Coding Intravenous Infusions with Hydration; Medical Decision Making

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Q. We perform a lot of IV infusions in our urgent care facility. Sometimes we also perform IV pushes and hydration at the same time as the infusion. We have been billing CPT codes 36000, 96365 -59, 96360 -59, and 96374 -59. Medicare pays for these codes when we append the -59 modifier but I am concerned that this may not be the correct way to bill after reviewing some articles on the CMS website. What is the proper way to code IV infusions with hydration?

A. If an IV infusion and IV push are performed concurrently in the same IV site, you should only bill one "initial" code. According to CPT guidelines, only one "initial" service code should be reported for a given date, unless protocol requires that two separate IV sites must be used. When these codes are performed in the physician office, the "initial" code billed is the code that best describes the primary reason for the encounter and should always be reported irrespective of the order in which the infusions or injections occur.

Certain procedures and supplies are included and not reported separately if performed to facilitate the infusion or injection:

- Use of local anesthesia
- IV start
- Access to indwelling IV, subcutaneous catheter or port
- Flush at conclusion of infusion
- Standard tubing, syringes, and supplies

For example, a patient is diagnosed with dehydration (276.51) and the provider orders an infusion of 1000 cc of normal saline to rehydrate the patient. Based on the documentation, the key reason for the visit is dehydration. The hydration infusion is started at 3:00 p.m. The patient becomes nauseated 10 minutes later and the provider orders 25 mg of Phenergan to be pushed at the same access site, which is performed at 3:13 p.m. The infusion is completed at 4:00 p.m. and the IV disconnected. The proper coding for the procedure is 96360, "Intravenous infusion, hydration; initial, 31 minutes to 1 hour," J7030, "Infusion, normal saline solution, 1000 cc," and J2550, "Injection, promethazine HCl, up to 50 mg."

However, let's say the same patient from our example above returns to the clinic later the same evening still nauseated. The patient is then diagnosed with nausea (787.02) and the provider orders an IV push of 25 mg of Phenergan. The IV is started, the Phenergan is administered from 7:05 p.m. to 7:10 p.m., and the IV is disconnected. In that case, you would bill CPT code 96374, "Intravenous push, single or initial substance/drug" with modifier -59 because the incident is separate from the first visit and another IV placement had to be performed.

Another example is a patient who has come in for a therapeutic infusion of "Antibiotic A," which is started at 1:00 p.m. using the same access site; a bag of 1000 cc of normal saline is hung at 1:02 p.m. to facilitate the infusion. The provider then orders a push of 60 mg Toradol to help with the discomfort. The push is performed from 1:10 p.m. to 1:13 p.m., again in the same access site. At 1:22, "Antibiotic B" is administered as a push per direction of the provider using the same access site and completed at 1:25 p.m. The IV is disconnected at 2:00 p.m.

To code, you need to first establish the primary reason for the encounter. In this case, that would be the infusion of the antibiotic, so your "initial" code is 96365, "Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, put to 1 hour." You would bill codes 96365, J7030, J1885, "Injection, ketorolac tromethamine, per 15 mg" (4 units), and the HCPCS codes for both of the antibiotics administered.

You will want to make sure that your documentation and coding are very accurate in case of an audit. Time is a factor in all hydration and infusion codes. Therefore, we recommend that start and stop times for each individual procedure be clearly documented. ■

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CODING Q & A

"Time is a factor in all hydration and infusion codes."

Q. An established patient presented with sore throat, fever, and pain on swallowing. The provider did a full History of Present Illness (HPI) (5 elements), full Review of Systems (ROS), and full Past Family and Social History (PFSH.) Eight systems were documented for the Physical Exam (PE). The rapid strep test was negative. Could this be billed with 99214 or would the Medical Decision Making (MDM) be too low?

A. Actually, if you were just counting the elements as noted in the 1995 E/M guidelines, the algorithm for the documentation noted would produce a 99215. According to CPT guidelines using the case you present above, the history component would be deemed comprehensive, the PE deemed comprehensive, and the MDM straightforward. The final code should result from meeting at least two of the three key components (Hx, Px, CMDM) for an established patient visit. Thus, you drop the lowest component and then code results from the lowest remaining component. However, many providers routinely bill a lower code, even if the documentation might support a higher code.

According to the *Medicare Internet-Only Manual*, pub. 100-4, chapter 12, "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed."

It is up to the provider to determine what information is medically necessary to evaluate the patient and document accordingly.

If this was an otherwise healthy patient with a sore throat, the question for you to answer is this: "Was it medically necessary to perform a comprehensive history and exam?" This is a provider decision, but in many cases in urgent care, the provider is not very well acquainted with the patient (even if officially an "established" patient), so doing a more thorough history and physical exam is often quite appropriate in the urgent care setting. ■