Mastering Injections & Infusions for APCs

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Presentation Faculty

Duane C. Abbey, Ph.D., CFP – Dr. Abbey is a healthcare consultant and educator with over 20 years of experience. He has worked with hospitals, clinics, physicians in various specialties, home health agencies and other health care providers.

His primary work is with optimizing reimbursement under various Prospective Payment Systems. He also works extensively with various compliance issues and performs chargemaster reviews along with coding and billing audits.

Dr. Abbey is the President of Abbey & Abbey, Consultants, Inc. A wide range of consulting services is provided across the country including charge master reviews, APC compliance reviews, in-service training, physician training, and coding and billing reviews.

Dr. Abbey is the author of eight books on health care, including:
"*Non-Physician Providers: Guide to Coding, Billing, and Reimbursement*"
"*Emergency Department: Coding, Billing and Reimbursement*", and
"*Chargemasters: Strategies to Ensure Accurate Reimbursement and Compliance*".

His most recent book, "*Compliance for Coding, Billing & Reimbursement A Systematic Approach to Developing a Comprehensive Program*" is now available from the Productivity Press.

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Mastering Injections & Infusions
Introduction

- **For most hospitals, outpatient coding commenced in conjunction with the implementation of APCs by the Medicare Program on August 1, 2000.**
  - **Some hospitals were already under various APG-type payment systems.**
- **Under APGs, injections and infusions were generally bundled into an associated service. ← See recent CMS move to increase packaging. Will this eventually lead to packaging injections/infusions??**
- **In a very surprising move, CMS decided to pay separately for injections, infusions and chemotherapy administration.**
  - **However, hospitals were not correctly coding and billing for these services prior to APC implementation.**
- **Incorrect coding and charge data then led to skewed payments for injections, infusions and chemotherapy.**
- **CMS has *constantly* made changes to the APC payment structure and has modified the Q-Codes that were used on a bundled, 'session' basis.**

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Mastering Injections & Infusions
Introduction

- In 2005, the AMA announced and pre-published a whole new structure and coding logic for injections, infusions and chemotherapy.
- The new codes and coding structure were placed in the AMA's CPT Manual for 2006.
  - For the APCs, CMS adopted only a portion of the new codes. CAHs did start using all the new CPT codes starting in CY2006.
    - CMS still wanted to use the 'per-session' coding and payment logic.
    - A whole series of new Level II HCPCS C-Codes were developed.,
      - CMS indicated that these codes were developed for the 'benefit' of hospitals.
- In the proposed changes to APCs for CY2007, CMS indicated that they planned to continue the C-Codes as a benefit to hospitals.
  - Hospitals responded by requesting that CMS implement the new CPT codes immediately. CMS adopted the new codes for CY2007 with one C-Code retained.

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Introduction

- In a surprising move, the AMA decided to renumber the injection and infusion codes for CY2009. The chemotherapy codes did not change as such. The placement of the renumbered injections and infusion is more logical.
- While the actual code numbers are being translated, careful study is needed to determine if the language and instructions associated with the codes has been substantively changed.
- As much as possible, any changes in the CPT Manual instructions will be given during this teleconference. However, coding, billing and service area personnel are cautioned to look at the 2008 CPT manual relative to the changes in the 2009 manual.
- There appear to be no changes to the chemotherapy codes, as such. However, there appear to be changes to the discussion in CPT preceding the chemotherapy codes. This new language will need to be carefully compared to the CY2008 CPT manual.
  - Note: For chargemaster coordinators this change is significant and requires reworking various chargemaster entries.

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Objectives

- To review the CPT codes for injections, infusion therapy and (briefly) chemotherapy.
- To identify key policy and procedure elements in the use of the injection and infusion CPT codes.
- To appreciate how to establish the chargemaster to properly utilize the injection and infusion codes.
- To understand the potential reimbursement for injections and infusion therapy under APCs.
- To appreciate the operational difficulties for hospitals to capture charges for injections and infusion therapy.
- To delineate the policy and procedure decisions that must be made relative to injections, infusion therapy and chemotherapy.
- To explore related issues such as 'integral-part', 'not to be reported separately', and intraoperative packaging guidance from CPT and CMS.
  - Note: We will concentrate on infusion and injections with chemotherapy as a secondary consideration.

