FAQs

Injections and Infusions:
Review of Drug Administration Coding, Billing, and Charging for Hospitals

January 30, 2013

Q: We get an NCCI edit when billing an intramuscular/subcutaneous injection (96372) during the same encounter as billing an injection, infusion, or hydration. Should we append modifier -59 (distinct procedural service)? Does it matter if there is already an IV line in place at the time of the intramuscular/subcutaneous administration?

A: It would be appropriate to report modifier -59 on the intramuscular/subcutaneous code to indicate this is a separate and distinct service from another injection, therapeutic infusion, or hydration. If a line has already been started for another service, it is still okay to report the modifier -59 on the intramuscular/subcutaneous injection because the modifier is signifying that the intramuscular/subcutaneous injection is a separate service that is not a part of another injection or infusion.

Q: I have a question regarding the clinical example on slide 57. It states to start the normal saline infusion at 1524 because it is not reportable for time infusing concurrently with ceftriaxone. My question is, did the normal saline start during the ceftriaxone infusion and you just subtracted that time out of the total normal saline to charge the 96361 X3?

A: Yes, we should have indicated better on the slide that the hydration did in fact begin with the ceftriaxone and that is why we do not count that time but instead begin the time counting at 1524 because at that point, the hydration is no longer running concurrently with the ceftriaxone infusion.

Q: If we have 2 medically necessary IV sites and they both run for 24 hours (from midnight to midnight) with therapeutic infusions. Is it okay to bill over 24 hours in one day of 96366 since there are 2 sites?

A: When you have 2 medically necessary IV sites, it is appropriate to report multiple codes and one of them with modifier -59. So in your example, we believe it would be most accurate to report the following:

96365 x 1 and 96365-59 x 1
96366 x 23 and 96366-59 x 23

This way you are showing very clearly that there were two sites running and that each ran for 24 hours. We wish to be clear that two IV sites indicate two intravenous insertions in two different physical locations and not merely two lumens in a single IV site.

Q: Can you help with my question regarding chemo wastage? Three patients receive a chemo drug from a single dose vial and there is wastage. Can you confirm my understanding that the first two
patients would get charged for the dose they received, and that the third would get charged for his or her total dose along with any wastage? Can you please provide guidance from CMS that describes this?

A: Your understanding is correct and you can find more information and an example on this from CMS in the Claims Processing Manual, Chapter 17, Section 40.

Q: We get edits on most infusions/injections provided on the same date as a procedure falling within the range of 10021 to 69999. The logic as we understand it is that these are presumed to be operating room procedures, and thus the infusions/injections integral to those procedures are bundled. However, a number of procedures in this range do not use the operating room – chest tube insertions, lumbar punctures, wound repairs, etc. Is it appropriate to apply modifier -59 to the infusions/injections provided on the same day as the procedures when the infusion/injection is completely unrelated to the performance of the procedure, i.e. antibiotics in any of the cases cited, pain meds provided for reasons other than pain at the site of the procedure, etc?

A: More edits started surfacing for drug administration CPT codes several years ago when CMS activated the NCCI edits related to these codes. As long as drug administration services are medically necessary, separate from the surgical service (i.e., not integral to the performance of the surgical service and/or procedure), and unrelated as stated above, it would be appropriate to use modifier -59.

Q: Can you help with the drug administration coding for the following scenario? A patient is admitted to observation status Monday and the codes billed are 96375, 96372 and 96374. The patient is still in observation Tuesday and 96376 and 96372 are billed and finally 96376 is reported on Wednesday while the patient is still in observation (total observation time is 41 hours).

Is it appropriate for the facility to report 96374 as the initial service Monday and 96376 as an add-on code Wednesday? We are asking because it seems like add-on codes by definition should never be reported as a stand-alone service.

A: This is a great question. In general we agree with you that add-on codes are not reported as stand-alone codes, but remember that facility reporting of CPT drug administration codes is really different from how most other services are reported.

For example, the coding hierarchy must be followed and it allows codes from different drug administration sections to be reported. That means that you may often have an initial service from one section (like chemotherapy) and another service, essentially an add-on code from another section (like an IV push).

In addition, only one initial drug administration code should be reported for a single encounter (unless separate IV lines are started) and remember CMS looks at drug administration encounters as full encounters even if they cross the date of service. So while it may seem counterintuitive to report an add-on code two days after the initial service code, it is likely correct if you are following the facility drug administration coding rules.

