

Billing for Infusion Services in an Outpatient Neurology Clinic

Christine Mann, MBA

Director of Infusion Services

Dent Neurologic Institute

Overview of Infusion Billing Codes

Current Procedure Terminology (CPT) codes for infusion services are comprised of codes related to the type and duration of the administration, and Healthcare Common Procedure Coding System (HCPCS) Level II codes (typically J-codes) which describe the medicine being administered [1][2]. The types of administration include subcutaneous or intramuscular injections, intravenous push (IVP) procedures, and therapeutic infusions. Infusion durations of 15 minutes or less use IVP codes, 16 minutes to 90 minutes use “initial hour” codes, and each “additional hour” codes are applied when durations exceed 31 minutes beyond the previous one hour period (eg 91 minutes of infusion is eligible for a subsequent hour).

Specific HCPCS Level II codes are defined for most agents; otherwise a generic J-code must be used, if it is acceptable to the local payer. Chemotherapeutic and complex biologic drugs require a different set of administration codes. Additional codes and conditions arise when multiple medications are used in the same visit and when evaluation and management services are also rendered in the same day. Specific codes describe concurrent and subsequent administration of different medications or hydration. Note that patient assessment (eg vitals) before and during the procedure, the application of a local anesthetic, starting an IV or access to a indwelling IV, catheter or port, flushing on completion of infusion and standard supplies are considered part of the administration and not coded separately.

To ensure proper coding, maximize reimbursement, and minimize denials, it is critical to become very familiar with the CPT codebook and NCCI edits for detailed code definitions. Departmental standard operating procedures and internal reference guides also need to be updated on a regular basis to reflect each payer’s local coverage determinations (LCDs), which define appropriate referring diagnoses, bundling considerations, and other payment policies.

Multiple Infusions

Determining the Initial Service and reporting hierarchy differs depending on whether the service is rendered in a “non-facility” or a “facility” setting. If billing as a non-facility, the initial service code should represent the primary reason for the encounter, regardless of the order of administration. If billing as a “Facility”, the services must be billed according to the following hierarchy, with the highest ranking service billed as the initial service:

1. Chemotherapy: Infusions, then IV Pushes, then Injections
2. Then ... Therapeutic/Prophylactic/Diagnostic Infusions, then IV Pushes, then Injections
3. Lastly... Hydration

Hydration services should only be billed when specifically ordered, and not when not when fluids are solely used as part of the administration of another drug or to keep a line open. Hydration is not a billable service if the duration is 30 minutes or less.

Sequential infusion codes represent the initiation of new substances following the initial or primary service. Concurrent codes represent that multiple substances are infused using separate bags but the same IV site (including the use of multilumen catheters). It is considered a single infusion, not concurrent, if multiple substances are mixed in one bag. Concurrent codes are not time based and reported only once, even if there is a third or more substance. Administration through separate IV sites is also not considered concurrent, but rather warrants use of a -59 modifier as described below.

Modifiers

The National Correct Coding Initiative (NCCI) should be consulted to identify procedures that should not be billed together unless the typically bundled services are separate and distinct, and identified by an appropriate modifier [3]. The most common modifiers for infusion services are -59 and -25. Modifier -50 is used for bilateral injections.

Modifier 59 is applied to a second initial administration code in circumstances such as multiple same-day encounters requiring that a new IV line be placed, or if there are separate IV sites. The modifier is also applied when multiple procedures that are typically bundled through NCCI edits are performed at different times in the same day. The modifier is applied to the initial procedure in the infusion lab, as well as any additional hours codes associated with this initial drug administration, but is not applied to any sequential codes for the administration of additional drugs.

Modifier 25 should be applied to a same day E/M visit that was conducted separate and distinct from the infusion, such as when a patient is seen for an office visit and then referred for an infusion that day. Extensive use of modifiers may flag a payer audit. Examples 1 and 2 illustrate the use of modifiers -59 and -25. In practice, there can be local carrier variation on the need for, or acceptability of, modifier codes. Be sure to consult your local coverage determination for each payer.