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General Process

- Master the logic that comprises the coding guidance provided in the CPT Manual,
  - Proper coding/billing requires that the overall case be reviewed to determine correct code and charges
- Develop typical scenarios in the ED and other outpatient service areas,
- Establish the chargemaster with the new codes and set appropriate pricing,
- Develop written policies and procedures for coding and billing injections including the use of modifiers when necessary,
- Identify and incorporate any special coding/billing considerations based upon specific guidance from given third-party payers,
- Develop and conduct extensive training for nursing staff,
  - Develop 'coding sheets' or 'coding templates'.
- Establish ongoing training and auditing for correct charge capture and subsequent coding and billing.

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The Injection/Infusion/Chemotherapy Codes

- Code Summary with APC Payments
  - Hydration -
    - 96360 (1st Hour) - $73.67
    - 96361 (Each Additional Hour) - $24.89
  - IV Therapy –
    - 96365 (1st Hour) - $128.62
    - 96366 (Each Additional Hour) - $24.89
    - 96367 (Additional Sequential) - $36.13
    - 96368 (Concurrent) - $ 0.00 – Status Indicator "N"
  - SQ Infusion –
    - 96369 (1st Hour) – $73.67
    - 96370 (Each Additional Hour) - $36.13
    - 96371 (Additional Set-up New Site(s)) - $24.89
  - IM/SQ Injection - 96372 - $24.89
  - IV Injection –
    - 96374 (Initial IV Push) – $36.13
    - 96375 (Sequential IV Push) - $36.13
    - 96376 (Each Additional IV Push) – SI="N" - Packaged

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Introduction

- For CY2008, the CPT Manual introduced four new entries. Here are the CY2009 updated codes:
  - 96369 – Subcutaneous infusion for therapy or prophylaxis; initial up to one hour, including pump set-up and establishment of subcutaneous infusion site(s)
    - 15 Minutes or less use 96372
  - +96370 - each additional hour
    - 30 minutes out of one hour (Half-Time Unit Rule)
  - +96371 - additional pump set-up with establishment of new subcutaneous infusion site(s)
    - 96369 and 96371 Only once per encounter
  - +96376 – Therapeutic, prophylactic or diagnostic injection; each additional sequential intravenous push of the same substance
    - 30 Minute Rule – Don't use unless more than 30 minutes for the same drug
- Also Slight Change for 96360 → Initial Hydration – 31 minutes to 1 hour

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The Injection/Infusion/Chemotherapy Codes

- Code Summary with APC Payments - Continued
  - IA Injection - 96373 - $36.13
  - Miscellaneous Injection – 96379 - $24.89 ← Avoid Using!
- Related Chemotherapy Administration Codes
  - 96401 – SQ/IM Non-Hormonal Anti-Neoplastic APC=0437-$36.13
  - 96402 – SQ/IM Hormonal Anti-Neoplastic APC=0437-$36.13
  - 96409 – IV Push, Single or Initial APC=0439-$128.62
  - +96411 – IV Push, Each Additional APC=0438-$73.67
  - 96413 – IV Infusion – 1 Hour, Sing or Initial APC=0440-$187.96
  - +96415 – IV Infusion – Each Addn'l Hour APC=0437-$36.13
  - 96416 – Prolonged Portable/Implantable Pump APC=0440-$187.96
  - +96417 – IV Infusion – 1 Hour (Different Drug) APC=0438-$73.67
- CMS Retained – C8957 – Prolonged IV Infusion Requiring Pump
  - APC=0440-$187.96

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Comparative Payment – New vs. Old

