OPPS vs. CPT: Coding injections and infusions

Coders already know that CMS doesn’t always follow the language in the CPT Manual.

For instance, code descriptions in many sections of the manual refer to “physicians.” However, CMS has said the term “physician” does not have to apply to hospitals in certain instances because other qualified nonphysician practitioners may be eligible to bill for a particular service under applicable Medicare coverage and payment policies.

Deviations like this can cause confusion for those who expect to read and follow CPT to the letter. Coders need to be careful and understand that they may have to rely on other sources to see where CMS has created exceptions to the CPT text.

The most recent example is the use of initial codes for injections and infusions when a patient’s visit lasts past midnight and the service is not continuous. Although the AMA added new introductory text to the 2011 CPT Manual addressing this scenario, that guidance only applies to physician reporting, not hospitals. Facilities could receive significant overpayments if their coders apply the wrong guidelines.

“How are hospital coding and billing staff supposed to know this, though?” asks Jugna Shah, MPH, president of Nimitt Consulting in Washington, DC. Unfortunately, knowing which guidance to apply requires coders or someone in the HIM department to critically read the new CPT text, notice the differences between it and CMS’ Claims Processing Manual, and raise questions about the differences with CMS.

The deviation for drug administration marks a change in CMS’ recent trend of following CPT guidelines, says Kimberly Anderwood Hoy, JD, CPC, director of Medicare and compliance for HCPro, Inc., in Danvers, MA.

When CMS first instituted the OPPS payment system, many of the CMS guidelines differed from CPT, which made things very difficult for providers. More recently, CMS has followed CPT more closely, as evidenced by recent critical care changes in which CMS modified its payment policy rather than deviating from new CPT coding guidelines.

But drug administration remains an area where the rules differ.

“You almost end up with two standards of coding, which is very, very difficult,” Hoy says. “That’s why CMS has stayed away from deviating from the CPT guidelines lately.”

“It’s so easy to trip yourself up trying to figure out which guidelines apply even though codes haven’t changed.”

—Kimberly Anderwood Hoy, JD, CPC

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Although the actual CPT codes for drug administration services have not changed, the guidance has, says Hoy. “It’s so easy to trip yourself up trying to figure out which guidelines apply even though codes haven’t changed.”

New CPT instructions

The AMA added a new subheading, “Time,” in the introduction to the 2011 edition of the manual. In that section, the guidelines state that if time-based services extend across the midnight hour and the services are interrupted, the provider should report an initial code for services on the second date of service. The CPT Manual includes the following example:

If intravenous hydration (96360, 96361) is given from 11 PM to 2 AM 96360 would be reported once and 96361 twice. However, if instead of a continuous infusion, a medication was given by intravenous push at 10 PM and 2 AM, as the service was not continuous, both administrations would be reported as initial (96374).

The above example makes clear that an add-on code would be inappropriate for the second injection because it is provided on a different date of service.

This is enormously confusing, says Shah, because the new text does not delineate a setting to which the new language applies. Naturally, when hospitals first saw the new text, they assumed that they would be required to change how they report these services in 2011. However, the new CPT guidance conflicts with long-standing CMS instructions to hospitals regarding how they should report drug administration services.

CMS guidance

In its January OPPS update transmittal, R2141CP, CMS provided guidance that contradicts the new CPT guideline. CMS instructs facilities to follow the instructions in the Claims Processing Manual, Chapter 4, Section 230.2(B), which states:

Drug administration services are to be reported with a line item date of service on the day they are provided. In addition, only one initial drug administration service is to be reported per vascular access site per encounter, including during an encounter where observation services span more than 1 calendar day.

In addition, under section C, “Payments for Drug Administration Services,” CMS states:

Beginning in CY 2007, hospitals should report only one initial drug administration service, including infusion services, per encounter for each distinct vascular access site, with other services through the same vascular access site being reported via the sequential, concurrent or additional hour codes. Although new CPT guidance has been
issued for reporting initial drug administration services, Medicare contractors shall continue to follow the guidance given in this manual.

CMS has published a number of FAQs directing providers to follow CPT guidelines in other coding areas. But in the case of drug administration, providers could end up in trouble with CMS if they do so.

**Applying the correct guidelines**

Because the *Claims Processing Manual* has not changed, coders and providers may not know they should not follow the new CPT guidelines for drug administration unless they saw the January transmittal. While new manual sections draw attention, providers don’t always go through all transmittals in detail, Hoy says, which could mean they are following the most recent CPT guidelines for drug administration even though they don’t apply to hospitals.

