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Infusion Best Practices:
Basic Coding & Documentation

Presented by

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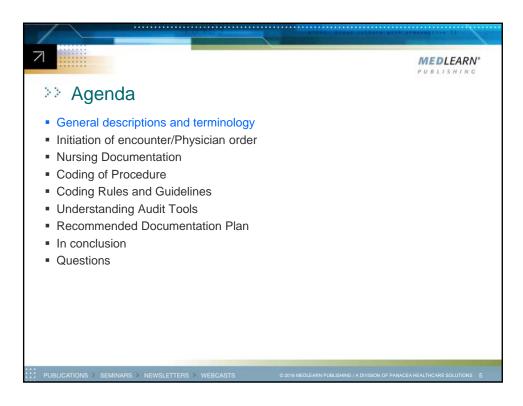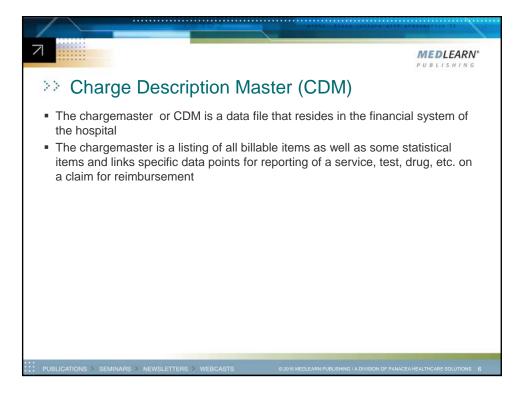**Kim Charland, BA, RHIT, CCS**

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Objectives

- To understand coding and documentation essentials, including definitions, CPT® codes, coding hierarchies, and the documentation required for code assignment
- To understand coding guidelines for hydration, drug administration and chemotherapy
- To understand documentation and selection of appropriate CPT procedure codes
- To correctly apply the complexity logic of the CPT coding hierarchy
- To successfully navigate through common compliance issues

Agenda

- General descriptions and terminology
- Initiation of encounter/Physician order
- Nursing Documentation
- Coding of Procedure
- Coding Rules and Guidelines
- Understanding Audit Tools
- Recommended Documentation Plan
- In conclusion
- Questions

Charge Description Master (CDM)

- The chargemaster or CDM is a data file that resides in the financial system of the hospital
- The chargemaster is a listing of all billable items as well as some statistical items and links specific data points for reporting of a service, test, drug, etc. on a claim for reimbursement

Charge Description Master Example

SAMPLE CHARGEMASTER						
Tran Code / CDM # / EAP # / Item #	Charge Description	CPT/ HCPCS Code	UB Rev Code	Dept #	Dept Name	Price
XX1040Z	IV HYDRATION 1ST HR	96360	260	930	OP INFUSION	$ 125.00
XX1041Z	IV HYDRATION EA ADDL HR	96361	260	930	OP INFUSION	$ 30.00
XX1050Z	IV INFUS 1ST HR	96365	260	930	OP INFUSION	$ 135.00
XX1055Z	IV INFUS EA ADDL HR	96366	260	930	OP INFUSION	$ 50.00
XX1051Z	IV INFUS EA ADDL SEQ 1HR	96367	260	930	OP INFUSION	$ 60.00
XX0051Z	IV INFUS CONCURRENT	96368	260	930	OP INFUSION	$ 60.00
XX0953Z	IVP INJ INITIAL MED	96374	940	930	OP INFUSION	$ 65.00
XX0095Z	IVP INJ EA ADDL MED	96375	940	930	OP INFUSION	$ 65.00
XX0096Z	IVP INJ EA ADDL SAME MED	96376	940	330	OP INFUSION	$ 65.00
XX0853Z	BLOOD ADMIN UP TO 2 HRS	36430	391	930	OP INFUSION	$ 200.00
XX0085Z	BLOOD ADMIN >2 HRS <4 HRS	36430	391	930	OP INFUSION	$ 300.00
XX0087Z	BLOOD ADMIN 4 TO 6 HRS	36430	391	930	OP INFUSION	$ 400.00
XX0801Z	NORMAL SALINE 250CC	J7050	258	250	Pharmacy	$ 55.00
XX0802Z	NORMAL SALINE 500CC	J7040	258	250	Pharmacy	$ 5.00
XX0803Z	NORMAL SALINE 1000CC	J7030	258	250	Pharmacy	$ 100.00
XX0530Z	BENADRYL INJ 50MG	J1200	636	250	Pharmacy	$ 22.00
XX0111Z	METHOTHREXATE 50 MG	J9250	636	250	Pharmacy	$ 15.00
XX0075Z	VINCRISTINE 1MG/2MG	J9370	636	250	Pharmacy	$ 55.00

Current Procedural Terminology
Healthcare Common Procedure Coding System

- CPT
  - CPT codes are five-digit, all-numeric codes designed to describe the procedures and services physicians provide to patients.
  - Although the CPT was developed for physicians, hospitals also use this set of codes to represent procedures, services, or items provided by clinical and ancillary departments.
  - **96360   Intravenous infusion, hydration; initial, 31 minutes to 1 hour**
- HCPCS
  - HCPCS codes, are five-digit codes—one letter followed by four numbers. The codes included in HCPCS Level II are predominantly "things" rather than "services."
  - The billing of outpatient infusion services will most usually include at least one HCPCS code from the J or P series, which represent separately billable drugs or blood products.
  - **J7030   Infusion, normal saline solution, 1000 cc**