- Change In Coding Structure Drives Changes in Payment
  - Infusions – Q0081 → 90781/90781 → C8950/C8951 → New Logic
    - Q0081 – $104.29 (CY2004) – Per Session
    - 90780 – $111.80 (CY2005) – 1st Hour
    - 90781 - $ 0.00 (CY2005) – Subsequent Up To 8 Hours
    - C8950 - $120.77 (CY2006) – 1st Hour
    - C8951 - $ 0.00 (CY2006) – Subsequent Up To 8 Hours
  - Hydration/Infusion (CY2007)
    - 90760->96360/90761->96365 – $111.20 - 1st Hour
    - 90761->96361/90766->96366 - $ 24.25 – Subsequent Hours
  - Hydration/Infusion (CY2008)
    - 90760/90761 – $114.64 - 1st Hour
    - 90761/90766 - $ 25.13 – Subsequent Hours

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Comparative Payment – New vs. Old

- IV Therapy Financial Exercise
  - Compare payment from CY2005 through CY2009 for:
    - Two hours of hydration
    - Four hours of IV therapy
    - Nine hours of IV therapy

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Comparative Payment – New vs. Old

- Injection/IV Therapy Financial Exercise
  - Sylvia, the Chargemaster Coordinator at the Apex Medical Center, has been asked by the CFO to work up a financial analysis to estimate the increase/decrease in reimbursement from Medicare under the new hydration, infusion and injection coding structure.
    - Outline how you would go about performing such an analysis.
    - Do you think there will be any problems in developing the model?
    - What is you general 'feeling' about how these new codes and the associate logic will affect Medicare payments?
  - Both the CFO and Sylvia know that injections and infusion therapy are not be captured for observation patients. Assuming there are 1,000 observation cases per year, and that 50% of these case involve at least two injections of some type, what is the potential financial impact of capturing these charges?

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CPT Coding Guidelines & Logic

- The basic logic, as enunciated in the CPT Manual, is *initial/primary* versus *subsequent/secondary* with *concurrent* thrown in for infusion therapy. The basic idea is that there is an 'initial' or 'primary' infusion or injection.
  - "*The "initial" code that best describes the key or primary reason for the encounter should always be reported irrespective of the order in which the infusions or injections occur. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported.*"
- This logic is embedded in guidance provided within the coding structure itself.
- As we will see, for hospitals this logic is only partially used.
  - Hospitals are supposed to use a hierarchical approach is choosing primary versus secondary or subsequent.
  - Thus, read CPT with some care and in the context that the language has been developed primarily for physicians.

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CPT Coding Guidelines & Logic

- Embedded CPT Guidance ← Study Carefully
  - 96360 – Hydration 1 Hour → Do not report if performed as a concurrent infusion service.
    - What does this mean?
  - +96361 – Hydration Each Additional Hour
    - Use 96361 in conjunction with 96360
    - Use 96361 to identify hydration if provided as a secondary or subsequent service after a different initial service
      - 96360, 96365, 96374, 96409, 96413
  - 96365-96379 series is for administration of substances/drugs.
  - Note the 15 minute rule to distinguish between 'IV Injection' and 'IV Therapy'
  - Note the 30 minute rule for each additional hour to be counted within the sequence of codes supporting the each additional hour.

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CPT Coding Guidelines & Logic

- Embedded CPT Guidance ← Study Carefully
  - Do not report 96365-96379 for codes in which these services are an inherent part. (Contrast materials for interventional radiology, etc.)
  - 96365 – IV Infusion Up To 1 Hour
  - +96366 – IV Infusion Each Additional Hour
    - Add-on Code
    - Generally used with 96365 (IV Therapy 1st Hour) and/or 96367 (Additional Sequential Infusion 1st Hour)
      - This is interesting!
  - +96367 – IV Infusion Additional Sequential 1st Hour
    - Add-on Code
    - Report only once per sequential infusion of the same infusate mix
    - Generally used with 96365, 96374, 96409, 96413 if secondary or subsequent service