EXAMPLE #1

Provider Claim	99215 Mod 25	E-M <i>(Column 2 code for 96365)</i>
Infusion Claim	96365 96375 <i>(x #units)</i>	Initial IV Infusion Sequential IV push

EXAMPLE #2

Provider Claim	64615	Botox –Migraine Injection
Infusion Claim	96365 Mod 59 96366 96367	Initial IV Infusion <i>(Column 2 code for 64615)</i> Each additional hour Sequential IV Infusion <i>(new drug)</i>

Flow of Information and Documentation

The ordering process must define the primary purpose for the visit, the type of treatment, drug dosage, as well as the specific diagnoses as identified by the ICD-9-CM or ICD-10-CM codes that support medical necessity. There is typically an authorization process, and may result in approval for multiple treatments that are scheduled over a time course of several months. The infusion department must document how the therapy was given (IV infusion or injection, subcutaneous, intramuscular, combination) and the duration of each (specifically noting <15 min, 15+ minutes, first hour, and subsequent hours). The HCPCS Level II codes for the drug administered is reported in billing units, not weight or volume, as determined by the conversion factor listed with the appropriate code [3]. Note that billing with unclassified J-codes is always problematic. Despite the addition of appropriately applied National Drug Codes, most payers continue to deny either the unclassified HCPCS or the entire claim. Separating these services can often expedite reimbursement on the claim, leaving you only to deal with the unclassified drug via an appeal.

Refer to Table 1 for an example encounter form that summarizes documentation requirements. The procedure list is organized into chemo/complex and general therapeutic, and is stratified for clarity according to the billing hierarchy for facilities. Duration and site of infusion is noted with each procedure to help justify the procedure code. Procedures need to match the type of drug administered, so it is helpful to separate the prescribed drug list accordingly. Most of the example HCPCS level II codes apply in a neurology setting. Sample codes are also provided for some agents used in non-neuro procedures in recognition that once the investment is made in developing an infusion center, its capacity, expertise and referral patterns may warrant expanding the clientele. Although indications are not explicitly shown here, it is helpful to group frequently used J-codes into categories, such as tumor, migraine, peripheral neuropathies, multiple sclerosis, musculoskeletal and other miscellaneous indications, and supportive therapies and procedures such as anti-emetics or hep-lock to keep IV ports open. Table 2 lists procedure codes for chemodenervation along with candidate HCPCS codes for the injected toxin.

Compliance

Documentation must be a priority, with particular attention to properly documenting medical necessity, order details (primary reason for the referral, drug(s) and dose(s), type of administration and location/route), and recording specifics of the procedure, including specific CPT codes for the administration, HCPCS Level II codes for drug (if required), and start and stop times for each injection, IV Push and Infusion. Note that some payers who directly provide drugs through specialty pharmacies may still require coding of the drug used (e.g. billed with a zero dollar charge); consult local payer policies.

Medical necessity for both the drugs and supporting orders such as antihistamines, antiemetics or hydration must be substantiated by signs and symptoms documented in the patient's plan of care.

It is also important to have written policies and procedures, internal and external billing and operations audits, and regular documented training sessions for ordering providers, nursing and coding staff.

When administering chemotherapy or other highly complex drugs or biologics, direct physician supervision is required for patient assessment, provision of consent, safety oversight, and intra-service supervision. Be sure

to document the supervising physician in the note (check payer policy to determine if a physician assistant or nurse practitioner qualifies), and be able to prove that supervision was in place if an audit occurs (eg login sheet or EMR schedule that indicates immediate availability).

Conclusion

Local coverage determinations may vary substantially, and billing is further complicated when multiple carriers are involved. It is critical to obtain proper authorizations in order to avoid the risk of a claim denial after an expensive agent has already been purchased and administered. Specialty pharmacies that purchase the infusion drugs on behalf of the insurance carrier is an option that mitigates this risk, and may be required by some payers. The American Academy of Neurology (www.aan.com), American Academy of Professional Coders (www.AAPC.com) and other references listed below offer additional guidance [4-6].