Hospital Outpatient

- An outpatient encounter is a type of ancillary, medical or surgical care performed at a hospital without expectation of an overnight hospital stay.
- These outpatient services include:
  - Blood transfusions
  - Administration of drugs or biologicals
  - Emergency department services
  - Physician / Occupational Therapy
  - Pulmonary / Cardiac Rehabilitation Services
  - Outpatient clinic services, including same day surgery
  - Diagnostic radiology and other imaging services
  - Hospital billed laboratory test
- Some circumstances may require an overnight hospital stay without qualifying for admission as an inpatient. This overnight stay would still be qualified as an outpatient service.
  - Post-procedure recovery (up to 6 hours)
  - Extended transfusion or drug administration service

Hospital Inpatient

- In addition to the physicians medical decision or clinical judgment Medicare suggests that an inpatient admission requires criteria based on intensity of care screening and medical necessity screening to support the admission to this level of care.
- Most hospitals utilize InterQual or Milliman criteria to screen a patient for inpatient admission.
  - Standardized scoring system in either electronic or paper format
  - Medical history and severity of signs and symptoms
  - Expectation that care will require at least an overnight stay in a hospital bed.
- Physician Advisor criteria may also be utilized
- Physician order defines the level of care
  - Outpatient or Inpatient
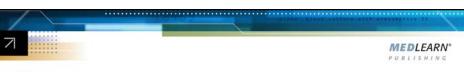
Observation

- Outpatient level of care includes observation services and procedures as deemed medically necessary
  - Observation is not a defined level of care
  - Observation represents a clinically defined set of services for short term assessment and reassessment for further medical decision making
  - Patient's current level of severity does not meet the criteria for admission to inpatient status
  - Patient's clinical condition is uncertain and does not support discharge from either a clinic or emergency department encounter
  - Patient's condition may either improve or deteriorate during observation period and a medical decision is made to either discharge or admit to inpatient status
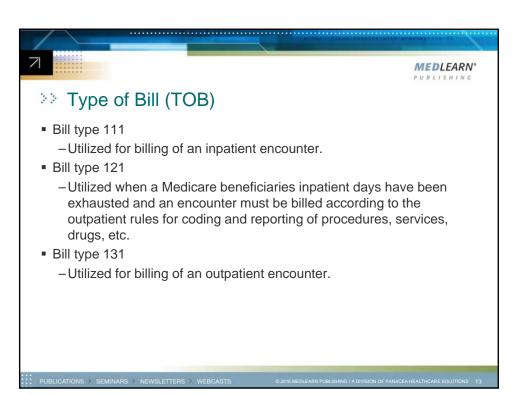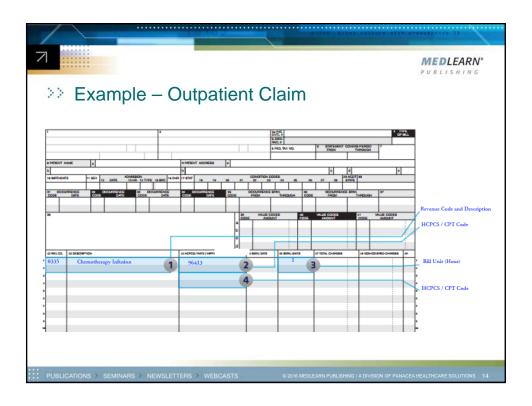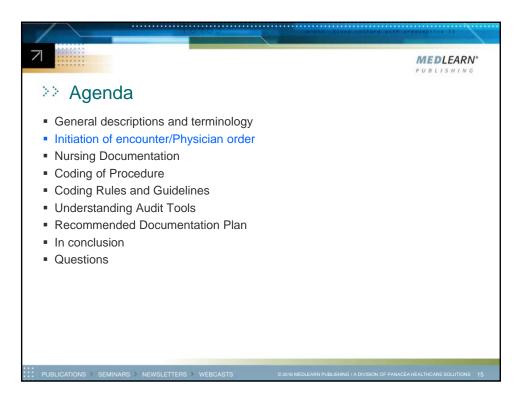
Outpatient Prospective Payment System
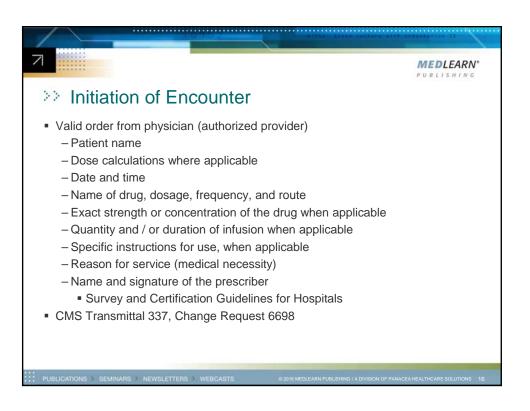
- The rules and guidelines for reporting outpatient hospital services to Medicare are defined in the outpatient prospective payment system (OPPS)
- Outpatient care in an acute care hospital is reimbursed by Medicare through assignment of a service, supply or drug to an ambulatory payment classification (APC)
- APC reimbursements are directly linked by Medicare to the applicable CPT or HCPCS code reported on the outpatient claim submitted by an acute care hospital.
- Critical access hospitals (CAH) are reimbursed under a cost-based strategy for the billed services.
  - Also referred to as non-OPPS hospital

Type of Bill (TOB)

- Bill type 111
  - Utilized for billing of an inpatient encounter.
- Bill type 121
  - Utilized when a Medicare beneficiaries inpatient days have been exhausted and an encounter must be billed according to the outpatient rules for coding and reporting of procedures, services, drugs, etc.
- Bill type 131
  - Utilized for billing of an outpatient encounter.