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CPT Coding Guidelines & Logic

- Embedded CPT Guidance ← Study Carefully
  - +96368 – IV infusion Concurrent
    - Add-on Code
    - Report only once per encounter
    - Use with 90761->96365, 90766->96366,96413, 96415, 96416, 96422, 96423
  - 96369, +96370, +96371
    - New sequence for CY2008 – Appears to stand alone as with SQ/IM and IV pushes.
  - 96372 – SQ/IM Injection
    - Our old friend with a new code
    - New guidance – "(Do not report 96372 for injections given without direct physician supervision. To report, use 99211)"
      - What does this mean?
        - ❑ For hospitals? Provider-based clinics?
        - ❑ For physicians? Physician (freestanding) clinics?

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CPT Coding Guidelines & Logic

- **Embedded CPT Guidance ← Study Carefully**
  - **96373 – Intra-Arterial Injection**
    - **Basically the old code with a new number.**
  - **96374 – IV Push, Single or Initial Substance Drug**
    - **The wording has been revised to fit the new logic.**
    - **There is no parenthetical guidance.**
  - **+96375 – IV Push, Each Additional Sequential Push of New Substance/Drug**
    - **Add-on Code**
    - **Use with 96365, 96374, 96409, 96413**
    - **Use to identify IV push of a new substance/drug if provided as a secondary or subsequent service after a different initial service is provided.**
  - **+96376 – IV Push, Each Additional Pus of Same Substance/Drug**
    - **However, this is a 30 minute rule!**
  - **96379 – Unlisted Injection/Infusion ← Avoid Using!**

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Coding Logic

- **CPT Guidelines Seem Reasonably Straightforward**
  - **Well, until you try to apply to real life situations!**
  - **Basic Idea - Physicians**
    - **Identify the "initial" service. Other services in this area will be secondary.**
      - **"When these codes are reported by the physician, the "initial" code that best describes the key or primary reason for the encounter should always be reported irrespective of the order in which the infusions or injections occur."**
    - **However, in order to identify the initial service, the 'encounter' will have to be completed.**
      - **For cases like observation services, this could be tricky because the coding cannot be completed until after the encounter is completed.**
        - Or is the physician 'encounter' different from the hospital 'encounter'?

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Coding Logic

- CPT Guidelines Seem Reasonably Straightforward
  - Basic Idea – Hospitals (Facilities)
    - Use a hierarchical approach in selecting initial and subsequent.
      - "When these codes are reported *by the facility*, the following instructions apply. The initial code should be selected using a hierarchy whereby chemotherapy services are primary to therapeutic, prophylactic, and diagnostic services which are primary to hydration services. Infusions are primary to pushes, which are primary to injections."
  - The big question is who will be doing the coding?
    - Professional Coding Staff?
    - Nursing Staff in Service Areas?
    - Both?

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Coding Logic

- CPT Guidelines Seem Reasonably Straightforward
  - Next big question is who is going to make the decision as to which service was the "initial" or "primary" service using the hierarchy?
  - When and by what mechanism will this decision be made?
  - Will the process be different depending upon the service area?
  - How will the charging process enter into the overall way in which claims are generated for these services?
  - Are there any concerns about chargemaster setup and organization?
  - Should there be written policies and procedures? Templates?
- Ancillary Concerns Not Addressed By CPT Codes/Guidelines
  - "Integral Part" – Injections/Infusions – Pre- and Post-Surgery
    - See Increased Packaging – Intra-Operative for APCs in CY2008
  - IV Solutions – Not Separately Reportable - Billable

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Case Studies

- **Case Study #1 – Elderly patient present to the ED and is diagnosed with dehydration. Patient is placed on IV for hydration. Hydration provided for six hours. Patient is discharged home.**

- **Case Study #2 – Patient presents to ED. An IV is started KVO. One IM/SQ injection is provided along with one IV injection. After three hours the patient is discharged home.**

