Codify by AAPC

Outpatient Facility Coding Alert

Chemotherapy: Don't Miss These Key Revisions to 96401-96549 Guidelines

One coding example specifically applies to facilities.

CPT® 2013 includes nearly half a page of new or revised portions to the chemotherapy administration guidelines. Although a large portion of the guidelines for codes 96401-96549 (Chemotherapy administration ...) are marked as revised, only a few changes were made -- but overlooking these could sink your pay for these services.

Biggest shift: The AMA revised the language to clarify that any qualified health care professional (not just a physician) may provide the work or monitoring required. The same revision applies to procedures throughout CPT® 2013.

Remember: The CPT® code set is explicitly neutral on stating which provider types are qualified to report a service. That means you should review your specific state scope of practice for each non-physician provider type and review individual payer requirements to determine which providers may perform and bill for specific services.

Pay Attention to This Example

Although the chemotherapy-specific guidelines didn't change much, there is a notable change regarding initial service coding in the 2013 guidelines for "Hydration, Therapeutic, Prophylactic, Diagnostic Injections and Infusions, and Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration."

The revision updates an example for coding multiple infusions performed at a single encounter that spans multiple dates. The multi-day nature of the example and comments in AMA's CPT® Changes 2013: An Insider's View indicate that the example pertains to facility reporting rather than to a typical office administration. But any coder may be interested to see the concept supported by CPT® 2013.

2012 statement: The 2012 guidelines indicate that when services extend beyond midnight, the date of service change is like a reset button, allowing you to report an initial infusion code for the first infusion of the new day. The 2012 example states, "a medication was given by intravenous push at 10 PM and 2 AM, as the service was not continuous, both administrations would be reported as an initial service (96374)."

2013 update: In 2013, CPT® administration guidelines instead indicate that services that extend from one day to the next should be considered a "single encounter" and coded accordingly, says **Kelly C. Loya, CPC-I, CHC, CPhT,** Director of Enterprise Risk, Internal Audit, and Compliance for Sinaiko Healthcare Consulting Inc., a reimbursement services division of Altegra Health.

The revised 2013 language reads as follows: "a medication was given by intravenous push at 10 PM and 2 AM, as the service was not continuous, the two administrations would be reported as an initial service (96374) and sequential (96376) as: (1) no other infusion services were performed; and (2) the push of the same drug was performed more than 30 minutes beyond the initial administration."

This concept of using a single initial infusion code per encounter mirrors the new-for-2012 example for continuous infusions lasting beyond midnight. The 2013 example further supports the concept that the encounter, rather than the date of service when administrations are given during an overnight stay, determines when an initial administration code can be used.

'Initial service' assignment take-away: "Be sure to report an initial service only once over the span of a 'single encounter' regardless of the date(s) on which they occurred," Loya advises.

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