References

1. American Medical Association. 2016 CPT Professional Edition. Chicago: AMA, 2016
2. Centers for Medicare and Medicaid, 2015 Alpha-Numeric HCPCS File, <http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html>, accessed February 20,2015
3. National Correct Coding Initiative Edits, Centers for Medicare and Medicaid Services, <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html> , accessed February 16, 2015.
4. M Endicott. "Taking the Sting out of Injection and Infusion Coding." Journal of AHIMA 83, no.11 (November 2012): 74-76.
5. AL Smith. "Infuse Yourself with Coding Knowledge. Tips and tricks for proper drug administration coding." AAPC Cutting Edge, (February 2013): 34-37.
6. MC Palmeter. "Eliminate Infusion Confusion. Proper coding of drug administrations in non-facility settings starts with good documentation." AAPC Cutting Edge, (July 2011): 20-23

Table 1. Example Encounter Form

Pt. Name:	Acct #:	Provider Name:
Address:	DOB:	Order Date and Time:
		Supervising MD:
		Start/Stop Time:
Primary Reason for Therapy:		
Dx Code(s):		
Special Instructions:		
SPECIALTY PHARMACY: YES NO		

UNITS	LOC/TIME	CPT	CHEMO/COMPLEX	NOTES
		96413	Infusion/Chemo, first hour	16 to 90 minutes
		96415	Infusion/Chemo, each additional hour (>30min past prior hr)	>1:30, >2:30, ...
		96417	Infusion/Chemo, additional sequential	new substance
		96409	IV Push/Chemo, Initial	15 minutes or less
		96411	IV Push/Chemo, Additional	new substance
		96401	Injection (Subcut, IM)/Chemo	

Use Sequential if any "1st hour" or "initial" code already used

UNITS	LOC/TIME	CPT	THERAPEUTIC, NON-CHEMO, NON-COMPLEX	NOTES
		96365	Infusion, first hour	16 to 90 minutes
		96366	Infusion, each additional hour (>30min past prior hr)	>1:30, >2:30, ...
		96367	Infusion, additional sequential	new substance
		96368	Infusion, concurrent medications	multiple bags, same line; (use -59 if multiple IV ports)
		96374	IV Push, Initial	15 minutes or less
		96375	IV Push, Additional	new substance
		96372	Injection (Subcut, IM)	
		96360	Hydration	> 30 min
		96361	Hydration, each additional hour (>30min past prior hour)	>90 min, >150 min, etc

Table 2. Chemodenervation procedure codes

CPT	Chemodenervation	NOTES
64615	Chemodenervation of muscle(s); muscle innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral	Chronic migraine
64616	Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral	Add Modifier 50 for bilateral.
64617	larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed	Do not add additional guidance. Add Modifier 50 for bilateral.
64642	Chemodenervation of one extremity; 1-4 muscle(s)	Not eligible for modifier 50.
+64643	Chemodenervation of each additional extremity, 1-4 muscle(s)	Not eligible for modifier 50.
64644	Chemodenervation of one extremity; 5 or more muscle(s)	Not eligible for modifier 50.
+64645	Chemodenervation of each additional extremity, 5 or more muscle(s)	Not eligible for modifier 50.
64646	Chemodenervation of trunk muscle(s); 1-5 muscle(s)	
64647	6 or more muscles	
+95873	Electrical stimulation for guidance	
+95874	Needle electromyography for guidance	

Associated HCPCS Level II drug codes for chemodenervation

CPT	Chemodenervation	Unit conversion
J0585	BOTOX (Onabotulinumtoxin A)	1 unit
J0586	DYSPORE (Abobotulinumtoxin A)	5 units
J0587	MYOBLOC (Rimabotulinumtoxin B)	100 units
J0588	XEOMIN (Incobotulinumtoxin A)	1 unit