“My biggest concern is that people will assume they are coding correctly because they received education on the new codes before CMS’ transmittal came out,” Hoy says. Most coders attended education on the new codes and guidelines in November and December 2010 before *Transmittal R2141CP* was published. So they may assume they are coding correctly when, in fact, they are creating a compliance problem.

Every facility needs to have a point person to monitor the transmittals that CMS issues, Hoy says. Staff members in the revenue cycle area, not coders, are the ones most likely to have seen the transmittal. “They need to make sure they are communicating these coding-specific items to their coders and the chargemaster staff,” Hoy says.

Shah says coders and hospital staff alike should raise questions any time they see something that seems odd or contradictory. In the case of drug administration, that’s exactly what many did: They began asking CMS whether it intended to change its policy for hospital reporting or whether hospitals were supposed to again “ignore” the information in the *CPT Manual*.

Coders generally want to code to the CPT standards and may argue that they don’t code to payer policy, but they really have to, Hoy says. “If they don’t code to Medicare’s policy, they may have overpayments that could be considered fraud.”

Because Medicare is such a large governmental payer, it makes some of its own rules, Hoy says. That allows CMS to do things that are technically contrary to HIPAA standards.

Other third-party payers may also default to the Medicare rules, so someone within the organization needs to determine which guidance each third-party payer is following. “If you have it figured out for Medicare and you know a limited number of your payers are using the Medicare rule, just follow the Medicare rule for them,” Hoy says. “For everyone else, standard coding rules should be applied.”

Organizations also need to tune in to their individual MACs, Hoy says. Many of the differences between Medicare policy and CPT guidelines reside in local MAC guidance about how to document or use the codes. Although some national standards exist, CMS often defers to the MACs. So some MACs may have different rules than others. Fortunately, most organizations only have one MAC’s rules to learn.

HIM staff should make sure those coding rules are reflected in their coding software, as well, because that will make it easier to keep track of the different rules.

“Somewhere in their encoding software, there needs to be prompts showing Medicare’s rule deviates here,” Hoy says. Many encoders already have such a feature, so HIM staff should check to make sure the encoder includes prompts specific to their MAC.

“I think this has the potential to sneak up as a very big compliance issue,” Hoy says.

Shah fully agrees noting that reporting two initial service codes when only one should be reported could lead to significant overpayment.

Dig into the details of wound care documentation

Documentation is central to accurate coding and reimbursement. It justifies treatment, supports the diagnosis, and captures patient severity and acuity. None of that comes as a surprise to coders, who often have to deal with documentation shortcomings.

Some patient information, such as age, address, and insurance carrier, is simple and easy to find. The clinical information, documentation, and data, however, can be very complex, says Gloryanne Bryant, RHIA, RHIT, CCS, CCDS, regional managing director of HIM (Northern California Revenue Cycle) for Kaiser Permanente in Oakland, CA. “Lots of different rules and caveats surround that information,” Bryant says.

Templates, in paper or electronic form, can help ensure complete documentation. If your facility does not already have a template, consider creating one.

To support services provided, coding, and reimbursement, providers should include in the medical record information that shows an assessment of the patient, the condition, and what the provider observed on that date.

So what should providers document and coders look for in order to accurately code for outpatient wound care? Documentation should describe the following, in detail:

➤ Patient’s condition, using terminology that includes specific diagnoses, symptoms, and reasons for the visit
➤ Observed condition and wound
➤ Treatment or procedure provided

Let’s take a closer look at wound care documentation.

Wound characteristics

First, there should be specific details regarding the wound(s). Coders should look for documentation of the following:

➤ Onset and duration: Knowing whether a wound is chronic or acute will help with treatment and outcome planning. It will also become more important after the switch to ICD-10-CM because coders will need additional detail to select the appropriate code.

