Clarifying the Infusion and Injection Quandary

by Laurie M. Johnson, MS, RHIA

Coding infusions and injections has been a source of confusion and frustration since the Centers for Medicare and Medicaid Services (CMS) introduced C codes in 2006. However, in calendar year 2007, CMS made an about face and eliminated the C codes, reverting back to the published 2007 CPT codes. The only exception to this rule is code C8957, Nonchemo prolonged infusion pump.

Coders must understand these guidelines in order to code these services correctly so that their organizations are reimbursed fully. This article outlines the basic application of these CPT/HCPCS codes from a hospital outpatient service and CMS perspective. (Note: payers differ on code requirements and coverage for infusions and injections.)

Pre-2007, Coding Per Visit

Prior to 2007, injections and infusions were coded and billed based on a per-visit determination, with subsequent hours considered a package service of the APC assignment. Although this might sound like an easy coding and billing concept, it was fraught with problems. CMS heard the cries for clarification from the healthcare industry and began to revise the process.

In 2007 CMS changed the methodology, published in CMS Transmittal 1139CP, in anticipation of clarifying the coding and billing of these services. In an effort to help coders assign injection and infusion codes and clarify coding requirements, CMS moved the infusion and injection codes to the medicine section of the CPT manual.

There is an unofficial hierarchy that assists coders in sequencing and assigning the correct CPT code in this section:

- Chemotherapy infusions
- Chemotherapy injections
- Therapeutic (nonchemotherapy) infusions
- Therapeutic (nonchemotherapy) injections
- Hydration infusions

This list assigns the highest priority to chemotherapy infusions; however, it is important for coders to know the primary reason that a patient seeks services. Clinical documentation is an important part of appropriate injection and infusion coding and billing.

Injection versus Infusion

Length of time, calculated by the start and stop times, determines whether a procedure is coded as an infusion or injection. To ensure accurate coding and billing, providers must understand the start and stop documentation requirement. Any infusion less than 15 minutes should be coded as an intravenous push injection.

This year, CMS adjusted six new APC levels, which allows for a separate payment for the initial administration and additional payments for each additional hour of infusion.

Injections

Injections are included in CPT codes 90772–90779, 96401–96411, and 96440–96450. There are several types of injections, including intravenous push, intramuscular, subcutaneous, and intra-arterial.

An injection lasts 15 minutes or less and may be therapeutic, chemotherapeutic, or for immunization. Clinical documentation should include the injection type, purpose, and duration.

Chemotherapeutic injections include hormonal, nonhormonal, intralesional, intravenous push, intra-arterial push, pleural cavity, peritoneal cavity, and intrathecal. Immune globulin administration is coded using injection codes.

It is important to remember that injections are coded per injection, not per medication.

Vaccine Administration

Vaccine administration is immunization as a preventive measure against specific conditions. A vaccine administration code should be assigned whenever a vaccine product is used.

CMS has assigned reimbursement for vaccine administration beginning in calendar year 2007 under the outpatient prospective payment system (OPPS). Vaccine administration is coded with CPT codes (90465–90474) or HCPCS codes (G0008, G0009, G0377). This service is a frequently missed charge in emergency departments.

Infusion

Hydration and nonchemotherapeutic and chemotherapeutic services are included in infusion codes. Chemotherapeutic infusions may include antineoplastic agents for treatment of noncancer diagnoses, substances such as monoclonal antibody agents, and other biologic response modifiers. Coders should identify the primary reason for the visit before assigning the infusion code.

CMS began reimbursing infusions on a per-hour basis beginning in calendar year 2007 under OPPS. The following guidelines apply when coding for infusions:

- Only one initial service may be coded per encounter.
- A bolus of prepackaged fluids or other specific medications should be coded as therapeutic.
- The calculation of hours is based on start and stop times. The additional hour can be included only when the infusion has lasted more than 30 minutes into the second hour.
- Concurrent chemotherapy should be assigned code 96549.
- Concurrent nonchemotherapy infusion should be assigned code 90768 with a unit of one per encounter.
- Prolonged infusions requiring a pump are coded to C8957 for Medicare patients. Other payers may need to be queried for an appropriate crosswalk.

