Intravenous Therapy

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Q. We perform a lot of intravenous (IV) infusions in our urgent care facility. Sometimes we also perform IV pushes and hydration at the same time as the infusion. What is the correct way to code multiple IV infusions? Do we have to document start and stop times for each IV service?

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 *Current Procedural Terminology* (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 the procedures for these codes are performed in the physician's office, the initial code billed is the code that best describes the primary reason for the IV fluids and should always be reported irrespective of the order in which the infusions or injections occur.

Certain procedures and supplies are included and are not reported separately if used 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 has dehydration (ICD-9-CM[1] 276.51 or ICD-10-CM[2] E86.0), and the health-care provider orders an infusion of 1000 mL of normal saline. On the basis of 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 (promethazine) to be pushed via the same access site, and that procedure is performed at 3:13 p.m. The infusion is completed at 4:00 p.m., and the IV line is disconnected. The proper codes for the procedure are as follows:

- **96360:** "Intravenous infusion, hydration; initial, 31 minutes to 1 hour"
- **J7030:** "Infusion, normal saline solution, 1000 cc"
- **96375:** "Each additional sequential intravenous push of a new substance/drug"
- **J2550:** "Injection, promethazine HCl, up to 50 mg"

"According to Current Procedural Terminology (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."

However, say that the same patient from our example returns to the clinic later the same evening, still nauseated. The diagnosis then is nausea (ICD-9-CM 787.02 or ICD-10-CM R11.0), and the provider orders an IV push of 25 mg of Phenergan. The IV is started, the Phenergan is administered from 7:05 to 7:10 p.m., and then the IV line is disconnected. In this 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. You will want to make sure that your documentation for both visits is very clear in case of an audit.

In another example, a patient has come in for a therapeutic infusion of "antibiotic A," which is started at 1:00 p.m. Via the same access site, a bag of 1000 mL of normal saline is hung at 1:02 p.m. to facilitate the infusion. The provider then orders a push of 60 mg of Toradol (ketorolac tromethamine) to help with the discomfort. The push is performed from 1:10 to 1:13 p.m., again via the same access site. At 1:22 p.m., "antibiotic B" is administered as a push at the direction of the provider, using the same access site, and this is completed at 1:25 p.m. The IV line 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

1. *International Classification of Diseases, Ninth Revision, Clinical Modification.*
2. *International Classification of Diseases, 10th Revision, Clinical Modification.*

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CODING Q&A

antibiotic, so your initial code is 96365. You would bill codes as follows:

- **96365:** "Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour"
- **J7030:** "Infusion, normal saline solution, 1000 cc"
- **96375 X 2:** "Each additional sequential intravenous push of a new substance/drug (list separately in addition to code for primary procedure)"
- **J1885 X 4:** "Injection, ketorolac tromethamine, per 15 mg" (4 U)
- **The Healthcare Common Procedure Coding System (HCPCS) codes** for both of the antibiotics administered[3]

Time is a factor in hydration and infusion codes. There is no specific direction on how the time must be documented; however, a chart auditor will generally expect to see start and stop times for each individual procedure clearly documented in the medical record. ■

Q. When is it appropriate to bill for normal saline with a hydration procedure?

A. If the urgent care center purchased the saline, you can bill for it in addition to the administration codes. For example, when performing hydration—CPT code 96360, "Intravenous infusion, hydration; initial, 31 minutes to one hour" and add-on code 96361, ". . . each additional hour"—you would bill for the saline separately.

You may also bill separately for normal saline used to help facilitate drug infusion if the normal saline was purchased by the center. For example, a patient was given 1 g of Rocephin (ceftriaxone) with a 250-mL bag of normal saline intravenously over a period of 30 minutes. You would bill using the following codes:

- **96365:** "Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to one hour"
- **J7050:** "Infusion, normal saline solution, 250 cc"
- **J0696 X 4:** "Injection, ceftriaxone sodium, per 250 mg"

However, if you are infusing a drug for which normal saline is already packaged in, you would not code separately for the saline. Some payors may bundle the normal saline with the procedure, so you will want to check individual payor policies and contracts. ■

3. See http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html.

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