Q&A: Resolve confusion around injection, infusion coding

Many HIM professionals, coders, and billers continue to struggle with correct coding for injections and infusions. Jugna Shah, MPH, president of Nimitt Consulting in Washington, DC, and Angela Simmons, CPA, director of clinical revenue and reimbursement at The University of Texas MD Anderson Cancer Center in Houston, answered these questions as part of HCPro’s April 8 webcast “Injection and Infusion Coding Made Easy: A Case Study Approach to Accurate Charge Capture.”

What can a hospital report for a PICC line flush and dressing change when no infusion service is provided? Is a low-level clinic visit appropriate? Or are these services something that the patient should be performing outside the hospital on his or her own? Our FI, Noridian, is not allowing a clinic visit for these services because they believe the patients can perform this service themselves.

Report CPT code 96523 (irrigation of implanted venous access device for drug delivery systems) for a port flush. If that’s all that occurs on a given date of service, then report it without an E/M and CMS will pay for the flush via APC payment.

Can a hospital bill for a prefilled syringe (normal saline or Heparin) as a separate line item charge (either as a supply or pharmacy item) in addition to an infusion service? Or must the prefilled syringe be included in the infusion charge and CPT code when billed?

Yes, it is acceptable to bill the prefilled syringe using a separate line item by reporting a revenue code, units, and a dollar charge rather than including it in the infusion charge.

If we have drugs running in two lines at the same time for a period of six hours, how should we report this?

If you have two lines and both have therapeutic drugs running for six hours, you would report the following:

> 96365 (IV infusion, for therapy, prophylaxis, or diagnosis [specify substance or drug]; initial, up to 1 hour) x 1 and 96366 (IV infusion, for therapy, prophylaxis, or diagnosis [specify substance or drug]; each additional hour) x 5, for one line
> 96365-59 x 1 and 96366-59 x 5, for the second line

You would need to report modifier -59 (distinct procedural service) for the services being billed for the second line to signify that two initial service codes are being reported on purpose and that the additional hours for the second line are separate from the additional hours associated with the first line.

Must we use a modifier for repeat injections represented by the same code? Or is the modifier hard coded in the chargemaster?

We do not recommend hard coding modifiers, such as modifier -59, in the chargemaster. It may be possible that an NCCI edit will surface when you have to report the same injection CPT code multiple times. In these cases, we recommend you understand why the NCCI edit is surfacing and determine whether it would be appropriate to use modifier -59 to bypass the edit. Remember, payment is generated when you apply modifier -59, so you want to use it carefully and not systematically.

Do we need an order for hydration or does the order need to contain the word “hydration”?

There are two different questions being asked here. You do need an order for medically necessary

> continued on p. 10
Q&A  < continued from p. 9

hydration in order to charge for and be paid separately for hydration. If the physician wants to hydrate a patient for any number of reasons, we believe the order would naturally contain the word “hydration” or “hydrate,” but there is no specific requirement that we are aware of that states that the order must contain a specific word or a specific diagnosis.

The main thing auditors will look for is whether orders exist and whether services rendered to patients are medically necessary. This applies to all services, not just hydration.

Can you define what is meant by an inherent procedure?

We recommend that you review the NCCI edit manual, which includes a discussion about procedures that are considered part of or inherent to others or procedures that are components of comprehensive procedures.

One way people think of inherent services or procedures is when the item or service is always part of another item or service or when one service cannot be done without the other. However, these are just our interpretations. Therefore, we recommend asking your FI/MAC or CMS to define this.

What is the appropriate way to charge IV infusion in a situation when the patient is ordered IV antibiotics twice daily? Do you charge for the initial hour once per day or per dose given?

In the question being asked, it is not clear whether the patient comes in the morning for one antibiotic infusion, leaves, and returns later in the day for the second infusion. If so, you would report each visit separately with the appropriate code(s) and hour(s) based on the duration—you would have two initial services billed on this date of service, and one would require modifier -59.

If the patient receives two infusions of the same antibiotic during a single session with some amount of time in between them, you would report one with the initial infusion service code and the other with the sequential infusion code.

When blood is drawn on the same date of service as an infusion, can we capture 36591 (collection of blood specimen from a completely implantable venous access device) or 36592 (collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified)?

Yes, you can report a blood draw with the appropriate CPT code on the same day as an infusion service.

When we have a 500cc saline bag hanging with blood or a 250cc bag of saline with Venofer, are we charging for or recouping revenue for the saline?

You can and should report your saline supply charge using an appropriate revenue code and dollar charge.

What is the appropriate assignment of codes for the following scenario:

A patient is ordered Vancomycin IV twice daily for five days. He presents to the IV room at 8am and 8pm daily. Each infusion lasts two hours.

Should we charge 96365 x 2 (once for each visit) and 96366 x 2 (once for each additional hour per visit) each day, or 96365 x 1 with 96366 x 3 for additional hours each day?

Charge 96365 x 1 plus 96366 x 1 for the 8am infusion, then 96365-59 x 1 plus 96366 x 1 for the 8pm infusion. Billing will likely group the two 96366 codes together so that the claim goes out clean.
We are a critical access hospital and I would like to know if, in this scenario, it is all right to add a modifier to the injection/infusion code.

A patient comes in for cellulites and is entered as an observation patient and started on antibiotics. Later that same day, the patient goes to surgery for abscess drainage. These injection/infusion codes are going to prompt NCCI edits.

In this case, is it appropriate to add modifier -59 to the codes since the antibiotics were provided in the ER prior to going to surgery?

Yes, for the scenario you describe, you may append modifier -59.

Editor’s note: To order this webcast on demand, visit www.hcmarketplace.com/prod-8536/Injection-and-Infusion-Coding-Made-Easy.html.