

Internal Medicine Coding Alert

Get \$90 for Each Therapeutic Infusion Service

Supervision is key to avoiding denials

To get your internist paid for therapeutic infusion services (90780-90788), you first have to know Medicare's physician supervision requirements for infusion procedures.

Documenting Direct Supervision Pays

If you know your internist's role in infusion therapy, you have a good chance of collecting \$90 when you report 90780 (Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour), coding experts say. In 2004, Medicare pays twice as much for 90780 as it did last year, when the code brought only \$42, according to national averages.

Planning: Before you assign 90780, make sure the physician either administered the drug or provided "direct supervision" over the staff member who did. But "direct supervision" doesn't mean that Medicare requires the physician's presence in the room. Instead, the physician must be present in the office suite and immediately available to provide assistance and direction, according to the Medicare Carriers Manual (MCM), section 2050.1.

For example, your internist uses infusion therapy to administer Remicade for rheumatoid arthritis (714.0). Because the therapy lasts one hour and your physician provided the services, you report 90780. If the nurse, for instance, gave the drug, you could bill the code under an "incident-to" service. But the physician should have been immediately available in the office suite. If the doctor offered guidance or assistance over the phone, you couldn't assign 90780.

Tip: You should also pay attention to the therapy's time. Suppose the Remicade therapy lasted two hours; you should report +90781 (... each additional hour, up to eight [8] hours [list separately in addition to code for primary procedure]) along with 90780. The add-on code pays an average of about \$35, up from \$21 in 2003.