Top 10 audio questions

Question 1

Scenario: A patient is admitted to the ED for acute abdominal pain. The documentation states that he receives the following:

- Infusion normal saline, 22:30
- Zofran IV push, 22:30

What should the initial charge be? My theory is that the infusion is the initial charge, because if the physician did not have to administer the IV push of Zofran unless the infusion of normal saline was necessary. An in-house coder interprets it as the Zofran is the medication used to treat the abdominal pain, and therefore the IV push should be the initial code. Can you help clear this up, please?

Answer: Unfortunately there are two ways to answer this question. The first has to do with the text in the 2006 CPT Manual which states that you should select the initial service code based on the main/primary reason for the visit. In clinic settings this is pretty straightforward—if the patient is scheduled to come in for a specific service, this is the primary reason for the visit.

In the ED the answer is harder and the initial service selected is often the first service performed, since that is the reason the patient came to the ED. It may be later that you find out that other services are required and then you begin to wonder what service should be reported as the initial. Based on this line of thinking, you will likely charge the hydration as the initial service and the Zofran push with CPT code 90775 for each additional sequential push of a non-chemo IV drug.

However, the text and parenthetical notes in the CPT book do not indicate that CPT code 90775 should be used with CPT code 90760 even though all other initial service CPT codes are listed. This may be an oversight, or perhaps we are being told that whenever hydration is provided along with other drug administration services, the hydration should not be selected as the initial service. Hospitals should request additional clarification on this issue from the CPT Editorial Panel.

The only exception to reporting hydration as the initial service may be when drug administration services, such as intramuscular injection, CPT code 90772 or others that do not include the word initial are provided in addition to the hydration. In such cases, you should report the hydration as the initial service only because it may not be appropriate to report the additional hours of hydration without some "initial" service code – this is of course if your payers begin editing for certain code pairs.

Question 2

We have a question regarding CPT hydration codes 90760 and 90761 as used in the ED. It was mentioned in the Q&A period that facilities may want to implement protocols that would show necessity for hydration (e.g., "replace volume, hypotension, etc"). You mentioned the rate of the infusion as a possible indicator.

We have been using 100 ml/hr (125ml/hr was also recommended) as a standard, but realize this rate of infusion can be lower if treatment is for an infant or elderly patient. We often see the term "KVO" (keep vein open) with no rate documented, but do not consider that to be therapeutic.

Is there a reference that states what a therapeutic rate for hydration is? There is little guidance on the use of hydration codes and part of the confusion stems from the code descriptors only mentioning time as a factor for selecting them.
Answer: It is critical to include clear documentation in the patient’s medical record that states why the physician has ordered hydration. Simply using the order or the documented flow rate in the record is not the best way to determine whether hydration or a therapeutic infusion should be charged, given that the flow rate may be increased or decreased depending on the patient’s condition.

An appropriate protocol would indicate a clinical sign and symptom and then appropriate solutions and flow rates. “For example, hyperemesis 4-6 hours prior to ED presentation, initiation IV hydration with normal saline at 100 ml/hr for average sized adult.” You are correct that it is not appropriate to charge for an infusion when KVO is the only documentation.

Question 3

I have a question regarding the clinical example no. 3. You indicated that for multiple push injections of the same drug, you can code the four pushes with a 90774 and 90775 x 3. According to the CPT definition, it states a push of a new substance /drug. Please clarify the definition of a new drug. If Lasix is given three separate times, is this considered a new drug each time? Please advise the proper code assignment.

Answer: This is probably the most controversial issue at present, given that the definition for CPT code 90775 states, “new substance/drug”.

However, in a new FAQ released by CMS on Thursday, February 9, the confusion was cleared up: Hospitals can bill multiple units of C8952 only when different substances or drugs are provided in the same encounter. The FAQ states:

Hospitals are to bill for additional IV pushes of different substances or drugs using multiple units of the appropriate push code. This means that hospitals are to bill multiple units of C8952 only when different substances or drugs are provided via intravenous push in the same encounter.

