Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Perfect Your Injection and Infusion Claims With These Quick Tips

Consult payers for proper codes when new drugs hit the market.

Injection and infusion coding knowledge is a must for most practices, but getting these claims just right takes practice--and patience.

You can submit successful claims that will stand up to payer audits by following just three steps, broken down by the experts.

Step 1: Choose the Proper Administration Code

The first thing you need to do when coding an injection service is determine the proper administration code you should be reporting. You might think that all injections are the same, but CPT® offers several administration codes to choose from. You'll have to figure out which type of drug therapy your physician ordered to get to the right code. You'll select from the following codes:

- 96365 -- Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to one hour -- Use for Zometa.
- +96366 -- ... each additional hour (list separately in addition to code for primary procedure) -- Report 96366 in conjunction with 96365 to identify each second and subsequent infusion of the same drug/substance, says **Michael A. Ferragamo, MD, FACS,** clinical assistant professor of urology, University Hospital, State University of New York, Stony Brook. This is an add-on code to 96365, 96367, so you should not code this alone as an independent code or reduce its fee.
- +96367 -- ... additional sequential infusion of a new drug / substance, up to 1 hour (list separately in addition to code for primary procedure) -- Use for any new drug the physician gives after an initial infusion. This is an add-on code to 96365, 96374, 96409, or 96413, so you should not use it alone.
- +96368 -- ... concurrent infusion (list separately in addition to code for primary procedure) -- Use for any drug infused concurrently (at the same time) as an initial infusion. This is also an add-on code to 96365 and 96366, so you should not code it alone.
- 96372 -- Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular -- Use for testosterone injections, antibiotic injections and for other drugs such as B12 or Epogen.
- 96374 -- ... intravenous push, single or initial substance/drug -- Use this code for intravenous antibiotic injections your physician gives.
- +96375 -- ... each additional sequential intravenous push of a new substance/drug (list separately in addition to code for primary procedure) -- Use for any additional drugs your physician administers intravenously during the same session as above. This is an add-on code to 96365, 96374, 96409, or 96413, so you should not use it alone.
- 96401 -- Chemotherapy administration, subcutaneous or intramuscular; non-hormonal ant-neoplastic -- Use this code for Xgeva administration.
- 96402 -- ... hormonal anti-neoplastic -- Use this code for Lupron, Zoladex and Trelstar injections.
- 96409 -- Chemotherapy administration; intravenous, push technique, single or initial substance/drug.

Tip: "Check with your major payers when new drugs are introduced into the market," says **Karla Dickerson,** billing and reimbursement coordinator at Salina Urology Associates in Kansas. "Payers look at new meds differently and may have different opinions on what administration code is most fitting. [An] example would be CPT® code 96402. The code description indicates 'chemotherapy administration,' but the heading in the code section makes reference to not only chemotherapy medications but 'other highly complex drugs or biological agent administration.' Some payers may choose

to include non-chemotherapy medications as the best fit to use with this administration code."

Additionally, many drugs have specific frequency issues and can only be administered and billed for on a certain schedule, says **Elizabeth Hollingshead, CPC, CUC, CMC, CMSCS,** corporate billing/coding manager of Northwest Columbus Urology Inc. in Marysville, Ohio. "You don't what to give a Lupron several weeks early. That's a pretty large bill to eat, as are many others. Check with your carriers as this can vary state to state. Some allow an injections or infusion every X number of days while another might put it in weeks or months. Also, don't forget to check if a prior authorization is required!"

Step 2: Know When You Can Report a Separate E/M Code

If the physician performs a separately identifiable service at the same time as the injection, such as an office visit, you can report that service separately using modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service).

"A separate E/M service can be billed in conjunction with an injection administration as long as the documentation supports the E/M service," Dickerson says. "When reviewing the service, you should be able to identify a 'stand alone' examination, medical decision making, and/or HPI (history of present illness) to support the E/M service."