Associated Services

According to the 2007 CPT codebook, anesthesia; IV start; access to indwelling IV, subcutaneous catheter, or port, catheter flush at conclusion of infusion; and standard tubing, syringes, and supplies are included in the CPT code. There are services that may be charged separately. They include:

- 96521, Refilling and maintenance of portable pump
- 96522, Refilling and maintenance of implantable pump or reservoir for delivery, system (e.g., intravenous, intra-arterial)
- 96523, Irrigation of implanted venous access device for drug delivery systems
- 99201–99205; 99211–99215, Separate clinic visits for complications of care or separately identifiable problem during patient's clinic visit
- G0332, Pre-administration services for the administration of intravenous immune globulin

Modifiers and OCE Edits

There are two modifiers that are prevalent in coding infusions and injections. The -25 modifier may be appended to the visit code when a separate service is provided during the patient's encounter. The -59 modifier may be appended when infusions or injections have been provided in two separate visits in the same calendar day. The Outpatient Code Editor (OCE) limits the coder to the units for the -59 modifier that is applied to services, outlined below:

- Chemotherapy administration by other technique except infusion: 2 units
- Chemotherapy administration by infusion only: 2 units
- Infusion therapy except chemotherapy: 4 units

The OCE edits that should be managed are:

- 19 (mutually exclusive procedure that is not allowed by NCCI even if appropriate modifier is present)
- 20 (Code2 of a code pair that is not allowed by NCCI even if appropriate modifier is present)
- 39 (mutually exclusive procedure that would be allowed by NCCI if appropriate modifier were present)
- 40 (Code2 of a code pair that would be allowed by NCCI if appropriate modifier were present)

Note that the OCE edits will be generated when CT scans, MRIs, et cetera are also performed. The edit program assumes that unbundling of injections and infusions has occurred, so the -59 modifier may be appropriately appended in these situations.

Considerations

Billing infusion and injection services requires coordination between the chargemaster coordinator, coders, and billing staff. Organizations should consider the following questions:

- How will these services be charged?
- Will codes be assigned by coders or the chargemaster?
- Who will provide the education on the charging process and requirements?
- Who will review OCE results?
- How will the OCE results be resolved?

These services create billing issues and are an area of frequently missed charges. In some facilities the assignment of injection and infusion codes has been moved from the clinic (nursing staff) to the HIM coding department. Coders have the ability to review the documentation within the record and apply the appropriate CPT code that reflects the services provided.

Other facilities have chosen to assign a team of individuals to review issues such as this in a weekly or monthly meeting. The team consists of coders, billers, nurses, chargemaster personnel, and possibly emergency department personnel. The team can meet and review issues surrounding their facility's issues with appropriate injection and infusion coding. In addition, these meetings can result in the development of educational materials for clinical providers to ensure that clinical documentation supports the services rendered and accurately reflects the patient's care.

Coding Case Studies

Example 1

A patient presents to the emergency department for the treatment of acute pain. The patient is administered an injection (IVP) of Toradol 30 mg. A second dosage of 15 mg was administered because the pain continued.

Code assignment: 90774, Therapeutic, prophylactic, or diagnostic injection; intravenous push, single or initial substance/drug. A second injection is not coded as the substance is the same.

Example 2

A 25-year-old patient presents to the emergency department with a hand laceration that requires sutures. The patient fell, and a piece of rusty metal cut the hand. The patient's tetanus status could not be determined, so tetanus and diphtheria toxoids (Td) adsorbed through intramuscular injection was given.

Code assignment: 90471, Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections: one vaccine [single or combination vaccine/toxoid]); 90718, Tetanus and dipththeria toxoids (Td) adsorbed when administered to 7 years or older, for intramuscular use.

Example 3

A patient presents for scheduled intrathecal chemotherapy for lymphoma. The therapy begins at 10 and is completed at 10:30.

Code assignment: 96450, Chemotherapy administration, into CNS (e.g., intrathecal) requiring and including spinal puncture. The lumbar puncture would not be coded separately.

Example 4

A patient presents for refilling of the implantable reservoir. The patient notified the physician of the rash on the abdomen. The physician performed a history and physical to evaluate the patient's new condition.

Code assignment: 96522, Refilling and maintenance of implantable pump or reservoir for delivery, system (e.g., intravenous, intra-arterial); and 9921X-25. The visit code is submitted because a separate problem has been identified; it should be based on the facility's clinic visit criteria. The -25 modifier is appended because 96522 is an "S" status indicator.

Resources

American Hospital Association. *Coding Clinic for HCPCS,* Third Quarter 2006.

American Medical Association (AMA). *CPT Assistant,* February 2003.

AMA. *CPT Assistant,* April 2005.

AMA. *CPT Assistant,* November 2005.

AMA. *CPT Assistant,* September 2006.

AMA. *CPT 2007 Professional Edition.* Chicago, IL: AMA, 2007.

Centers for Medicare and Medicaid Services (CMS). 2007 HCPCS Index. Available online at www.cms.hhs.gov/HCPCSReleaseCodeSets/Downloads/2007_indx.pdf.

CMS. "CMS Manual System Pub 100-04 Medicare Claims Processing, Transmittal 902." April 7, 2006. Available online at www.cms.hhs.gov/transmittals/downloads/R902CP.pdf.

CMS. "CMS Manual System Pub 100-04 Medicare Claims Processing, Transmittal 1139." December 22, 2006. Available online at www.cms.hhs.gov/transmittals/downloads/R1139CP.pdf.

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