Due to this new guidance, despite what was said in the 1/25 audioconference regarding four units of C8952 being allowed, we now confirm that CMS has clearly stated that four pushes of Lasix can ONLY be reported with one unit of C8952 (Medicare). For non-Medicare reporting, this corresponds to only one unit of 90774 and no units of 90775.

The confusion over this issue stemmed from a number of sources, beginning with CMS’ Transmittal 785 which states, “Hospitals are to bill for additional IV pushes of different substances or drugs using multiple units of the appropriate push code.” For many providers, this statement implied that you could report multiple units of the IV push code C8952 only if different drugs were administered, yet the official HCPCS C-code definition does not indicate that a new substance/drug has to be pushed in order to report C8952. In addition, both the Kansas FI and UGS (another FI) released guidance stating that hospitals could report multiple IV pushes even if the same drug was pushed during a single encounter.

Furthermore, in the 2006 Final OPPS Rule dated November 10, 2005 (pages 68677 and 68679), CMS states that it intends to pay for drug administration payments in 2006 in the same manner as payments were made in 2005 and also references that the C codes were for each intravenous push injection.

Therefore, it was understandable that providers believed that multiple units of C8952 could be reported when the same drug is pushed multiple times during one encounter. For example, in 2005, if Lasix was given four separate times during one visit, hospitals should have reported CPT code 90784 x 4 and were paid for all four units.

If your FI had released information allowing you to report multiple IV pushes of the same substance/drug to be reported during the same encounter, follow up with them to see if they are
Question 4
Help me understand the difference between

- 96416 - initiation of prolonged chemotherapy infusion (more than 8 hours) requiring use of portable or implantable pump; and
- 96522 - Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic

For example, a patient’s implanted pump is filled with a chemotherapeutic agent at the hospital on several occasions, and they are sent home for the continued infusion, often over several days. Is 96416 meant to be used only for the very first time this occurs for the patient, and should we report 96522 for every time after the first?

And what is the code for the encounter when the patient returns after the several days of infusion, and needs attention to the pump (e.g., turning it off, cleaning it up). Is that

- maintenance of the implanted pump 96522;
- an EM level to account for the hospital resources;
- or nothing at all, because the incurred charges are assumed to be covered at the time the pump is filled?

Answer: Report 96416 at the beginning of each new cycle of chemotherapy. The patient will have been unhooked from the pump (i.e., a CADD pump) for a period of time, and is not receiving any chemotherapy (could be a day, a week, several weeks etc). The key is that the nurse in the clinic has to obtain the pump, either from the patient, pharmacy, supply, etc., and then place a new drug cassette/bag etc. into the pump, and program it to run over the specified period of time.

Report 96522 when the patient comes back to the clinic during a cycle of chemotherapy to have more drug added to the pump to complete the infusion for that cycle, re-programming to change the rate because it is infusing too fast or slow, etc.

You can also report 96522 when a patient has an implanted pump (different than a portable pump, a CADD pump for instance), that requires routine heprinization to maintain patency when it is not being used.

For Pain Controlled Analgesia (PCA) portable pumps the use of the codes is similar. If the pump is connected and initiated in the operating room, do not bill C9857/90779. However at the next insertion of a PCA syringe, you can bill 96522. If the PCA pump is connected and initiated at the bedside or in PACU, bill C8957/90779 for the initiation of the pump.

Note we do not believe these codes are intended to be used for intravenous infusions through single or multi-channel IV pumps in the hospital to better control the flow rate of infusions. These pumps are not intended for patient use at home. We believe the pumps these codes reference are implantable or portable pumps that the patient can control and that are intended for the patient to be sent home with.

Question 5
An outpatient receives chemo treatments in the course of a single day. The regimen requires the patient to come to the infusion clinic two times per day. The patient receives a pre med non-chemo infusion lasting one hour, and a chemo infusion that lasts three hours—at each visit.
On the second visit of the day can we charge same charges as first visit and add modifier -59, or are the second visit charges sequential infusions?

