infusion coding and Billing

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DISCLAIMER

The information provided in this presentation is only intended to be a general summary. It is not intended to take the place of written regulations. We encourage you to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.
agenda

- Review patient flow through office
- Guidelines
- Hydration, Therapeutic and Chemotherapy Infusions
- Break down each category
- Review documentation
- ICD-10
- Drugs, including unclassified drugs
- Rules
- Physician Orders
To have a better understanding of billing for different types on infusions or hydration

- Bill drugs appropriately
- Coder will be able to look for what is needed in the documentation
- Coder will understand
Appointment Scheduling

- Phone calls
- In Office
- Follow-up from hospital
Patient Registration

- Information received over the phone
- Information received in the mail
- Information received from hospital
- Inaccurate information obtained delays claim
Patient Exam

- Patient seen by Physician
- Patient seen by lab
- Patient seen by Nurse
- Patient seen by NP
Documentation

- Documentation entered by clinical staff that has had encounter with patient
- Documentation NOT signed off and approved, delays claim
Guidelines

- ICD-10
- CPT
- HCPCS

- Each section begins with guidelines, it is best to read the guidelines for complete understanding of proper coding.
- Be sure to read ICD-10 guidelines, contains rules for proper coding of neoplasms
Hydration, therapeutic and chemotherapy infusions and injections

- Three main categories
  - Hydration
  - Therapeutic
  - Chemotherapy

If used to facilitate the infusion the following services are included and not reported separated:

- Use of local anesthesia
- Starting IV
- Access to indwelling IV
- Flush at conclusion of treatment
- Standard supplies
infusions

- **Initial Infusion**
  - The key or primary reason for the encounter reported irrespective of the order in which the infusion was administered
  - Facility reporting, initial infusion is based using the hierarchy.
  - Only one initial infusion should be reported unless the protocol requires two separate IV sites

- **Sequential infusion**
  - Infusion or push of a new substance or drug following an initial service
  - Requires a “new” drug

- **Concurrent infusion**
  - Infusion of a new substance infused at the same time as another drug or substance
  - Not based on time
  - Reported only once per occurrence
HYDRATION

- Intended to report a hydration of pre-packaged fluid (EX: NSS, D5W)
- Not used to report infusion of drugs
- Typically require direct supervision
- Some chemotherapy treatments require pre and post hydration
- Not reported to keep vein open
- Minimum time duration of 31 minutes
Hydration

- 96360 – INITIAL, 31 minutes to 1 hour
- 96361 – each additional hour, list separately in addition to code for primary procedure. Must be more than 31 minutes to report additional hour.

- 96361 – is reported for hydration when other infusions are reported during the same encounter. Can only report if patient receives hydration before or after chemotherapy. At least 31 minutes.
- Add modifier -59 with other infusions
Therapeutic infusions

- Administration of drugs
- Fluids used to administer the drug(s) are included in the administration code and not reported separately
- Typically require direct supervision
- Used to administer antibiotics, antiemetic’s, narcotics, analgesics, steroidal agents
Therapeutic infusions

- 96365 – INITIAL, infusion, up to one hour
- 96366 – Additional hour, must be over 31 mins
- 96367 – addl. sequential infusion, up to 1 hour
- 96368 – concurrent infusion, only one per encounter
- 96372 - subcutaneous or IM injection
- 96374 – INITIAL, push (15 minutes or less)
- 96375 – each addl. subsequent push (15 minutes or less)
Chemotherapy and highly complex drug administration

- Apply to anti-neoplastic drugs
- Monoclonal antibody agents
- Biologic response modifiers
- Requires highly trained staff
- Typically require direct supervision
- Fluids not billed separately when used to facilitate the infusion
- Chemotherapy in 96401-96549 includes highly complex drugs or highly complex biologic agents
Chemotherapy infusions

- 96401 – sq or IM injection, non-hormonal anti-neoplastic
- 96402 – sq or IM injection, hormonal anti-neoplastic
- 96409 – INITIAL, push
- 96411 – each addl. sequential push
- 96413 – INITIAL, infusion, up to 1 hour
- 96415 – each additional hour, must be over 31 mins
- 96416 – initiation of prolonged infusion (more than 8 hrs) requiring the use of a portable or implantable pump
- 96417 – each sequential infusion, up to 1 hour
Others

- 96420 – intra-arterial push
- 96450 – chemo admin into CNS requiring and including spinal puncture
- 96521 – refilling and maintenance of portable pump
- 96522 – refilling and maintenance of implantable pump
- 96523 – port flush, not reported when other services or an E&M are performed
Multiple drug administrations

- Each encounter needs ONE (1) INITIAL administration codes.
- Report initial code for main reason patient is being seen
- When more than one drug is mixed in the same bag, only one administration code is reported
RULES

- To bill an additional hour, it must be 31 minutes or over (total admin time 91 + minutes)
- To bill an infusion, it must be over 16 minutes
- If a drug is infusing at the same time of another drug, in a separate bag, that is a concurrent infusion. Only use once per encounter. There is no code for additional hours with a concurrent infusion.
- 15 minutes and under is considered a push
- Fluids used to administer drugs are not reported separately
Drugs

- You can usually identify a chemo drug, USUALLY starts with J9xxx
- Drugs with J codes under J9xxx are non-chemo drugs
- Regardless of type of drugs and order of drugs administered, always bill an initial code for the MAIN REASON the patient is being seen
Billing unclassified drugs

- Report appropriate unclassified code;
  - J3490
  - J3590
  - J9999
- Must report the name of drug, dose administered and NDC number
- Practice Management Systems will differ with reporting drug information.
- Medicare – unclassified drugs, billing units = 1
Drugs

- Drugs are billed with a unique J code
- Each J code has a billing unit attached to it
- Round up
- Single dose vial (SDV) must report waste
- Modifier JW on a separate line for Medicare and Medicare Advantage Plans. Some commercial carriers require this as well
- Documentation MUST support dose and waste
Nursing documentation MUST show **start and stop times** for EACH Drug

If a patient is given a drug that is a single dose vial (SDV), documentation MUST show waste

Documentation must support what is billed

If reported diagnosis codes do not reflect what patient is being seen for, must speak to physician for clarification

Read all notes and coding guidelines for each section

Must have signed physician order
Physician orders

- Drug
- Dose
- Route of administration
- Frequency
- Duration
- Signature
DIAGNOSIS codes

- Each diagnosis code reported must be supported in documentation
- When looking for a diagnosis code, begin by looking for the main term
- Always select a code to its highest specificity (additional digits)
- Usually the first code listed represents the patient’s reason for the visit
- Do not report conditions that no longer exist or do not pertain to the visit
- Use current year codes
- Use NEC and NOS appropriately
coding misconceptions

- Multiple infusions – when more than 1 drug is mixed in the same bag, report only one administration code.
- Saline Supplies – saline and supplies are not reported separately, they are included in the administration
- Medication provided by other sources – only report HCPCS for medications supplied by the physician
Procrit and Aranesp

- Modifiers (EA, EC)
- Diagnosis codes
  - Anemia due to chemo treatment
  - Anemia due to Chronic Kidney Disease (CKD)
- Report Hgb or HCT
Chemo examples
QUESTIONS
Contact Info:
Fran Spine, LPN, CCS-p, CHONC, CPMA, CPCO, AAPC Professional
fspine@oncologybilling.com