Internal Medicine Coding Alert

Overhaul Remicade Coding With 6 Fundamentals for 2006

CPT and CMS agree that these infusions fall into chemotherapy arena

CPT's restructuring of infusion codes requires you to educate yourself and representatives on Remicade reporting.

"What codes should you use for Remicade infusions in 2005 and in 2006?" asks **Pat Strubberg, CPC**, at Patients First Health Care in Washington, Mo. The answer depends on the claim date, the insurer, and these basics.

1. Classify Remicade as Chemotherapy

Based on CPT 2006 and Medicare guidelines, you should now classify Remicade infusions as chemotherapy administration. Although Remicade is not a chemotherapy drug, Medicare considers infusions involving the drug to be complex enough to warrant using chemotherapy administration codes. CPT 2006's revisions to the subsections "Hydration, Therapeutic, Prophylactic, and Diagnostic Injections and Infusions (Excludes Chemotherapy)" and "Chemotherapy Administration" mirror CMS' earlier distinction.

Problem: Although CPT splits infusions into two main subsections--you use either a nonchemotherapy code or a chemotherapy code--the distinction between the drugs that fall into those categories is not straightforward. Drugs other than chemotherapy drugs may qualify for chemotherapy administration codes.

CPT 2006's introductory notes allow the use of chemotherapy administration codes for other non-chemotherapy agents, says **Stacie Heller**, director of health policy affairs for Lash Group. The new definition means you should apply chemotherapy administration codes to four substances:

• non-radionuclide anti-neoplastic drugs for parenteral administration
• anti-neoplastic agents provided for treatment of noncancer diagnoses, such as cyclophosphamide for auto-immune conditions
• monoclonal antibody agents
• other biologic response modifiers.

Good news: CMS didn't expect you to be an expert on what substances qualified for the above definition. "Transmittal 129 actually included a 'Partial List of Drugs Commonly Considered to be Monoclonal Antibodies and Hormonal Antineoplastics.' " Heller writes in the December 2005 Oncology Now. The partial list includes drugs commonly considered to fall under the category of monoclonal antibodies, such as infliximab (the generic version of Remicade).

2. Combat Chemotherapy Denials With 2 Tools

The partial list, however, isn't the final authority on Remicade infusion coding. CMS gave carriers leeway to decide which drugs should be billed with which drug administration codes. Although most carriers allow the chemotherapy administration codes for all drugs included in the partial list, "many carriers are not giving all drugs in those classes the same allowance," Heller says.

If a carrier rejects chemotherapy administration codes for Remicade infusions, you have two options:

1. Follow the insurer's required method even if it contradicts CPT guidelines provided you have written notice of the insurer's billing policy. **Tip:** Check insurers' Web sites for provider newsletters, which usually contain this information.

2. Appeal the denial with CPT 2006. "Per CPT guidelines, the chemotherapeutic codes indicate monoclonal antibodies, and that means Infliximab (Remicade)," says **Kathleen Mueller, RN, CPC, CCS-P, CCC, CMSCS**, an independent healthcare consultant. "Use those guidelines to argue with your carriers for the chemo codes."

3. Use 96413-96415 Based on Infusion Duration

Part of the problem with coding Remicade infusions stems from insurance companies' slow implementation of this year's new method.

Old way: You should have reported Remicade infusions based on insurer. For private payers, you should have used CPT's generic infusion codes: 90780 and 90781.

In 2005, Medicare instructed providers to use G0359 (Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug) and G0360 (Each additional hour, one to **eight** [8] hours [list separately in addition to code for primary procedure]) for Remicade infusion, says **Matthew Lautzenheiser,** senior administrative manager at Johns Hopkins Medicine in Baltimore.

New method: Theoretically, you should use new CPT 2006 chemotherapy administration codes for all insurers. CMS deleted G0359-G0360 via the HCPCS Level II 2006 Manual, effective Dec. 31, 2005.

