumes are down or examples such as that.
when pain medication is administered inravenously what code do we use is it 96374 or 96372, please explain thank you	If it is an injection (IM or Sub-q) 96372. IV is a push 96374
What type of supplies can be billed to the patient for a chemo infusion.	No supplies can be billed - even though they have a cost, we cannot bill them.
A patient receives infusion of calcium gluconate for hypocalcemia. The calcium gluconate in mixed in 250NS by pharmacy. Is it correct to bill this with therapeutic admin codes?	Yes! That is exactly correct!
IVIG is administered in the doctors office taking 5 to 6 hours to infuse. The IVIG drug is administered by using an IV syringe pump. Can we use the administration codes 96365 and 96366?	An IV syringe pump does not require the constant attendance of a nurse, so although syringe sounds like a push, it is not. Since it is a form of IV infusion, you would use the 96365 and 96366 codes for the IVIG infusion.
on slide 66 why would the dexa be a sequental infusion if the time administered was 15 minutes? wouldnt it be a push?	Slide is redone
if Claritin is given to a patient prior to the administration of a biologic, is it billable?	It depends, why was it given to the patient? If it is part of the protocol/order, then yes. If not, then no.
Procrit billed with 96375? Shouldn't it be with a 96372?	Slide is redone
Can we bill for the huber needle or the IV Tubing for a chemo infusion?	Unfortunately, even though these are costly items, we cannot bill for the supplies used in infusion therapies.
can we bill 96367 for a patient administering infusion therapy from their home when two medications are being infused?	Home infusion services use a different code set. The 99500-99602 range. I cannot confirm that carriers would accept the 96367 code.
On Slide 65, shouldn't Procrit be used w/ 96372 when used as IM? If not, please explain	Slide has been corrected
On slide 66, should the Procrit admin Sub-q be 96372, or 96375?	Slide has been corrected

infusion and facility	In your scenario, the chemo is the initial service, the 1st antiemetic is the sequential and the 2nd is a push - because you indicated it was documented as a push, time does not matter and the hydration add=on
Do any of these examples need modifiers?	I would only add the 59 modifier to the Procrit injection on slide 66
how about J1200 is it ok to be included in the chemo treatment	J1200 is diohenhydramine and if it is given as part of the order, then yes it is allowed - we use it quite frequently.
why would the Procrit inj example be billed with 96375-59 if it was an injection and why would you use a mod 59 with an add on code in example page 33?	Slide is redone
If patient comes to Urgent Care and an IV line is started but patient is then sent to ER, does UC charge for starting that IV line?	Yes - the UC can bill for the start of the IV
What CPT would you use for starting the IV line in Urgent Care?	If only fluids are running you can either bundle it into other servces being performed - like an E&M service - or the only code would be a hydration code with documentation on why the line was started.
what would be the proper way to code infusion therapy being administered by patient in their home? we supply the redi med balls which holds the medication. Patient receives the teaching part here in the office before being sent home with meds. We're being denied for billing hcpcs code A4305 when billed twice per day. This happens when the patient has two different medications to be administered>	A4305 has a quantity limit meaning it has restrictions on how frequently if can be reported - looks like once per day. This is the actual delivery system would it be replaced after each use? Home infusions are in the 99500-99602 range. This would need more research and a bit more information.
If the physician sees a patient in the clinic and the infusion center, should he/she add the additional time to the visit prior to patient reporting for treatment?	If the physician sees the patient in the infusion center for a reason other than "how are you doing?" then the additional time could be added to the initial visit. Documentation must indicate the additional information/time
what is the push is documentated as a infusion of 14 minutes? are the 2 infusions combined since they are the same drug? this refers to the previous question where I had to answer infusion and facility. thanks!	An infusion cannot be 14 minutes. Anything 15 minutes or less is a push. Remember, facilities have to wait 30 minutes between pushes of the same drug.
Why was dexamethazone 20 mg billed as 96367 when it was only 15 minutes?	slide is redone

What is the correct set of codes for the following scenario-hydration or therapeutic?Chemo pt coming in for hydration, found to have low potassium on lab draws receives 1L NS with 4gm Magnesium sulfate. Also receives 20meq KCL in 250 NS over 1 hour. For facility.	Therapeutic initial code followed by hydration. Therapeutic outranks hydration
Can a PA do infusion without the physician on site?	By their very scope of licensure, a PA cannot work without supervision. So in this case, no the PA cannot do infusions without a physician on site. In addition, many carriers would not credential a PA for independent services so they could not be used on claim forms.
Does the diagnosis also need to be on the order?	No, the elements of an order do not specifically include a diagnosis. It must be in the chart, of course, but not necessarily in the order.
I am a little confused, can infusion services be billed under the supervising as opposed to the ordering and still be incident to? And if so, can the supervising be a pediatric MD when the patient is an adult?	Incident-to regulations require services be billed under the supervising physician. Another provision of incident to is the need for the supervising physician to be part of the same group. If the pediatric physician is part of the group then yes. The infusion codes do not have age specific restrictions.
thank you clarifying about IM injections and IV push.....thank u	You are very welcome!
Should the procrit be coded as 96372-59, is this is an IV admin code.	Slide is redone
Since the nurse is the one who is giving the infusion, does the supervising provider have to sign the infusion record?	I have not seen anything that has been published to indicate that the physician must countersign the infusion record - order yes, flowsheet/administration record no. When we had our infusion audit, they did not indicate this was a missing item and our physicians do not counter sign.
If a patient is given a drug that they bring from the pharmacy that requires a 6 hour observation period, how would you suggest billing that observation period for 6 hours?	This is a hard question. The only observation codes are for hospital use (does not have to be in an observation area) but the service require the elements of an E&M code. An E&M code needs to be performed by the physician, PA, NP and documentation would be required. Since I cannot give you a specific way to handle this, contact one of your insurance carrier representatives or your State Medical Society to see how it should be reported.