Example – Outpatient Claim

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>> Initiation of Encounter

- Valid order from physician (authorized provider)
  - Patient name
  - Dose calculations where applicable
  - Date and time
  - Name of drug, dosage, frequency, and route
  - Exact strength or concentration of the drug when applicable
  - Quantity and / or duration of infusion when applicable
  - Specific instructions for use, when applicable
  - Reason for service (medical necessity)
  - Name and signature of the prescriber
    - Survey and Certification Guidelines for Hospitals
- CMS Transmittal 337, Change Request 6698

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Nursing Documentation of Encounter

- At a minimum, documentation for drug administration should include the following components:
  - Service line complexity (chemotherapy, drug administration, hydration therapy)
  - Drug name (classification / categorization)
  - Mode of administration (Route)
  - Access site
  - Start time and stop time
  - Rate of administration
  - Dose and / or total volume
  - Flush or clearing of the line

Nursing Documentation of Encounter

- Documentation to support that the care provided meets the facility standard of care as well as the charges reported for the service:
  - Name of person inserting catheter
  - Type, length, and gauge of catheter
  - Date and time
  - Name of vein accessed
  - Number and location of access attempts
  - Dressing application
  - Patient toleration of procedure
  - Infiltration at access site
  - Indication for management of multiple IV access sites

Nursing Documentation of Encounter

- Also document:
  - Dressing or tubing changes
  - Changes in orders
  - Specific safety or infection control measures
  - Other medication(s) administered – oral medications
  - Addition / change of a bag of solution with time recorded
  - Complications and interventions
  - Discontinuance of the therapy and removal of the IV

Documentation in the Electronic Health Record

Medication Orders			
NaCl 0.9% [577188507]		Ordering Provider:	MD
Electronically signed by:	RN#1 on 01/19/16 0711	Ordering Mode:	Written / Paper
Ordering user:	RN#1 on 01/19/16 0711	Class:	Normal
Authorized by:	MD	Discontinued By:	Auto: Discharge
Frequency:	Continuous 01/19/16 – 01/20/16		
Released by:	RN#2 on 01/19/16 1413	Discharge from hospital	01/20/16 0218
Acknowledged by:	RN#2 on 01/19/16 1413 for Placing of Order		
Route:	Intravenous	Dose:	25mL / hr
Start:	01/19/16 1415	End:	01/20/16 0218
Priority:	Routine	Status:	Discontinued

Documentation in the Electronic Health Record

All Medications and Administrations			
NaCl 0.9% [577188507]			
Ordering Provider:	MD	Starts / Ends:	01/19/16 1415 – 01/20/16 0218
Ordered On:	01/19/16 1413	Frequency:	Continuous
Dose (Remaining Total):	25mL / hr	Status	Discontinued (Past End Date/Time)
Priority:	Routine	Reason	Discharge from hospital
Administration Instruction:			
Comments:			

Administration:	Status:	Dose:	Route:	Site:	By:
01/19/16 1429	New Bag	25mL / hr	Intravenous		RN#2
Start:	01/19/16 1415	Rate:	25mL / hr	End:	01/20/16 0218

Documentation in the Electronic Health Record

MEDICATIONS	4010-215515477600	COMPLETED	01/02/15	16:00

ROCEPHIN

MEDICATION		DOSE		PER

DISCONTINUED   01/02/15   15:59

ROCEPHIN   1GM

D5W   VOL: 100ML

	ROUTE	FREQUENCY	SCHED	PRN	Reason
	IV	AS DIRECTED	X		

RATE: 100 MLS/HR

STOP DATE / TIME: 01/04/14   15:59

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2016 CPT Codes & APC Status Indicator

CPT	Description	SI
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	S
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	S
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour	S
96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)	S
96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (List separately in addition to code for primary service)	S
96368	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary service)	N
96369	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); up to one hour, including pump set-up and establishment of subcutaneous infusion site(s)	S
96370	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary service)	S

2016 CPT Codes & APC Status Indicator

CPT	Description	SI
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	S
96373	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intra-arterial	S
96374	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	S
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)	S
96376	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure)	N
96379	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion	S
C8957	Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump (non-chemo)	S

2016 CPT Codes & APC Status Indicator

CPT	Description	SI
96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	S
96402	Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic	S
96409	Chemotherapy administration; intravenous, push technique, single or initial substance/drug	S
96411	Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)	S
96413	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug	S
96415	Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure)	S
96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump	S
96417	Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure)	S

2016 CPT Codes & APC Status Indicator

CPT	Description	SI
96521	Refilling and maintenance of portable pump	S
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial)	S
96523	Irrigation of implanted venous access device for drug delivery systems	Q1
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	S
96549	Unlisted chemotherapy procedure	S

Coding of Procedure – Complexity Level

- **Chemotherapy Administration**
  - These highly complex services require advanced practice training and competency for staff who provide these services; special considerations for preparation, dosage or disposal.
    - Commonly, these services entail significant patient risk and frequent monitoring.
- **Therapeutic / Diagnostic Drug Administration**
  - Typically, such infusions require special consideration to prepare, dose or dispose of, require practice training and competency for staff who administer the infusions, and require periodic patient assessment with vital sign monitoring during the infusion.
    - The administration typically requires minimal monitoring and minimal patient risk.
- **Hydration Therapy**
  - Typically such infusions require little special handling to prepare or dispose of, and staff that administer these do not typically require advanced practice training.
    - The infusion typically entails little risk and minimal or no monitoring.