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Case Studies

- **Case Study #3 – An elderly patient presents in the morning through the ED with dehydration and general weakness. The attending physician decides to admit. An IV is started for hydration. The patient is taken to a medical/surgical bed. The patient continues to receive hydration for five hours. An IM/SQ antibiotic injection is given. The patient is discharged in the afternoon. Utilization Review intervenes just before discharge and changes the case to Observation with Condition Code 44.**

- **Case Study #4 - A patient is encountered in an outpatient area for one of a series of IVIGs (Immune Globulin). 50 grams of IG is provided by IV infusion over a period of four hours.**

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Case Studies

- **Case Study #5 - A patient presents to the ED. An IV is started KVO for possible drug administration. The IV is maintained for three hours during which an IV injection is provided and infusion therapy of a drug is started after half an hour and continued until the end of the third hour. Also, another drug is piggy-backed and provided as an additional infusion therapy for the second of the three hour encounter. The patient is discharged home.**

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Case Studies

- **Case Study #6 - A patient arrives at the Apex Medical Center's ED after a 45 minute trip. An IV was started before the ambulance left and hydration was provided during the trip. During the next two hours, the IV is continued with two IV injections and one bolus of medication are provided. The patient is admitted to observation over night. While the IV is kept in place, no further medications are provided and the patient is discharged the next morning.**

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Case Studies

- **Case Study #7 – A patient presents to the ED. An IV is started KVO. The following injections are provided:**
  - **2:00 p.m. - Dilaudid 1 Milligram (IVP)**
  - **2:30 p.m. - Zofran 4 Milligrams (IVP)**
  - **4:00 p.m. to 6:00 p.m. – Levaquin – 500 Milligrams (IVB)**
  - **5:00 p.m. – Phenergan – 25 Milligrams (IVP)**
  - **7:00 p.m. – Phenergan – 25 Milligrams (IVP)**

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Case Studies

- **Case Study #8 - A patient presents to the ED with complaints of mild chest pain. The chest pain protocol is followed. An IV is started KVO. The patient is scheduled for a cardiac catheterization for the next morning. Due to kidney concerns the physician orders hydration overnight to reduce toxicity of the LOCMs (Low Osmolar Contrast Media). Hydration is provided over an eight hour period. During the observation stay, two subcutaneous injections are provided along with an IV bolus of another drug infused over a ten minute time period. There is also a piggy-back infusion over a three hour time period.**

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Case Studies

- **Case Study #9 – A patient is encountered in the ED. An IV is started KVO. The physician determines the patient is dehydrated. The attending physician arrives and orders a second IV to be started for administration of antibiotics and pain medications. The patient is admitted to observation. The patient is hydrated for a total of 9 hours. An antibiotic is provided through IV infusion over a period of two hours. Three different IV injections of morphine are provided to achieve the desired titration level. The patient is discharged the next morning.**

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Case Studies

- **Case Study #10 – An elderly patient presents to the ED in the late afternoon with chest pains. The chest pain protocol is followed. An IV is started KVO. A mild analgesic is provided IV over a period of three hours. The patient is admitted to observation and is scheduled to have coronary catheterization services. Prior to the procedure the patient is given an prophylactic antibiotic injection (assume IM/SQ). Fentanyl and Versed are provided IV for conscious sedation. Therapeutic coronary catheterization services involve a stent placement. (Drug-Eluting, of course!) The patient is discharged in the afternoon.**

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Case Studies

- **Case Study # 11 -**
  - **Day 1 - A patient present for a schedule IVIG injection. Nursing assessment indicates patient is sick. Told to return tomorrow.**
  - **Day 2 – Patient receives a Benadryl 50 mg. IV Injection at 10:00 a.m. At 10:45 a.m. IVIG is started with 100 grams of IG. Infusion is stopped at 3:00 p.m.**
  - **Day 3 – Patient presents and is infused with 50 grams of IG. The infusion starts at 12:30 p.m. and is discontinued at 4:10 p.m.**