**Answer:** In Transmittal 785 CMS states the following:

> With respect to chemotherapy administration and non-chemistry drug infusion, the use of modifier -59 indicates a distinct encounter on the same date of service. In the case of chemotherapy administration or non-chemistry infusion, modifier -259 is appended to drug administration HCPCS codes that meet the following criteria:

1. The drug administration occurs during a distinct encounter on the same date of service of previous drug administration services; and
2. The same HCPCS code has already been billed for services provided during a separate and distinct encounter earlier on that same day.

The first criterion has to do with whether the patient has more than encounter on the same date of service. In the example given, this criterion is met. Once this is met, you have to ask the second question: Have you already billed the same HCPCS code. If the answer is yes, you must report modifier -59 otherwise you will not be paid appropriately for all of the services rendered.

**Question 6**

Should we assign add-on CPT code 96415 for chemotherapy IV infusion individually for each infusion service as applicable? Or should we add together all additional hours of infusion cumulatively in order to assign the total units of 96415?

For example:

- Chemo, initial infusion 89 minutes
- Chemo, sequential infusion #1 89 minutes
- Chemo, sequential infusion #2 89 minutes

Is the most likely answer: 96413 and 96417x2? Or is the answer 96413, 96417x2 and 96415?

**Answer:** For non-Medicare payers, you have to be aware of whether a single chemotherapy infusion was provided or if multiple chemotherapy drugs are infused during the visit. In 2005, the answer to this question was straightforward as we had no sequential infusion CPT codes to report additional infusions that might have been provided. Therefore, all of the chemotherapy infusion time was added together and the first hour code was reported with a unit of one. The additional hours add-on code (96412 in 2005) with the appropriate units reflected the additional hours.

Today, the rules are different for how to report infusion services using the CPT codes for your non-Medicare payers vs. using the HCPCS C-codes for reporting the same services to Medicare. The fundamental difference is that there are now sequential and concurrent infusion CPT codes but no equivalent C-codes for reporting to Medicare.

What this means is that you **cannot** simply add up all of the time related to multiple sequential infusions for non-Medicare and report as you did in 2005. You have to know whether additional infusions were given. If so, report the first hour of the sequential infusion with the sequential chemotherapy infusion code, and then the additional hours of both the first infusion (if there are additional hours to report) service as well as any additional hours of the sequential infusion using the same add-on CPT code, 96415.

Therefore, the correct answer to the clinical scenario shown above is:
Medicare: Total chemotherapy infusion time is four hours and 27 minutes. This is reported to Medicare using the two chemotherapy infusion C-codes

- C8954 x 1
- C8955 x 3 (not 4 since we only have 27 minutes into the fourth hour. If this had been four hours and 31 minutes, then we’d charge 4 units of the additional hours code)

Note: There is no sequential infusion C-code for Medicare reporting therefore the time is simply added together and reported just as it was in 2005.

Non-Medicare: (From the way the example is provided, it appears as if the patient received three different chemotherapy infusions. Therefore, we have the initial service code and two sequential infusion codes or two units of CPT code 96417. Do not report the additional hours code 96415 since none of the infusions meet the time test to report additional hours.)

While it might be tempting to report modifier -59 in this situation to indicate that 96417 x 2 represents two separate sequential infusions, we do not believe it would be appropriate given CMS’ guidance in Transmittal 785 about when to use modifier -59. However, make sure to check with your non-Medicare payers requiring CPT codes for drug administration services for how they want you to report this scenario.

- 96413 x 1
- 96417 x 1
- 96417 x 1

Question 7

On page 24 of the presentation there are guidelines for reporting services to inpatients and outpatients. It states “Once you must report the charge separately under OPPS, the above reference instruct hospitals to also report it for inpatients. Use a routine revenue code 230 for services provided by nurses...etc.”