Here's how: As in years past, you must keep track of exactly how long a Remicade infusion session lasts. You should report the first hour of infusion with 96413 (Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug). For each subsequent hour, use add-on code +96415 (... each additional hour, 1 to 8 hours [list separately in addition to code for primary procedure]), says **Linda Parks, MA, CPC, CMC, CMSCS**, an independent coding consultant in Lawrenceville, Ga.

Example: A patient with Crohn's disease in an unspecified site reports to the office for Remicade infusion. The internist infuses 300 milligrams of the drug over a two-hour period. Using CPT guidelines, you should report:

- 96413--first hour of infusion
- 96415--second hour of infusion
- 555.9--Crohn's disease NOS.

Remember, you can start counting a second unit of 96415 when the infusion lasts more than one hour and a half past the first hour. For instance: If the above infusion lasted 2 hours and 31 minutes, you would code two units of 96415.

The time you report should be based only on the administration time for the infusion, according to CPT Changes 2006--An Insider's View, published by the AMA. In other words, the infusion time includes services leading up to the infusion and to conclude the infusion (for example, starting the IV and monitoring the patient postinfusion). Do not report these services separately or count them toward the infusion time.

Watch your site of service: You should only report infusions that take place in the internist's office, not those that occur in a hospital inpatient/outpatient setting.

4. Code Additional Administrations as Subsequent

Don't forget to code for any antiemetics that the patient receives in conjunction with the Remicade infusion. When staff use different techniques to administer chemotherapy, you should "report separate codes for each parenteral method of administration employed," states CPT's chemotherapy administration introductory notes. Therefore, you should separately report any antiemetic therapies.

Key: Treat these infusions as add-on services. When staff perform multiple services during a single encounter, once you assign the "initial" code, you should report all other services with the "subsequent" or "each additional" codes, says **Cindy C. Parman, CPC, CPC-H, RCC**, cofounder of Georgia-based Coding Strategies Inc.

Action: You already used an initial infusion code: 96413. So stick with add-on codes for any antiemetics.

• For an infusion of an antiemetic, assign +90767 (Intravenous infusion, for therapy, prophylaxis, or diagnosis [specify substance or drug]; additional sequential infusion, up to 1 hour [list separately in addition to code for primary procedure]).

• Count an infusion that lasts 15 minutes or less as a push with +90775 (Therapeutic, prophylactic, or diagnostic injection [specify substance or drug]; each additional sequential intravenous push of a new substance/drug [list separately in addition to code for primary procedure]).

5. Disregard 59 Based on the Absence of Edits

Reporting additional infusion codes raises an additional question. "When coding infusions, injections, hydration and chemotherapy administration, do I need to use modifier 59 (Distinct procedural service)?" asks **Anita Mulligan, CPC,** billing manager at Albany Medical College in New York.

According to CMS, "It does not appear that modifiers will be required," Parman says. The National Correct Coding Initiative (NCCI) version 12.0 does not bundle subsequent or each additional codes into initial infusion codes. Only "initial codes bundle other initial codes," she says.

6. Assign J Codes for Supplies

In addition to the infusion service, you should report the drug supplies involved in the infusion encounter. The appropriate supply code for Remicade is J1745 (Injection, infliximab, 10 mg). Use one unit of J1745 per 10 mg that staff administer. For instance, code a 300-mg Remicade infusion's drug supply with J1745 x 30.

Disaster averted: Check with your major payers before using J1745. Some may prefer a local code for Remicade, or J3490 (Unclassified drugs).

With Remicade infusions, the internist typically infuses the pharmaceutical with saline. You can bill for that supply using J7050 (Infusion, normal saline solution, 250 cc) for every 250 cc the physician administers, Lautzenheiser says.

Don't forget to also bill a J code for any antiemetics, such as Benadryl for nausea. Report a Benadryl push with J1200 (Injection, diphenhydramine HCl, up to 50 mg).