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Case Studies

- **Case Study #12 – An elderly patient presents for a blood transfusion of two units of packed red blood cells. An IV is started and the patient is given an antibiotic IV injection. The first unit of blood is provided over a two hour period. As per physician orders, the patient is hydrated for two hours after which the second blood unit is administered. The patient is observed for two hour and then released to go home.**

- **Case Study #13 – A patient presents to the ED. The physician orders IV hydration 'wide-open' for ten minutes. Presuming this is the only infusion/injection, how should this be coded?**

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Case Studies

- **Case Study #14 – Hydration with IV Infusion - A patient presents to the ED and is diagnosed with dehydration. Hydration is provided over a four hour period. During the third hour of hydration a mild antibiotic is provided on a prophylactic basis. The patient is discharged home at the end of the hydration. Assume that the record indicates that hydration is the primary service and that the one hour of infusion is secondary.**

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Case Studies

- **Case Study # 15 – During an ED encounter, the physician orders the following morphine IV injections –**
  - **10:00 p.m. – 15 mg**
  - **10:20 p.m. – 10 mg**
  - **10:40 p.m. – 10 mg**

Assume the same basic facts, but assume the same sequence of injections by ED nursing staff to obtain an appropriate tritation level.

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Case Studies

- Case Study #16 – Apex Medical Center – Infusion Center
  - A patient presents to the infusion center for chemotherapy services
    - An IV is started
    - The patient is hydrated for one hour
    - The patient is given an antibiotic IV injection
    - IV infusion chemotherapy is administered for four hours
    - After the chemotherapy administration, an antiemetic is provided intravenously for one hour
  - A patient presents to the infusion center for a blood transfusion
    - An IV is started
    - Benadryl is provided through an IV push
    - One unit of blood is transfused
    - Patient is hydrated with Lasix infusion for one hour
    - Second unit of blood is transfused

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Hierarchy For Coding

- If there are two or more primary services that can equally well be considered primary, then which one of the services is to be coded as primary?
- Today, CPT gives us general hierarchy of coding based upon the concept of an 'encounter'?
  - Can the encounter be different for physicians versus the hospital?
  - Chemotherapy → Therapeutic/Prophylactic/Diagnostic → Hydration
  - Infusions → Pushes
- When does an infusion of a substance become chemotherapy?
- What is a push?
- What if we perform additional services relative to chemotherapy?
  - "The administration of medications (eg, antibiotics, steroidal agents, antiemetic, narcotics, analgesics) administered independently or sequentially as supportive management of chemotherapy administration, should be separately reported using 96360, 96361, 96365, 96379 as appropriate."

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Mastering Injections & Infusions
Coding and Charging Flow

- Injection/Infusion/Chemotherapy Goal
  - Of course, we will assume that the hospital wishes to provide appropriate high quality healthcare relative to injections and infusion therapy.
  - To capture all appropriate charges and associated codes for injections and infusion therapy across all outpatient departments and service areas. Ultimately to generate good, clean, complete and accurate claims.
- For A Given Service Area, What Is The Best Way To Capture and Properly Code For These Services?
  - Example – Apex Medical Center ED
    - Physicians Order – Nurses Document Services
    - Dedicated ED coding staff reviews all clinical documentation
      - Codes the Services and Enters the Charges
  - Example – AMC Infusion Center
    - Chemotherapy Services
    - Other Infusion/Injection Services

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Mastering Injections & Infusions
Coding and Charging Flow

- Fundamental Question
  - Static Coding Through Chargemaster
    - versus
  - Dynamic Coding By Professional Coding Staff
- Special Issues
  - Judging what service is ‘primary’ or ‘initial’ using the hierarchy
  - Using “-59” modifier when needed
- Hospitals will probably use multiple approaches based upon the specific coding/billing flow for a given service area.
  - Emergency Department
  - Medical/Surgical Floors (Observation)
  - Pre- and Post-Surgery Areas
  - Outpatient Service Areas
  - Provider-Based Clinics