Here are some terms coders are likely to see for wound care, courtesy of Gloryanne Bryant, RHIA, RHIT, CCS, CCDS, regional managing director of HIM (Northern California Revenue Cycle) for Kaiser Permanente in Oakland, CA:

➤ Debridement: Removal of devitalized tissue and foreign matter from a wound. Various methods can be used for this purpose:
  – Autolytic debridement: The use of synthetic dressings to cover a wound and allow eschar to self-digest by the action of enzymes present in wound fluids.
  – Enzymatic (chemical) debridement: The topical application of proteolytic substances (enzymes) to break down devitalized tissue.
  – Mechanical debridement: Removal of foreign material and devitalized or contaminated tissue from a wound by physical forces rather than by chemical (enzymatic) or natural (autolytic) forces. Examples are wet-to-dry dressings, wound irrigation, whirlpool, and dextranomers.
  – Sharp debridement: Removal of foreign material or devitalized tissue by a sharp instrument such as a scalpel. Laser debridement is also considered a type of sharp debridement.

➤ Full-thickness tissue loss: The absence of epidermis and dermis.

➤ Granulation tissue: The pink/red, moist tissue that contains new blood vessels, collagen, fibroblasts, and inflammatory cells, which fills an open, previously deep wound when it starts to heal.

➤ Infection: The presence of bacteria or other microorganisms in sufficient quantity to damage tissue or impair healing. Clinical experience has indicated that wounds can be classified as infected when the wound tissue contains 105 or more microorganisms per gram.
➤ **Size:** All wounds must be measured in centimeters for length (vertical), width (horizontal), and depth. Be sure the documentation indicates whether a wound has increased in size. If so, the provider may decide to reevaluate the wound, and the documentation should reflect that.

➤ **Edema:** The presence of edema can indicate underlying diseases and signify infection.

➤ **Peri-wound:** Assessment must include inspection of the surrounding tissues.

➤ **Undermining:** Undermining indicates the presence of a cavity under the peri-wound that is caused by shearing forces.

➤ **Tunneling:** A tunnel is a tract or sinus extending into the underlying tissues from any point in the wound bed.

➤ **Exudate:** Record the amount (e.g., none, minimal, moderate, copious), color (e.g., red, greenish-blue, yellow-clear), and odor.

➤ **Necrotic tissue:** Document whether nonviable tissue is present and, if so, whether it is a particular color, such as black-brown (eschar) or yellow (slough).

➤ **Granulation tissue:** The development of granulation tissue is the goal for full-thickness wounds. This area of the wound will look red and beefy and should increase in size with each wound reevaluation.

For ongoing wounds, look for documentation of improvement—or lack of improvement—in the wound over time, Bryant says. This is great information to bring to the attention of providers to ensure specifics are within the medical record. “As healthcare providers, auditors, and professional coders, you want these characteristics to be present in the record,” she says.

### Treatment choices

Providers can choose from a wide range of treatment options, including debridement and excision. In some cases, excision can be performed down to the bone. When a physician performs a debridement or excision, documentation should include the size of the wound, the level of debridement performed, and the type of debridement. For example, was it a surgical debridement? Was

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**of tissue. Clinical signs of infection may not be present, especially in immunocompromised patients or patients with a chronic wound.**

– **Infection (clinical):** The presence of bacteria or other microorganisms in sufficient quantity to overwhelm tissue defenses and produce the inflammatory signs of infection (i.e., purulent exudate, odor, erythema, warmth, tenderness, edema, pain, fever, and elevated white cell count).

– **Local clinical infection:** A clinical infection confined to the wound and within a few millimeters of its margins.

– **Systemic clinical infection:** A clinical infection that extends beyond the margins of the wound. Some systemic infectious complications of pressure ulcers include cellulitis, advancing cellulitis, osteomyelitis, meningitis, endocarditis, septic arthritis, bacteremia, and sepsis.

**Necrotic tissue:** Tissue that has died and has therefore lost its usual physical properties and biological activity. Also called “devitalized tissue.”

**Partial-thickness tissue loss:** Wounds that involve the epidermis and can extend into, but not through, the dermis. These wounds heal mainly by epithelialization from the wound edges and from epithelial cells in the remaining hair follicles and glands.

**Peri-wound:** The area surrounding the wound. Assessment of the edges may help to identify undermining (blue-gray or blanched appearance), infection (erythema), or maceration (white margins).

**Undermining:** A closed passageway under the surface of the skin that is open only at the skin surface. Generally it appears as an area of skin ulceration at the margins of the ulcer with skin overlaying the area. Undermining often develops from shearing forces.
Wound care documentation

anesthesia used? The documentation should answer these questions.

If the provider is treating an infection, coders should look in the documentation for the type of infection and the specific type of treatment. Practitioners may apply a topical treatment, such as a wound dressing. Look for details about the type of dressing and any other topical treatments the provider used.