For facility billing is it generally acceptable to bill IV injection codes if you do not have start and stop times for infusions?	Yikes! You could be loosing money here. Are they documenting injections? If the note just "says drug A IV" then you could do the injection. But, they need to be accurate if the drug says to be administered IV over xx minutes, then you have an issue. Since this could be complicated, I will try to get a longer response when the full q&a is published.
The transcript of these questions and answers will be available at 2pm EST in the online account of the purchaser.	No comment needed
BOTOX- Yes, that makes sense, so if you don't give 1unit, but you give .5, then you can't bill at all, correct?	No - you bill the full vial size since it is SDV and document waste.
How can the dexamethasone be billed as a 96367 when it was only 15 minutes?	Slide is redone
If blood for testing is obtained through an IV access that is just being started, am I correct that you can not bill separately for a "venipuncture" since that access is going to be used for IV therapy?	You are correct.
Can you bill an office visit with chemo services on the same day	This is carrier specific so no hard and fast rule. We have 1 local carrier that with reject this combination even with documentation and the modifier. My best answer is to check the policies of your major carriers. Because we are finding more and more carriers declining these visits, we had to institute a policy of no visit the same day. If a patient requests it, we verify their individual coverage and they will either sign an acknowledgement that the service may be their responsibility or we make the exception if the carrier allows it and note it in their billing record.
Facility question - Do drugs have to have the same start and stop time in order to bill a concurrent code? Example: If Drug A runs from 10-11 and Drug B runs 10:30-11, how would this be coded?	In your example, drug B runs its total course with drug A so it is concurrent.
When an med is given for 21 cycles, is the order written good and what should be on the order to support the entire 21 cycles or 1 year of therapy?	The elements of an order require the length of the treatment so documenting 21 cycles would be appropriate.

If the supervising physician is there at the start of the infusion and leaves during the infusion how is it billed?	Incident to regulations state that a physician must be in attendance. It does not say that it has to be the same physician. We have 5 physicians with any number of them in the office during the day. Our coders look at the overall schedule and select the "doctor of the day". This is usually the physician that is there the longest. We then use this as the supervising physician. If, however, a patient has an issue and a different physician is called to intervene, we would change the supervising physician for that patient.
We have an issue with patients having dressing changes for wounds in addition to their infusion. What is the best way to do this?	Well, I'm not sure what the issue is so it is hard to give you some direction. Are you attaching the 59 modifier? Are they considering it supplies?
Are ASCO and CPT FAQ available online	Yes, they should be available at the websites.
Doyou have a reference to the information on billing for the supervising physician that is in the office the longest?	In the volume of questions and the speed of a response, detailed notes were hard to do. I added more information with the original question.
When you bill eg. Phenergan 50, but you only administer 25, do you have to indicate on the HCFA that 25mg was actually wasted?	If Phenergan is a SDV, then bill the vial size and document waste. If it is MDV, then just the administered amount
Two questions...Can you bill a 99211 if the patient has never seen a physician in the physician group that is supervising the infusion center? When is a 99211 appropriate for billing for infusion services?	1) 99211 is an established patient code and appropriate for a "new patient". 2) I cannot think of any example that I could offer that would support a 99211 with infusions. If you routinely add the E&M service as a way of saying yes the patient is ok for treatment, that is not a separate service. The only reason for that visit is infusion clearance.
I really do not get the hydration thing i was told that if it is part of protocal then you can not charge for it??	Hydration is a service that replaces fluids and electrolytes. It has a very distinct role in the treatment of patients. Many people get hydration and fluids confused. If you can document the medical necessity for hydration it is billable. If the fluids are running or used as a mix, this is not hydration that is a supply.
We show Gemzar with J9201 falling under the Chemotherapy drug section however, this session advises to bill with a non-chemo administration code. Pls clarify.	Gemzar is the initial code in the example.
To clarify incident to, did I hear correctly that the supervising physician on the same floor cannot see patients while patients are receiving chemo?	No - they can be doing anything they need to, but must be available.

Clarification-if you are billing initial infusion of chemo drug and then you start hydration therapy afterwards, would you still not be able to bill the initial start of hydration?	The initial hydration code cannot be used when an initial code for any other area has been selected - one per day, remember. But, what you can do is use the hydration add-on instead. The initial hydration code is the only initial service that must be at least 31 minutes. This was done so that it matched the add-on code requirements. This then allows us to use the add on code.
No - drugs are always one or the other. I tried to keep up!	No comment needed
I am extremely new to billing infusion therapy, is there a contact that AAPC can give that would be able to assist if we need it?	For all coding questions, we refer our members to the online forums: *Forum Posting Instructions* 1. Login to your online account 2. In the middle of the page you will see “discussion forums” 3. Click on “view all” – top right hand side 4. Select “general discussion” under “medical coding” unless you see a topic that suits you more – 5. On the top left side of the forum box, you will see a blue button, “new thread” – click on that 6. Type your question and submit 7. Check back in that location for answers as you please