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Mastering Injections & Infusions
Coding and Charging Flow

- Chargemaster Considerations
  - Coding – Static versus Dynamic
  - Structuring Charges
  - Special Third-Party Payer Requirements
  - Charge Sheets
  - Computer Charge Entry ← Build In Logic?
  - Pharmacy Categorization Issues → RC=636

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Mastering Injections & Infusions
Policy and Procedure Issues

- There is a long list of P&P issues surrounding Hydration, Injections and Infusion Therapy
  - Medical Necessity
  - Written Order
  - Drugs Charged Separately
  - IV Solution Charging
  - Start/Stop Times
  - 15-Minute Rule – IV Injection vs. IV Infusion Therapy
  - Half-Time Unit Rule ← Separate General P&P Hospital Wide
  - 1st Hour + Each Additional Hour Logic
  - KVO – Keep Vein Open Circumstances
  - Multiple Drugs
    - Injections – Mixing of Drugs
    - IV Therapy – Concurrent Concept

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Mastering Injections & Infusions
Policy and Procedure Issues

- There is a long list of P&P issues surrounding Hydration, Injections, Infusions and Chemotherapy
  - Multiple Sites
  - Vein Failure
  - Separate Encounters
  - Discontinue/Re-Establish
  - Routine, Integral Part ← See Hospital Wide General Policy
  - Multiple Injections, Same Drug
  - General Injection, Hydration, Infusion Therapy Logic
    - Primary/Initial vs. Secondary/Subsequent
    - Concurrent
    - Add-On Code Utilization
    - CPT Guidance

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Policy and Procedure Issues

- There is a long list of P&P issues surrounding Hydration, Injections and Infusion Therapy
  - Standard Examples
    - Hydration Only
    - Infusion Only
    - SQ/IM Injections Only
    - Infusion + IV Injection
    - Infusion + Hydration
    - Chemotherapy + Infusion/Injections
    - Concurrent Infusions
    - Hydration + Infusion + SQ/IM Injections
    - Multiple Site Infusion Therapy
    - KVO With No Other Services
    - KVO with SQ/IM Injections

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Mastering Injections & Infusions
Policy and Procedure Issues

- There is a long list of P&P issues surrounding Hydration, Injections, Infusions and Chemotherapy
  - Ancillary/Special Concerns
    - Immunizations and Vaccinations
    - Emergency Department Considerations
    - Observation Services Considerations
    - Recovery Services Considerations
    - Pre-Surgery Considerations
    - Interventional Radiology Considerations
    - Special Injection Situations → IVIG Series of Injections
    - Inpatient Changed to Outpatient Observation (Condition Code 44)
    - Blood Transfusions
    - Infusion Center Services

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Mastering Injections & Infusions
Policy and Procedure Issues

- Injections/Infusions Involving Surgery Services
  - Injections and infusions of various types are given in conjunction with surgeries.
    - Pre-Operative vs. Intra-Operative vs. Post-Operative
    - Are these injections/infusions to be separately coded and billed?
  - For instance, pre-surgery antibiotic injections that are sometimes provided for certain patients.
    - Not Integral-Part
    - Thus, separately codeable and billable?
  - FIs Have Generally Issued Guidance Prohibiting Coding/Billing
    - Payment is Packaged Into the Surgery Payment
  - Transmittal 1445, February 8, 2008 – Section 230.2(B) – Billing for Infusions and Injection – New Sentence Added
    - Hospitals should report all HCPCS codes that describe the drug administration services provided, regardless of whether or not those services are separately paid or their payment is packaged.
      - Coding/Billing Issue vs. Payment/Adjudication Issue

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Mastering Injections & Infusions
Training and Auditing Considerations

- Developing Training Materials
  - Educational Materials
  - Coding/Billing Templates
  - Coordination with Written P&Ps
- Delivering Training
  - Self-Study
  - In-Person, Small Group
  - Videotape with Facilitator
  - Self-Paced Computer Training
    - Stand-Alone
    - Internet/Intranet
  - Help Desk
    - Informal versus Formal
- Need for On-Going Training/Education