For diabetic patients with foot ulcers, providers will often use off-loading with casts, which is the process of preventing, reducing, or eliminating mechanical insults to skin and underlying tissue. Make sure the provider documents not only the characteristics of the ulcer, but also the type of ulcer and off-loading performed.

Healing process

Documentation of the healing process is important because it shows that what the provider is doing is working—it medically justifies continuing treatment. Many providers in outpatient facilities aren’t documenting the patient’s improvement, Bryant says.

“This is a very important piece of documentation when we are audited to show that we are continuing care because the wound is healing and the treatment is working,” Bryant says. “Showing the progress of the healing wound can be key for ongoing coverage.”

Wounds heal slowly, so don’t expect to see documentation of improvement from one day to the next. However, providers should see improvement from week to week and certainly month to month, and they should include that improvement in their documentation.

Other important documentation

The documentation requirements don’t stop there. Make sure the documentation contains a physician order that includes a diagnosis, signature, and date. The provider should also document the initial evaluation and a reevaluation at least every 30 days. If something changes drastically within 30 days, the provider may decide to reevaluate the patient sooner. The documentation must be labeled as a reevaluation and should include the reason for the reevaluation and details similar to the initial evaluation.

Daily treatment notes should include:

➤ Indications and impression
➤ Changes in condition, improvements, etc.
➤ Wound size and details
➤ Procedure details, including how the wound looked before and after the procedure

Make sure the notes are signed, dated, and timed. “The notes are often too short and lack detail,” Bryant says.

Catch errors with second-quarter NCCI edits

Check for newly bundled services

Coders may have seen some new edits show up for cardiac catheterization procedures in April, but it’s not because the codes or guidelines suddenly changed. It’s because the NCCI edits finally caught up with the annual code changes. As of January 1, cardiac catheterization codes 93452–93461 include contrast injections, imaging supervision and interpretation, and a report on the imaging that is typically performed.

The new codes are more inclusive than former codes for the same services. Coders should report only the more comprehensive code, rather than all the components separately as they may have done previously.

For example, a patient comes in for a left heart catheterization, selective coronary angiography, and left ventriculogram. In the past, coders would report five separate CPT codes. Now, they only report 93458, which includes catheter placement in coronary artery(ies) for
coronary angiography, intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, and left heart catheterization, including intraprocedural injection(s) for left ventriculography.

**Missing edits**

Many coders receive education about upcoming CPT changes in November or December, but may still rely on coding software to tell them when to bundle services or append a modifier. Generally, the encoders or the claims edit modules mirror the NCCI edits, says Kimberly Anderwood Hoy, JD, CPC, director of Medicare and compliance for HCPro, Inc., in Danvers, MA.

Because the hospital outpatient NCCI edits are one quarter behind the coding changes, coders may not receive prompts during the first quarter of the year telling them when services are bundled under new codes or descriptions. And even if some coders correctly use the composite codes for cardiac catheterization procedures, there are plenty of places for mistakes.

For example, some coders may realize the injection is included in the procedure, but the facility’s chargemaster may still be adding the radiology charges separately as it has in the past. In this case, no edit is triggered in the claims edit modules of the billing system; as a result, the bill is being paid with the incorrect codes, even though the coding guidelines now state those charges should be bundled.

So how can coders be sure they were coding correctly during the first quarter? Begin by reviewing the edits that started showing up in April, Hoy says. For example, if the radiology charges were incorrectly applied, then coders and billers would start seeing edits in April saying that the radiology code is bundled into the procedure and needs a modifier.

“That you know that you’ve probably been doing that incorrectly throughout the first quarter as well,” Hoy says. Coding or billing staff should go back and perform probe audits to see whether something has changed. “In all likelihood, if you start seeing new edits in April, it’s because the NCCI edits have caught up to the current year’s codes and it indicates you may have problems with the same services earlier as well,” she says.

Coders or coding supervisors can check with the business office to find out what new edits are showing up. Then they can check to see whether the edits represent a systemic problem.

“Sometimes new edits in April are the first clue hospitals have that there’s a problem,” Hoy says.

**Eliminated edits**

Coders can also run into the opposite problem: Annual code updates may necessitate deleting some edits, but the one-quarter lag time means hospitals will still encounter the problematic edits until April 1. For example, in the first quarter of 2011, CPT codes 97597 (debridement of an open wound, first 20 sq cm or less) and 97598 (each additional 20 sq cm) still hit an NCCI edit stating the codes cannot be used together.

