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Internal Medicine Coding Alert

You Be the Coder: Infusion Therapy

Question: When billing for IV infusion for therapy or diagnosis, we bill code 90780. To bill 90781, does the time have to be an additional full hour? In the situation where the infusion lasts for one-and-one-half hours, can we bill for both codes 90780 and 90781 or just 90780?

Illinois Subscriber

Test your coding knowledge. Determine how you would code this situation before looking at the box below for the answer.

Answer: There are no specific instructions for reporting infusion therapies that fall short of the one-hour increment in which these codes are billed. Code 90780 (IV infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour) is used to report the first full hour of IV infusion, while code 90781 (IV infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; each additional hour, up to eight hours) is used to report each additional hour, up to eight hours. The only instruction Medicare gives for billing the codes is that the claim for 90781 must indicate, in the unit field, the hours of infusion beyond the first hour, and should be reported in whole-hour increments.

When an infusion runs one-and-one-half hours, billing manager **Jim Stephenson** of Premium Medical Management Services, a multispecialty practice in Elyria, Ohio, bills for two hours of time by reporting 90780 and then 90781. Medicare practice for codes based on time (like critical care codes) is to round up to the next full increment when the previous increment is surpassed by 50 percent or more. Because the infusion codes are billed in 60-minute increments, any infusion running 30 minutes or more can be rounded up to a full increment.

The start and stop times of the infusion should be noted in the patients medical record but not reported separately on the claim. Frequently we will get paid for two hours of infusion therapy, notes Stephenson, who uses this method with both Medicare and private payers. Sometimes the payer will ask to see the patients medical record for further documentation, and may pro-rate the fee for 90781 based on the length of time the infusion actually took.

If the infusion runs for two-and-one-half hours, Stephenson recommends reporting 90780 first and then 90781. He reports a 2 in the unit field for 90781 instead of listing the code twice.

Another approach would be to report two hours of infusion therapy on the claim, and bill 90781 as a reduced service. I would report one unit with 90780, and two units as 90781-52, adding modifier -52 (reduced services) to prorate the fee for 90781, says **Tammy Chidester, CPC,** billing supervisor at Upshur Medical Management Services, a multispecialty practice in Buchanon, W.Va. A concise statement included with the claim should explain how the service differs from the usual.

Depending on the method used to report the infusion, the Medicare Carriers Manual states that claims submitted with 90781 should explain why the infusion lasted more than one hour.

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