Coding of Procedure – Complexity Level

- **Intravenous Infusion**
  - Intravenous infusion is defined as an infusion lasting more than 15 minutes through an IV access line, catheter, or pre-existing venous access device (VAD).
- **Intravenous Injection – Push**
  - An IV injection typically requires a commitment of time during which the healthcare professional administering the substance is *continuously present at the patient's bedside* to administer and observe the patient.
  - The drug is administered from a syringe and "pushed" into a venous access site.
- **Injection – Subcutaneous or Intra-muscular**
  - An injection is generally a small volume of medication delivered in a single shot. The substance is given directly by subcutaneous (SQ), intra-muscular (IM), or intra-arterial (IA) routes, as opposed to an IV injection (IV push) that requires a commitment of time.

Coding of Procedure – Time Increments

- 15-minute rule
  - The AMA and CMS have defined a time requisite for IV infusions lasting 15 minutes or less, requiring the procedure to be billed as an intravenous push injection (IVP) rather than IV infusion.
- 30-minute rule
  - Hydration therapy requires a minimum of 30 minutes of time to be recorded before this becomes a billable service.
  - Intravenous push injections require 30 minutes of lapsed time between injection of the same drug before a sequential procedure is billable.
- 60-minute rule
  - Codes defined as "initial hour" are reported for infusions lasting 16 minutes and up to 90 minutes.
  - For IV infusion of greater than one hour but equal to or less than 90 minutes, report only one code to bill for the initial hour of service.

Start and Stop Times
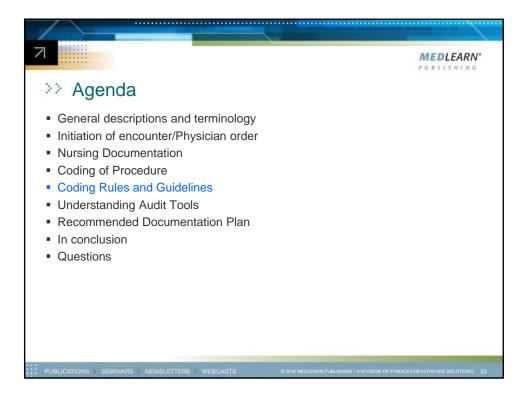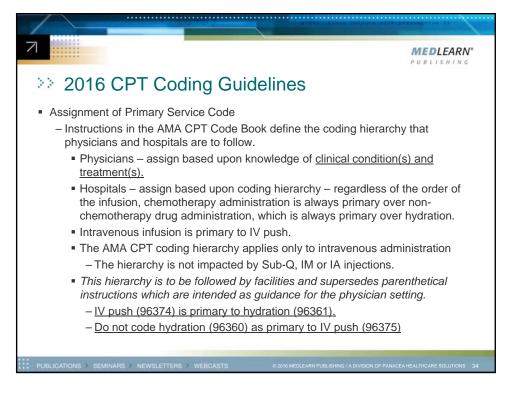
- "When a code describes a mode of administration that is time-dependent, such as 'per hour' the documentation in the patient record must provide an exact reference to start and stop times."
- AMA CPT Assistant
  - Coding Communication:
  - Drug Infusion Administration Services - Part 3 of 3
  - September 2007 Page 3

"Infusion time is calculated from the time the administration commences (i.e., the infusion starts dripping) to when it ends (i.e., the infusion stops dripping)."

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2016 CPT Coding Guidelines

- Assignment of Primary Service Code
  - Instructions in the AMA CPT Code Book define the coding hierarchy that physicians and hospitals are to follow.
    - Physicians – assign based upon knowledge of <u>clinical condition(s) and treatment(s).</u>
    - Hospitals – assign based upon coding hierarchy – regardless of the order of the infusion, chemotherapy administration is always primary over non-chemotherapy drug administration, which is always primary over hydration.
    - Intravenous infusion is primary to IV push.
    - The AMA CPT coding hierarchy applies only to intravenous administration
      - The hierarchy is not impacted by Sub-Q, IM or IA injections.
    - *This hierarchy is to be followed by facilities and supersedes parenthetical instructions which are intended as guidance for the physician setting.*
      - <u>IV push (96374) is primary to hydration (96361).</u>
      - <u>Do not code hydration (96360) as primary to IV push (96375)</u>

Coding Rules – Hydration

- The determination of whether to bill hydration as the Primary or Secondary service will depend on whether another intravenous administration has occurred during the same encounter.
  - Pre- and Post-Hydration times are added together and reported as secondary.
  - SubQ and IM injections do not affect the coding hierarchy for administration.
  - "Other Chemotherapy" procedures such as intraperitoneal infusion do not affect the coding hierarchy for intravenous administration.
  - Blood administration does not impact the selection of primary and secondary CPT.
  - In an emergent scenario where IV fluids may be infused at a rapid rate – if the infusion of fluid is complete in 30 minutes or less there is not a billable code for hydration therapy.
  - Hydration CPT codes are limited to the infusion of prepackaged fluids or electrolytes
    - When injecting a drug or electrolyte into a bag of prepackaged fluid the CPT code series for Drug Administration is reported, not hydration.
  - Management of a "free-flow line" during chemotherapy for administration of other drugs or during blood administration is incidental. Do not code as hydration therapy.

Counting time?