According to 2011 CPT guidance, those two codes are no longer mutually exclusive. Instead, 97598 is now an add-on code. But because the NCCI edit was still active for the first quarter of 2011, coders may have only used one code and not the other—resulting in underpayment to the facility.

The good news is CMS has stated in FAQ 3734 that when an edit is fixed, the fix is retroactive to the effective date of the edit and facilities can re-bill previous claims to take the correction into account. Hoy recommends facilities keep a running report of claims that should include a second code that is not being allowed. That way, facilities can re-bill the claims once CMS fixes the edit.

“This underpayment issue is one we’re going to be able to keep track of because we’re hitting an edit we don’t expect to,” Hoy says. That’s why potential overpayment situations, such as bundled cardiac catheterizations, are more dangerous. The claims are being paid, so facilities have no way of keeping track of the ones that were incorrect.

“That’s why they have to go back in April and figure out where they might have made errors,” Hoy says.
April I/OCE edits

Look for bilateral status changes, new modifier

As part of the April update to the I/OCE, CMS added 34 codes to the list of conditions that are conditionally bilateral. So when a provider performs one of those services bilaterally, coders need to append modifier -50 to the code, says Dave Fee, MBA, product marketing manager of outpatient products at 3M Health Information Systems in Murray, UT.

Fee also notes that CMS reissued the April I/OCE edits because of errors that were found in the original release.

All but two of the 34 codes has a status indicator of T (significant procedure, multiple reduction applies). As a result, when a procedure is performed bilaterally, CMS will reimburse the first code at 100%, but will only pay 50% for the second code.

In addition, CMS removed code 88177 (cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site) from the female-only list.

Modifiers -33 and -PT

CMS added modifier -33 (preventive service) to the list of active modifiers, effective January 1. On the surface, modifier -33 and modifier -PT (colorectal cancer screening test; converted to diagnostic test or other procedure) look the same, but they really aren’t, Fee says.

Modifier -PT is a HCPCS level II modifier, while modifier -33 was introduced by the AMA at the end of December 2010. That means it was not part of the January I/OCE release. So if coders appended modifier -33 prior to the April I/OCE release, they would receive a message stating the modifier was invalid.

Although both modifiers can be used for a colorectal cancer screening service that converts to a diagnostic service, modifier -33 designates all preventive services on the claim, Fee says. Consider the example of a male patient who comes in for a screening colonoscopy. During the screening, the physician finds something abnormal and performs a polypectomy. The service is now diagnostic. During the same visit, the physician performs a digital prostate exam.

In this example, both procedures started out as screenings, even though the colonoscopy became diagnostic. So coders would append modifier -33 to both codes. However, the digital prostate exam is not a surgical procedure, so coders should not apply modifier -PT; that modifier only applies to surgical services.

“Any preventive service that is performed, you append modifier -33,” Fee says. “Modifier -PT, however, you only place on the service that converts from a screening to a diagnostic, and it only applies to surgical...
services that are performed at the same date of service for the same patient.”

So what is a surgical service? CMS states that modifier -PT applies only to CPT codes 10000–69999, Fee says. “Anything in that range would have the deductible waived and would be considered a surgical service. Anything else would not.”

That includes any lab tests or manual screenings—basically anything else outside of that 10000–69999 range.

**Added codes**

CMS added five new codes as part of the I/OCE edits for April. Those codes are:

- C9280, injection, eribulin mesylate, 1 mg
- C9281, injection, pegloticase, 1 mg
- C9282, injection, ceftaroline fosamil, 10 mg
- C9729, percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with ligamentous resection, disectomy, facetectomy and/or foraminotomy, when performed) any method under indirect image guidance, with the use of an endoscope when performed, single or multiple levels, unilateral or bilateral; lumbar
- Q2040, injection, incobotulinumtoxin A, one unit

Codes C9280, C9281, C9282, and Q2040 have a G status indicator (pass-through drugs and biologicals), while C9729 has a T status indicator. Codes C9280, C9281, C9282, and C9729 are subject to edit 55 (non-reportable for site of service).