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Training and Auditing Considerations

- Auditing Activities
  - Due to all the changes made for CY2007, more codes in CY2008, renumbering of codes in CY2009, and the ongoing concerns in previous years, the need for auditing in the hydration, infusion therapy and injection areas is significant.
  - Auditing staff may look at many different aspects of this overall issue:
    - Clinical Documentation Correlated to Charge Capture/Coding
      - Number of Injections/Infusions Documented
      - Start and *Stop Time* and/or Documented Time
      - Correct Type of Injection/Infusion
      - Following Coding/Billing Logic
      - 15-Minute and Half-Time Unit Rule Observance
    - Correlation of Number of Drugs to Injections/Infusions
    - Claim Quality – Drugs, Revenue Codes, Codes
    - Charge Capture and Coding Flow Processes

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Mastering Injections & Infusions
Case Studies

- **Case Study #17 – Samantha, the Chief Compliance Officer at the Apex Medical Center is reviewing the results of an extended probe audit of infusion therapy at the hospital. A total of 45 cases were reviewed. The results of the audit are generally good. The clinical documentation is complete in terms of the services provided. Also, the number of drugs charged correlates well with infusion therapy services. The only real problem is that nursing staff was very good about indicating the time that an infusion started, but in about half the cases the stop time was not documented. However, charges for all the services were being entered.**
  - **Is this a compliance problem?**
  - **What steps should Samantha take in this case.**

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Mastering Injections & Infusions
Case Studies

- **Case Study #18 – Samantha, the Chief Compliance Officer at the Apex Medical Center is reviewing an audit report. There was an audit of 100 outpatient surgical cases. The results of the audit are reasonably good. The documentation was good for both the operative reports and the pre-surgery H&Ps. Both CPT coding and diagnosis coding were good with only a few errors noted. The auditor has also noted that for certain surgeries, the physicians order an IV infusion of an antibiotic. This service is well documented and the physicians' orders are clear.**
  - **Is this a potential compliance issue? Explain.**
  - **What steps should Samantha take?**
  - **Has the new packaging from CMS for CY2008 relative to intra-operative services affected this question?**

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Mastering Injections & Infusions
Case Studies

- Final Examination Case Study – Observation Over Three Dates of Service
  - An elderly patient presents through the ED where an IV is started, KVO. Attending physician arrives and places patient in observation.
    - Day 1 – Drug A – Infused Over 3 Hours + IV Injection of Drug B
    - Day 2 – Again, Drug A Infused Over 3 Hours + SQ Injection of Drug C
    - Day 3 – Again, Drug A Infused Over 3 Hours + Drug D Infused Concurrently with Drug A
  - Patient is discharged home.
    - Discuss how this case should be coded.
    - How will nursing staff accomplish this coding?

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Mastering Injections & Infusions
Summary & Conclusions

- Injections, Hydration and Infusions Can Be Complex and Confusing
- Starting in CY2006, CPT Introduced a New Set of CPT Codes
  - New Logic – "Initial/Primary" vs. "Subsequent/Secondary" plus "Concurrent"
  - Coding Can Only Be Accomplished After the Encounter (Case) is Completed
  - Correct Coding Is Difficult – Many Different Circumstances
    - Adopt Hierarchical Approach To Make Decisions
- New Codes Adopted for APCs in CY2007
- Additional Codes Added for CY2008
- Infusion and Injection Renumbering of Codes for CY2009
- Hospital Guidance → Use Hierarchical Approach Instead of Initial/Subsequent Logic (Eventually placed in CPT guidance.)
- Chargemaster Issues
  - Static Coding versus Dynamic Coding
  - Charge Development
- Compliance Issues
  - Documentation
  - Nursing Notes
  - Surgery Related Injections/Infusions
- Financial Implications – Variations in APC Payments

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