- **Hydration Therapy** – Large Volume Pre-packaged Fluids
  - 30 minutes or less time recorded = **non-billable service**
  - Initial hour of time begins at **31 minutes and continues to 90 minutes**
  - Additional hour of time begins at **91 minutes**
- Examples
  - Hydration started 9:30 stopped at 10:00 = non-billable
  - Hydration started 9:30 stopped at 10:45 = 1 hour Hydration Therapy
  - Hydration started 9:30 stopped at 11:00 = 1 hour Hydration Therapy
  - Hydration started 9:30 stopped at 11:01 = 2 hours Hydration Therapy

⟫ Coding Rules – Drug Administration

- The determination of whether to bill drug administration as a Primary or Secondary service will depend on whether another intravenous administration has occurred during the same encounter.
  - Intravenous drug administration will be secondary to intravenous chemotherapy administration by either IV push injection or IV infusion.
  - SubQ and IM injections do not affect the coding hierarchy for administration.
  - "Other Chemotherapy" procedures such as intraperitoneal infusion do not affect the coding hierarchy for intravenous drug administration.
  - Administration of albumin and coagulation factors is reported as drug administration, not blood transfusion.
  - In an emergent scenario where a drug may be infused at a rapid rate – if the infusion is complete in 15 minutes or less the intravenous infusion is billed as an intravenous injection (96374, 96375, or 96376) not as intravenous infusion.
  - Determination to bill for intravenous injection or intravenous infusion when stop time is not recorded in the medical record for drug administration is dependent on the coding and billing policies of the individual payers.

⟫ **Counting Time?**

- **Drug Administration** – Antibiotic, Pain Management, Pre-/Post-Medications
  - 15 minutes or less time recorded for intravenous infusion = **IV push injection**
  - Initial hour of time begins at **16 minutes and continues to 90 minutes**
  - Additional hour of time begins at **91 minutes**
- Examples
  - IV drug infusion started 9:30 stopped 9:45   = IV Push Injection – Drug Admin
  - IV drug infusion started 9:30 stopped 9:46   = 1 hour IV infusion – Drug Admin
  - IV drug infusion started 9:30 stopped 11:00 = 1 hour IV infusion – Drug Admin
  - IV drug infusion started 9:30 stopped 11:01 = 2 hour IV infusion – Drug Admin

Coding Rules – Chemotherapy
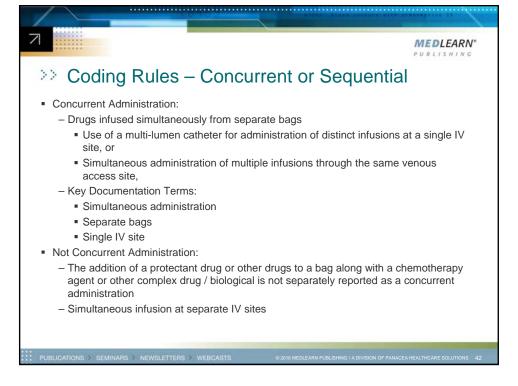
- The determination of whether to bill chemotherapy administration as the Primary service is dependent on the drug administered.
  - Chemotherapy when administered intravenously will always be coded as primary to drug administration or hydration therapy.
  - Complex drugs defined by a J9XXX code and J1745 (infliximab) when administered for non-cancer diagnosis are reported as chemotherapy administration, not drug administration.
  - SubQ and IM injections do not affect the coding hierarchy for administration.
  - "Other Chemotherapy" procedures such as intraperitoneal infusion do not affect the coding hierarchy for intravenous administration.
- The code series for chemotherapy does not include a CPT for concurrent administration of a chemotherapy agent.
  - When coding of a concurrent administration in addition to a chemotherapeutic administration the most likely scenario is that the additional drug is not a second chemotherapy agent and would accurately coded from the series for drug administration.
  - Concurrent administration of a chemotherapy agent is reported with CPT 96549, the unlisted procedure code for chemotherapy services.

Counting Time?

- **Chemotherapy Administration** – Anti-neoplastic, Highly Complex Drugs (MABs, BRM)
  - 15 minutes or less time recorded for intravenous infusion = **IV push injection**
  - Initial hour of time begins at **16 minutes and continues to 90 minutes**
  - Additional hour of time begins at **91 minutes**
- Examples
  - Intravenous chemotherapy started 8:00 stopped 8:15 = IV Push Injection – Chemotherapy administration
  - Intravenous chemotherapy started 8:00 stopped 8:20 = 1 hour IV Infusion - Chemotherapy administration
  - Intravenous chemotherapy started 8:00 stopped 9:20 = 1 hour IV Infusion - Chemotherapy administration
  - Intravenous chemotherapy started 8:00 stopped 9:31 = 2 hour IV Infusion - Chemotherapy administration

Coding Rules – Concurrent or Sequential

- Sequential Administration:
  - Secondary intravenous procedures are reported as sequential or additional hour
    - Different drug = sequential CPT
    - Same drug = additional hour CPT
  - Key Documentation Terms:
    - Sequential or following one after the other in sequence
    - Different drug
    - Same drug
  - Time requirements of the sequential or additional hour service codes must be met and recorded in documentation maintained in the permanent medical record
    - Greater than 30 minutes between intravenous injection of same drug
    - Greater than 15 minutes of intravenous infusion of different drug
      - 15 minutes or less is reported as intravenous injection
    - Greater than 15 minutes of intravenous infusion of same drug
      - 15 minutes or less is reported as intravenous injection

Coding Rules – Concurrent or Sequential

- Concurrent Administration:
  - Drugs infused simultaneously from separate bags
    - Use of a multi-lumen catheter for administration of distinct infusions at a single IV site, or
    - Simultaneous administration of multiple infusions through the same venous access site,
  - Key Documentation Terms:
    - Simultaneous administration
    - Separate bags
    - Single IV site
- Not Concurrent Administration:
  - The addition of a protectant drug or other drugs to a bag along with a chemotherapy agent or other complex drug / biological is not separately reported as a concurrent administration
  - Simultaneous infusion at separate IV sites