**Deleted codes**

As part of the I/OCE update, seven codes were deleted. Two codes were deleted effective January 1: 90470 (immune admin H1N1 im/nasal) and 90663 (flu vacc pandemic H1N1). The remaining five were deleted effective April 1. Those codes are:

- C9278, injection, incobotulinumtoxin A, one unit
- Q1003, new technology intraocular lens category 3 (reduced spherical aberration)
- S2270, insertion of vaginal cylinder for application of radiation source or clinical brachytherapy
- S2344, nasal/sinus endoscopy, surgical; with enlargement of sinus ostium opening using inflatable device (i.e., balloon sinuplasty)
- S3905, non-invasive electrodiagnostic testing with automatic computerized hand-held device to stimulate and measure neuromuscular signals in diagnosing and evaluating systemic and entrapment neuropathies

**APC, status indicator, and edit assignment changes**

CPT code 80100 (drug screen, qualitative; multiple drug classes) now has a status indicator of E (items, codes, and services not covered by Medicare) and is subject to edit 28 (code not recognized by Medicare; alternate code for same service may be available). CMS stated in the 2010 New Clinical Laboratory Fee Schedule Test Codes and Final Payment Determinations that it intended to make CPT 80100 no longer active and use G0430 in its place.

Code 80104 (drug screen; multiple drug classes other than chromatographic method, each procedure) is also now subject to edit 28.

CPT code 90654 (flu vaccine no preserv, ID) now has a status indicator of E and is subject to edit 9 (non-covered for reasons other than statute). Code A9273 (hot water bottle, ice cap or collar, heat and/or cold wrap, any type) has a new status indicator of Y (non-implantable durable medical equipment) and is subject to edit 61 (service can only be billed to the DMERC).

CMS also assigned new status indicators to two additional codes. G0010 (administration of hepatitis B vaccine) now has a status indicator of S; Q4119 (MatriStem wound matrix, per sq cm) has a status indicator of K (non-pass-through drugs and biologicals).

Editor’s note: To review all of the April I/OCE quarterly release specifications, go to www.cms.gov/OutpatientCodeEdit/ 02_OCEQtrReleaseSpecs.asp.
Specimen collection

Is it appropriate to charge CPT 36416 (collection of capillary blood specimen [e.g., finger, heel, ear stick]) with CPT 82962 (glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use)? These are services in our ED.

Per the Coder’s Desk Reference for Procedures, CPT code 36416 reads: “In 36416, a prick is made into the finger, heal, or ear and capillary blood that pools at the puncture site is collected in a pipette ... The blood is used for diagnostic study ...”

Also, Medicare Claims Processing Manual, Chapter 16, Section 60.1 states:

A specimen collection fee is allowed in circumstances such as drawing a blood sample through venipuncture (i.e., inserting into a vein a needle with syringe or vacutainer to draw the specimen) or collecting a urine sample by catheterization. A specimen collection fee is not allowed for blood samples where the cost of collecting the specimen is minimal (such as a throat culture or a routine capillary puncture for clotting or bleeding time).

These services do not bundle according to the NCCI edits, but 36416 has a status indicator of N, which means that it is always bundled or packaged. Medicare does not separately reimburse for the venipuncture.

The question here is whether the specimen collection should be reported at all, because it is considered minimal. Medicare states that the specimen collection fee is not allowed for blood samples where the cost of collecting the specimen is minimal, such as capillary puncture for clotting or bleeding time. I did not find that Medicare specifically excludes billing the two services together, but it is conceivable that the collection required for the glucose monitoring device would be considered minimal.

Procedures performed by nursing staff

Sometimes a nurse does a procedure and documents this in the nursing notes. Should we report CPT codes when procedures are done by the nursing staff? What if the procedure isn’t documented? What if the physician documents in his dictation that the nurse did the procedure?

If there is no documentation, the service cannot be billed. If the service was performed by the nurse, such as insertion of the Foley, this can be billed on the facility side only. If the nurse applies a splint (rather than just handing the splint to the patient) this can also be billed on the facility side, if documented. You should also consider what is included in your facility E/M levels. Are these items included in the level? (They probably should not be, as there are separate billable codes for these services.) Often, the facility level references patients who have injuries that may need splinting—but the criteria should indicate that reference to the procedure is a proxy for the acuity and not the performance of the procedure.

For hospital services, you should report the CPT code that best describes the service performed. Regarding the question of what to do if the physician documents in his dictation that the nurse did the procedure, we would say that the nurse should document that the service was performed before you bill that specific procedure.

Psychiatric patients in ED

Is there a compliant reimbursement path for psychiatric patients who have not been admitted as inpatients, yet remain as “ED boarders” waiting for an inpatient psych bed? May we charge an established patient outpatient visit for documented care provided each day?