Q: If infusion overlaps by 31 minutes and were given in the same IV line, are they deemed concurrent or can they be billed separately? For example, a drug was infused at 4:00 and then another drug was infused at 4:05. Both were infused for over 31 minutes total.
A: In this case the overlapping infusion time is far greater than the separate time either drug runs so we would recommend reporting the concurrent infusion code and the therapeutic infusion code.

Q: How frequently do you need to document hydration is running when the order states “administer over 60 minutes”?
A: We would expect to see a start and stop time and documentation in the record that the IV was started and that hydration was given at a certain rate, for a certain condition, and over a certain amount of time. We would also expect to see a note from the nurse sometime mid-way regarding how the patient is responding.

Q: Is a stamp time of 60 minutes for an infusion to run sufficient for start and stop time?
A: We do not believe orders that call for a certain rate or a certain time over which something should run are substitutes for actual start and stop times. We believe a best practice is to have actual start and stop times from which to determine exactly what codes and units are appropriate to bill.

Q: How are transfusions treated in conjunction with the drug administration hierarchy?
A: It’s fine to report a blood transfusion on the same date of service as drug administration services. There are no edits with the blood transfusion CPT code 36430 and drug administration CPT codes.

Q: How is the intramuscular/subcutaneous injection treated as far as coding? Can an intramuscular/subcutaneous be coded separately when performed on same day as an infusion and/or push? Are any modifiers necessary?
A: Yes, the intramuscular/subcutaneous injection can be reported and is not a part of the hierarchy. Yes you will need modifier -59 on intramuscular/subcutaneous injections.

Q: We are hoping to hear your opinions during the audio conference tomorrow on down coding vs. calculating time when a stop time is missing.

Palmetto GBA published an article on 7/15/2009 that states: When requested, providers should submit documentation indicating the volume, start, and stop times and infusion rates of any drugs and solution provided. In the absence of the stop time, the provider should be able to calculate the infusion stop time with the volume, start time, and infusion rate. How does this statement fit with the documentation requirements and what is the appropriate way to handle missing stop times?
A: Palmetto has continued to allow this practice (as recent as Oct 2011 and is probably still allowing this), in which case you can follow their guidance if they are your MAC.

BUT we do not think this is a good/best documentation practice. This option seems to be in the spirit of encouraging hospitals to improve documentation, but ask yourselves how can you really substantiate coding and billing extra hours for example from this sort of documentation especially over a large volume of accounts, if audited?

Rather, we strongly believe that explicit start and stop times are the best way to go and if you have a program of continuous monitoring and feedback, you should see fewer and fewer accounts where you
don’t have start and stop times where you rely on this sort of guidance to “calculate” time vs. going from actual documented start and stop times. By now, we strongly believe hospitals should have few accounts where start and stops are missing, like with new hires/staff who are just learning to document etc. but this should not be the norm.

Q: Is intrathecal chemotherapy considered an initial service? If a patient has intrathecal methotrexate and an intravenous push (IVP) of Vincristine, is the IVP or the intrathecal the initial?

A: No, intrathecal chemotherapy is not part of the intravenous injection and infusion drug administration hierarchy for facility coding. In your scenario, the IV push of Vincristine would be the initial service and reported with 96374.

Q: Are there any edits related to reporting the initial hour of chemo (96413) and the initiation of the portable pump (96416) when both are performed on the same day in the same clinic? Do we need to use modifier -59?

A: No, there are no NCCI edit so no need for modifier -59, but make sure to check your MAC’s LCDs to see if there is any additional information or guidance provided.

Q: I wanted to confirm with you some confusion I have surrounding the administration of medications and hydrations simultaneously. My understanding is that when a medication is being administered at the same time as hydration, the time that the medication is running should be subtracted from the time the hydration is running.

For example, the patient is receiving an infusion of an antibiotic for 45 minutes and, at the same time, is receiving hydration for 1 hour. The 45 minutes needs to be subtracted from the 1 hour hydration, leaving a total hydration time of 15 minutes. Is this correct? Are there any exceptions to this rule? This point has caused a lot of headache for our coding staff.

A: The CPT Manual explains that hydration provided concurrently cannot be reported. You probably also know that hydration that is incidental or that is a carrier solution also cannot be reported.

If you have medically necessary hydration, then your assessment is correct that you would not report concurrent hydration and instead only look at the time the hydrations runs by itself. That needs to be more than 30 minutes in order to report CPT code 96360 or 96361.