Does the above advice pertain to injections and infusions that are being charged for on the outpatient account? If so, how do we capture the same charge on the inpatient accounts? Does the above advice apply to all services that are charged on the outpatient accounts? Can we incorporate the charges into the room rate? Please advise.

Answer: The above citations support reporting a separate charge for each procedure or separate service when it is reported on outpatients. The hourly observation rate represents the outpatient charge that corresponds to the inpatient room rate. If you separately charge injections, infusions, chemotherapy, bladder catheterization and other procedures as you are required to do under OPPS for observation patients in beds, then the citations also support separately reporting the same services on inpatients.

An appropriate revenue code to report the charges on inpatients is 230. Capturing the charges is an operational issue each hospital must resolve for itself. If you have further questions regarding this issue, we recommend that you ask your Fiscal Intermediary’s Medical Director, as CMS Central Office has recently instructed hospitals to do this.
**Question 8**
We have a few questions particularly pertaining to oncology:

1. On pg. 15, it mentions that the flush at the conclusion of infusion is an included service. Our oncology department currently charges for saline flush before infusion and saline and hep-lock flushes after infusions. We understand that the flush at the conclusion is inclusive, but can we charge for the hep-lock flush solution because heparin is considered a drug?

2. Oncology currently has a patient who comes in every two weeks for chemotherapy. The nurses initiate a prolonged infusion via a pump that infuses for 48 hours at the end of the treatment that day. The patient then returns the next day for a replacement of the drug cartridge.

We do not provide the drug or the pump—these both come from an outside source that delivers it here for the nurses. We report 96416 for initiation of a prolonged chemotherapy infusion, but do we report this for both days? Or should we report 96416 only the first day, then charge a refill code (96521 or 96522) for the second?

**Answer 1:** Yes you should bill for the heparin. But the flush procedure itself, both before and after the infusion, is not separately billable and is considered a part of the infusion procedure.

**Answer 2:** In this scenario you would charge the initiation code (96416) the first day and the re-fill and maintenance code for a portable pump (96521) the second day.

**Question 9**
A patient stays at our hospital observation unit for two days. He is admitted to the unit on January 1, 2006, and nursing starts an IV on the second day (January 2, 2006) which runs for eight hours? How should we bill this?

**Answer:** The date for the initial IV service is one unit of 90760 or C8950 (depending on whether the payer is non-Medicare or Medicare) with a date of January 2, 2006 and the seven additional hours are reported as 90761/C8951 (again depending on whether the payer is non-Medicare or Medicare) with a date of January 2, 2006. This is true even if the seven hours caused the infusion to continue to January 3, 2006. Always report them with the date the infusion was initiated.

**Question 10**
Per the 2006 CPT Manual, pg 400, under Chemotherapy Administration:

> Chemo administration codes 96401-96549 apply to parenteral administration of non-radionuclide anti-neoplastic drugs; and also to anti-neoplastic agents provided for treatment of non cancer diagnoses (eg, cyclophosphamide for auto-immune conditions) or to substances such as monoclonal antibody agents and other biologic response modifiers.

We have patients who receive IVIG for diagnoses other than cancer (Devic’s disease/MS or Gamma Globulin Deficiency, for example). Because IVIG is a biological response modifier, should we assign chemo administration codes based on the definition in the chemo section?

We also have patients who receive Epogen, Darbopoetin, Neumega, Neulasta, Neupogen, all of which are biological response modifiers, and also receive these for non-cancer diagnoses. Should we assign these agents to chemo administration based on the definition above?

**Answer:** Up until this year, administration of the drugs mentioned above would have been billed with non-chemotherapy drug administration codes. We recommend you continue to bill administration of the above drugs in this fashion while asking your Fiscal Intermediary Medical Director this question. A technical answer to your question would be to bill the chemotherapy
administration codes, but ultimately whether or not this practice will pass scrutiny is up to your Fiscal Intermediary.