2016 CPT AMA Coding Guidelines

- Hospitals report only one initial administration per encounter for each vascular site.
  - 2016 AMA CPT Instruction related to Time
  - A unit of time is attained when the mid-point is passed.
    - For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and sixty minutes).
    - A second hour is attained when a total of 91 minutes have elapsed.
    - When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used. See also the Evaluation and Management (E/M) Services Guidelines.
    - When another service is performed concurrently with a time-based service, the time associated with the concurrent service should not be included in the time used for reporting the time-based service.
    - Some services measured in units other than days extend across calendar dates. When this occurs a continuous service does not reset and create a first hour.
  - However, any disruption in the service does create a new initial service.
    - For example, if intravenous hydration (**96360**, **96361**) is given from 11 pm to 2 am, **96360** would be reported once and **96361** twice. For facility reporting on a single date of service or for continuous services that last beyond midnight (ie, over a range of dates), report the total units of time provided continuously.
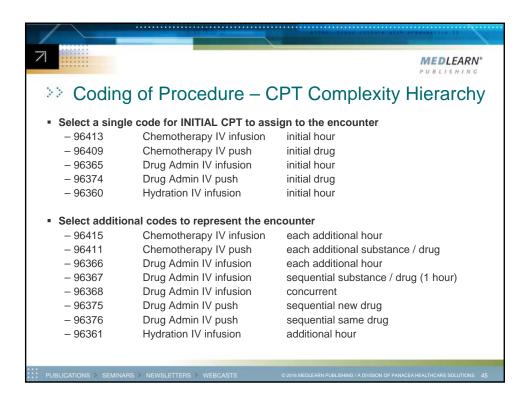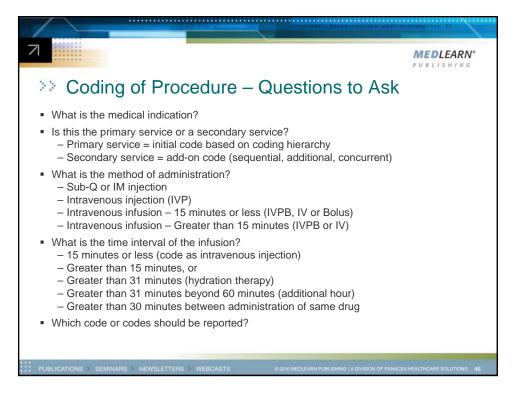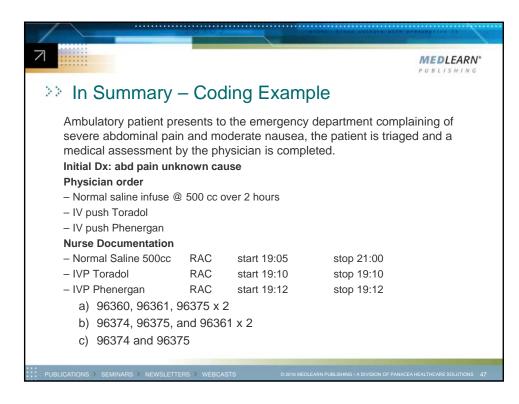
2016 CPT Coding Guidelines
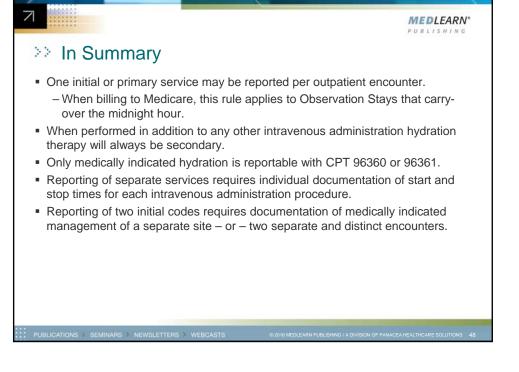
- An encounter that initiates in the Emergency Department and results in referral to the Outpatient Observation Unit is a single outpatient encounter.
- The observation stay that crosses over the midnight hour is also a single outpatient encounter.
- The date range reported on the claim should accurately reflect admit and discharge dates this will open the claim dates in the Outpatient Code Editor (OCE) to identify the claim as one encounter spanning multiple dates.
- An intravenous infusion that extends past the midnight hours does not reset the time for counting of billable hours and does not support addition of another "initial hour" charge.
  - The initial hour and additional hour charges are reported on the claim with a date of service that correlates to the date the intravenous infusion was initiated.

>> Coding of Procedure – CPT Complexity Hierarchy

- **Select a single code for INITIAL CPT to assign to the encounter**
  - 96413   Chemotherapy IV infusion   initial hour
  - 96409   Chemotherapy IV push   initial drug
  - 96365   Drug Admin IV infusion   initial hour
  - 96374   Drug Admin IV push   initial drug
  - 96360   Hydration IV infusion   initial hour

- **Select additional codes to represent the encounter**
  - 96415   Chemotherapy IV infusion   each additional hour
  - 96411   Chemotherapy IV push   each additional substance / drug
  - 96366   Drug Admin IV infusion   each additional hour
  - 96367   Drug Admin IV infusion   sequential substance / drug (1 hour)
  - 96368   Drug Admin IV infusion   concurrent
  - 96375   Drug Admin IV push   sequential new drug
  - 96376   Drug Admin IV push   sequential same drug
  - 96361   Hydration IV infusion   additional hour

>> Coding of Procedure – Questions to Ask

- What is the medical indication?
- Is this the primary service or a secondary service?
  - Primary service = initial code based on coding hierarchy
  - Secondary service = add-on code (sequential, additional, concurrent)
- What is the method of administration?
  - Sub-Q or IM injection
  - Intravenous injection (IVP)
  - Intravenous infusion – 15 minutes or less (IVPB, IV or Bolus)
  - Intravenous infusion – Greater than 15 minutes (IVPB or IV)
- What is the time interval of the infusion?
  - 15 minutes or less (code as intravenous injection)
  - Greater than 15 minutes, or
  - Greater than 31 minutes (hydration therapy)
  - Greater than 31 minutes beyond 60 minutes (additional hour)
  - Greater than 30 minutes between administration of same drug
- Which code or codes should be reported?