"You need to make sure that it truly is a 'separately identifiable service' as there is a degree of evaluation and management inherent to the injection," Hollingshead agrees.

Tip: If your physician lists two separate diagnoses -- one for the reason the patient is receiving the drug therapy and one for another unrelated problem -- then you should dig deeper to see if reporting a separate E/M service is warranted.

Example: An established patient comes to your office for a Lupron injection. The physician sees the patient prior to the injection and performs an exam because he suspects an active urinary tract infection (UTI). The physician also performs a urinalysis and prescribes an antibiotic. This E/M service certainly warrants a separate charge.

You can use established patient office visit codes 99212-99215 (Office or other outpatient visit for the evaluation and management of an established patient ...) to report your physician's services, depending on the work your physician performed. You would append modifier 25 to 99212-99215 to ensure payment when you bill them with 96402.

Therefore, if the physician provided a level-two E/M service in the example above, report 99212-25 for the clinical assessment, 96402 for the Lupron administration, and J9217 (Leuprolide acetate [for depot suspension], 7.5 mg) for the drug.

Pointer: When a nurse or medical technician administers a drug/substance, subcutaneous, intramuscular, or intravenously, you cannot bill for a nurse's E/M visit with 99211 as this code is included in all drug administration codes, such as 96365 and 96372.

Caveat: Two different diagnoses are not always necessary, however; and, having two diagnoses doesn't always make both services billable. Your physician has to document at least two (for established patients) or three (for new) of the required elements (history, exam, and medical decision-making) to report an E/M code.

"While modifier 25 does not require a separate diagnosis (for most Medicare carriers, while commercial insurance companies may be different), it helps support the medical necessity of what was being evaluated, separate to the reason for the injection," Dickerson explains.

Step 3: Don't Forget the Drug Supply Code

Once you've determined the CPT® codes you will be reporting, you need to select the proper HCPCS code to represent the actual drug your physician administered. Typically, you'll use the drug supply J codes to do this.

How it works: Review the drugs your physician uses most frequently. Note the drug HCPCS code as well as the dosage or units generally administered. When you submit a claim for drug payments, in many cases it is now necessary to also

include the full drug name, the total dosage or units administered, method of administration, and the National Drug Code (NDC) number.

Example: Your physician administers 4 mg IV Zometa over a period of more than 15 minutes. According to the code descriptor for Zometa (J3487, ... per one milligram), you will report the 4 milligram dosage with the number 4 in column 24G of the CMS-1500 form indicating the 4 milligrams were given. Because the Zometa was administered by an infusion greater than 15 minutes, you would also use administration code 96365.

No more LCA: In the past, some payers including Medicare would adjust your payment for drug codes down to the drug within the same classification with the lowest Average Sales Price (ASP), also known as applying the Least Costly Alternative (LCA).

The LCA policy said that "if you have two products and both products produce similar acceptable results but one product price is higher than the other, the reimbursement will be the cost of the lower priced product," explains **Maggie Mac, CPC, CEMC, CHC, CMM, ICCE,** president of Maggie Mac-Medical Practice Consulting in Clearwater, Fla. and Brooklyn, N.Y. "In other words, if there is no substantive evidence that the higher priced product produced superior results, then there was no need to use it and the lower priced product should have been utilized. Therefore, reimbursement will only be as high as the 'least costly alternative.'" In 2010, however, all MACS retired their existing LCA local coverage determinations (LCD) for LHRH drugs administered in a urology office. Payers will now pay you the average sales price (ASP) plus 6 percent.

Warning: If your provider has the patient pick up the drug somewhere else, such as a pharmacy, and bring it to your office, you cannot report the drug supply as your office has not incurred the cost of the drug. "Just bill for the administration of the drug, and note in Box 19 of the 1500 form or its electronic equivalent the drug information noted above," Ferragamo says. "Also note that the patient has supplied this drug for your administration."