Do you have any special documentation recommendations to meet medico-legal standards of care for these patients?
Unfortunately, boarding isn’t a billable service outside either a medically necessary observation or the ED visit levels.

CMS has been very clear about this in the past. If it is not medically necessary that the patients receive ED treatment, and they are being housed in the ED for administrative and not clinical purposes, the boarding service is not payable.

After patients have been formally admitted, they transition to inpatient status and cease to be outpatients. It is an extremely risky situation, as the emergency physician has transferred care to the admitting physician, meaning the admitting physician is responsible for the care. If patients are not admitted but remain in the ED, there is no visit code applicable. You might want to check with your local Medicare contractor.

As far as the medico-legal standards, please see ACEP.org for a wealth of information on ED boarding and the legal implications.

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**Hydration and observation**

Q We have been trying to decipher the available information regarding patients placed in our observation unit who receive hydration during their course of care. If we pull out the hydration time, can we bill for observation hours pre- and post-infusion?

A I think the key to whether you should carve out the hydration time comes down to active monitoring. Not all services require active monitoring. CMS states the following in FAQ 9974:

> The hospital must determine if active monitoring is a part of all or a portion of the time for the particular drug administration services. Whether active monitoring is part of the drug administration service may depend on the type of drug administration service furnished, the specific drug administered or the needs of the patient. For example, a complex drug infusion titration to achieve a specified therapeutic response that is reported with HCPCS codes for a therapeutic infusion may require constant active monitoring by hospital staff. On the other hand, the routine infusion of an antibiotic, which may be reported with the same HCPCS codes for a therapeutic infusion, may not require significant active monitoring. For concerns about specific clinical situations, hospitals should check with their Medicare contractors for further information.

In most cases, hydration would probably not meet the definition of a drug that requires active monitoring, and therefore would not be carved out of the observation.

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**Colonoscopy coding**

Q Colonoscopies are a coding nightmare at times. The hospital coding and the physician’s office coding do not match. Here’s an example: The patient had a colonoscopy five years ago with history of polyps found. The hospital coding will be V76.51 as primary, since it has been five years, and V12.72 secondary. The screening G-code G0105 will be used for low risk, since the polyps were not specified as adenomatous. The physician’s office is coding...

> continued on p. 12
V12.72 as the primary diagnosis along with the diagnostic CPT 45378. Please provide any assistance and references.

First, let’s address the portion of your question relating to the diagnosis codes:

- V12.72, Personal history of colonic polyps
- V76.51, Special screening for malignant neoplasms of the colon (screening colonoscopy NOS)

Based on the information provided, the hospital is correct. From the details of your question, the motivating factor for performing the colonoscopy on this patient at this time is the calendar (five-year screening) rather than a concern about the previous identification of the polyps. Therefore, if the patient has no known signs or symptoms, the standard of care that would support the medical necessity of the procedure (colonoscopy) is a screening every five years. The inclusion of the V12.72 is only necessary to justify a five-year rather than a 10-year screening schedule.

With regard to your question about the procedure codes, screening G-code G0105 is for high-risk patients, not low risk. Because the polyps are not identified as adenomatous, you should not report G0105 for this encounter.

### IV pushes of different substances

If IV pushes of Decadron®, Pepcid®, Benadryl®, and Ativan® were all given at 1:15 a.m., I would assign code 96374 (IV push initial substance or drug) and code 96375x3 (IV push new substance or drug). There is no documentation to show the medications were mixed, but I have been cautioned that if the time is the same, the interpretation is that they are one push. Is there specific authoritative guidance on this? So far, I have found nothing, so have obtained verbal statements that they are given separately. I’ve been going by the code description that states single or initial substance/drug for 96374, and each sequential push of new substance/drug for 96375. Since the meds are listed sequentially, that seems sufficient documentation.

We do not know of any authoritative guidance. As long as the drugs were not mixed together and given in a single syringe, you are correct to report them separately as described. We’d recommend documentation stating that these were separate injections and separate injection preparations, etc., so that there is never a question if an outside auditor were to make assumptions about a nurse’s ability to administer four separate injections during a minute. We also do not have any guidance on this other than statements made about drugs mixed in a single syringe should be reported as only push, but nothing about separate pushes. However, the CPT Manual makes clear that you can report each IV push separately, as you stated above.