In Summary – Coding Example

Ambulatory patient presents to the emergency department complaining of severe abdominal pain and moderate nausea, the patient is triaged and a medical assessment by the physician is completed.

Initial Dx: abd pain unknown cause

Physician order

– Normal saline infuse @ 500 cc over 2 hours

– IV push Toradol

– IV push Phenergan

Nurse Documentation

– Normal Saline 500cc	RAC	start 19:05	stop 21:00
– IVP Toradol	RAC	start 19:10	stop 19:10
– IVP Phenergan	RAC	start 19:12	stop 19:12

   a) 96360, 96361, 96375 x 2

   b) 96374, 96375, and 96361 x 2

   c) 96374 and 96375

In Summary

- One initial or primary service may be reported per outpatient encounter.
  - When billing to Medicare, this rule applies to Observation Stays that carry-over the midnight hour.
- When performed in addition to any other intravenous administration hydration therapy will always be secondary.
- Only medically indicated hydration is reportable with CPT 96360 or 96361.
- Reporting of separate services requires individual documentation of start and stop times for each intravenous administration procedure.
- Reporting of two initial codes requires documentation of medically indicated management of a separate site – or – two separate and distinct encounters.

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Getting Ready/ Understand Audit Tools

- CMS expects providers (hospitals) to know:
  - Where previous improper payments have been found (OIG, CERT, RAC)
  - If you are submitting claims with improper payments
  - How to respond to medical record requests
  - How to appeal when necessary
  - How to learn from your past experiences
- According to CMS, improving self-auditing programs may be the best defense against the audit programs.

Prepayment Claim Review Programs

- National Correct Coding Initiative (NCCI)
  - These edits were implemented in 1996 to ensure that providers bill only the most appropriate code or codes to the Medicare program and to provide accurate grouping of services for the purpose of reimbursement.
  - The CCI provides guidelines for accurate application of billing modifiers.
- NCCI Edits Overview Web Page:
  http://www.cms.hhs.gov/NationalCorrectCodeInitEd/
- NCCI Education Material Web Page:
  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How-To-Use-NCCI-Tools.pdf
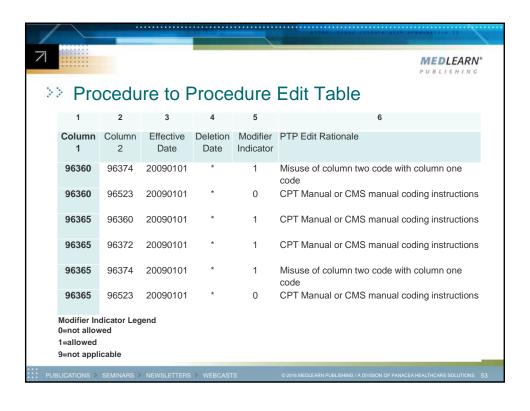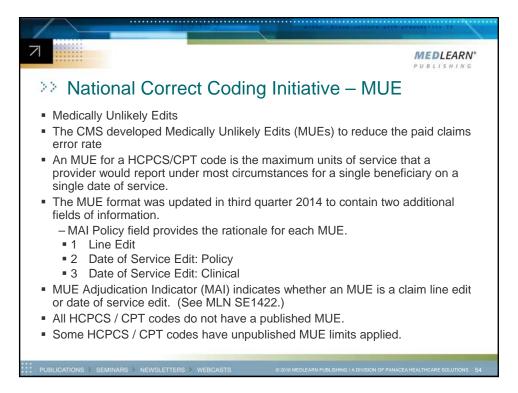
National Correct Coding Initiative – PTP
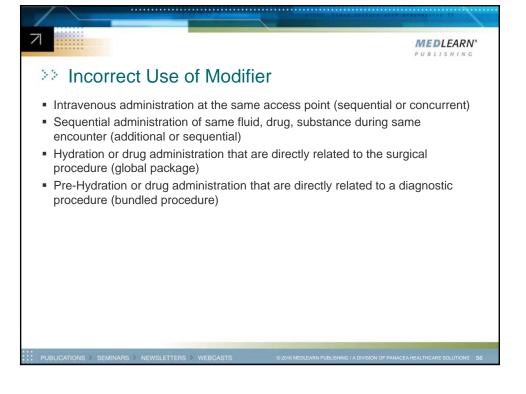
- Procedure – to – Procedure Edits
  - The Medicare NCCI procedure to procedure (PTP) edits are defined by two categories:
    - Column One/Column Two Correct Coding edit
    - Mutually Exclusive edit
  - Each category is based on the criterion for the code pair edit.
  - The Mutually Exclusive edits apply where two procedures could not be performed at the same patient encounter because the two procedures were mutually exclusive based on anatomic, temporal, or gender considerations
  - The Column One/Column Two Correct Coding logic applies to all remaining code pair edits to improve compliance with coding guidelines, identify potential coding errors and prevent improper payment when certain codes are submitted together.
- All PTP edits are published in a single table and follow the same logic for determination of payable code, code in question and modifier rules

Procedure to Procedure Edit Table

1	2	3	4	5	6
Column 1	Column 2	Effective Date	Deletion Date	Modifier Indicator	PTP Edit Rationale
96360	96374	20090101	*	1	Misuse of column two code with column one code
96360	96523	20090101	*	0	CPT Manual or CMS manual coding instructions
96365	96360	20090101	*	1	CPT Manual or CMS manual coding instructions
96365	96372	20090101	*	1	CPT Manual or CMS manual coding instructions
96365	96374	20090101	*	1	Misuse of column two code with column one code
96365	96523	20090101	*	0	CPT Manual or CMS manual coding instructions

Modifier Indicator Legend
0=not allowed
1=allowed
9=not applicable

National Correct Coding Initiative – MUE

- Medically Unlikely Edits
- The CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate
- An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service.
- The MUE format was updated in third quarter 2014 to contain two additional fields of information.
  - MAI Policy field provides the rationale for each MUE.
    - 1   Line Edit
    - 2   Date of Service Edit: Policy
    - 3   Date of Service Edit: Clinical
- MUE Adjudication Indicator (MAI) indicates whether an MUE is a claim line edit or date of service edit. (See MLN SE1422.)
- All HCPCS / CPT codes do not have a published MUE.
- Some HCPCS / CPT codes have unpublished MUE limits applied.

Medically Unlikely Edit Table

1	2	3	4	5
HCPCS/ CPT Code	Outpatient Hospital Services MUE Values	MAI	MUE Adjudication Indicator	MUE Rationale
96360	1	1	Line Edit	Code Descriptor / CPT Instruction
96365	1	1	Line Edit	Code Descriptor / CPT Instruction
96374	1	3	Date of Service Edit: Clinical	Code Descriptor / CPT Instruction
96376	10	3	Date of Service Edit: Clinical	Clinical: Data
96402	2	3	Date of Service Edit: Clinical	Clinical: Data
96405	1	2	Date of Service Edit: Policy	Code Descriptor / CPT Instruction
96406	1	2	Date of Service Edit: Policy	Code Descriptor / CPT Instruction
96409	1	3	Date of Service Edit: Clinical	Code Descriptor / CPT Instruction
96413	1	3	Date of Service Edit: Clinical	Code Descriptor / CPT Instruction

Incorrect Use of Modifier

- Intravenous administration at the same access point (sequential or concurrent)
- Sequential administration of same fluid, drug, substance during same encounter (additional or sequential)
- Hydration or drug administration that are directly related to the surgical procedure (global package)
- Pre-Hydration or drug administration that are directly related to a diagnostic procedure (bundled procedure)

Prepayment Claim Review Programs

- Reasonable and Necessary Services
  - National Coverage Determination (NCD)
    - Lists acceptable diagnosis codes for each CPT
    - Take precedent over LCD
  - Local Coverage Determinations (LCD)
    - Lists acceptable diagnosis codes for each CPT
      - Differs from state to state
    - Supplemental Articles
      - Coding and Documentation Guidelines specific to a published LCD
  - Advanced Beneficiary Notice (ABN)
    - Provides notice to beneficiary of potential for financial liability before a service is performed.

Post Payment Claim Review – CERT/MAC/RAC

- **Hydration Services**
  - Per the Current Procedural Terminology (CPT®) manual, 96360 and 96361 are intended to report a hydration IV infusion to consist of a pre-packaged fluid and electrolytes only.
  - They are not used to report infusion of drugs or other substances. Hydration that is integral to the performance of a surgical procedure or transfusion or to establish an initial and underlying IV flow for a diagnostic or therapeutic infusion is not separately billable.
  - A physician order for hydration is required to evidence that services are reasonable and necessary.
- **Medical Documentation Required**
  - Necessity for administration of hydration should be supported within medical documentation.
  - It is important to distinguish the medical necessity of hydration from the use of fluid administration intended only to initiate flow or to keep the vein open.

≫ Documentation and Code Assignment

- A 52-year-old male patient received an intravenous infusion of 500cc normal saline to treat dehydration. The infusion began at 9:00 a.m. and continued without interruption until 10:31 a.m. the same day.
- Answer the following questions:
  - Why was the patient treated?
  - What type of substance did the patient receive?
  - How was this administered?
  - What was the duration of this service?
  - What is the primary CPT code for this encounter?
  - Does this encounter qualify for assignment of an add-on code?

≫ In Summary

1. Review Documentation
2. Pick CPT Codes
3. Check Payer Rules
4. Finalize CPT Code Selection
5. Check MUEs
6. Check NCCI edits
7. Check Payer Rules
8. Add modifiers if needed
9. Prepare claim for submission of charges

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Recommended Documentation Plan

- Develop and / or revise documentation forms that conform to the coding guidelines for injections, IV push and IV infusions.
- Clinical personnel focus on patient care and ensuring accurate and complete documentation of the encounter.
- Pharmacist to communicate classification of drug, fluid or substance to aide in the correct application of procedure codes.
- Health Information Management ensure accurate billing through review of documentation in patient record, apply coding guidelines, assign CPT/HCPCS codes, apply modifier (if indicated), generate charges for administration, review accuracy of drug codes and billing units (*any / or all of above*).

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>> In Conclusion

- As a best practice employees should be aware of how the processes within their specific areas of responsibility affect the denial of a claim and ultimately result in lost revenue.
  - Review and read all publications as well as Local and National Coverage Determinations issued by your intermediary and be aware of coverage requirements.
  - Make sure that all clinical, coding and billing staff are familiar with claim filing rules.
  - Confirm that all systems utilized for the purpose of charge entry, coding or billing are reviewed and tested for accuracy of data.
  - Perform mock record audits to insure documentation reflects the requirements outlined in published LCDs and NCDs.
  - Conduct pre-bill audits by comparing charges against documentation in the patient records.
  - Create an educational program based on audit findings to enhance awareness of any specific coverage limitations, medical necessity requirements or documentation guidelines that have not been met for those services provided.

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≫ Thank you for your participation!

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