Infusion Coding Issues 2011

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Agenda

- Introduction
- Orders & Supervision
- Drug Administration Time
- Drug Units Billed
- Cloned Documentation
- Final Thoughts

Incentives for Incorrect Coding

- Reimbursement based on number of services or units performed
  - Not quality of care
- Physician bonuses based on RVUs billed

What is a "Modifier?"

CPT® Manual

A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.

Modifier 59

Distinct Procedural Service

- Indicates that a procedure or service was distinct or independent from other services performed on the same day
- Indicates that the ordinarily bundled code represents a service performed independently on the same date

CCI Instructions

It is very important that NCCI-associated modifiers only be used when appropriate.

In general these circumstances relate to separate patient encounters, separate anatomical sites or separate specimens.

The existence of the NCCI edit indicates that the two codes cannot be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic locations as recognized by coding conventions.

How do you know?

- Analyze number of codes with modifier 59 appended
- Look for overuse
- Examples:
  - Modifier 59 on lab codes
  - Modifier 59 on multiple drug administration codes

Orders & Supervision

Office/Freestanding Center

- Hospital can function as an "infusion center"
- Office/Freestanding – drug administration must meet incident-to requirements
  - Physician must be *managing* patient care
  - Not just performing infusion for another provider

How do you know?

- Analyze drugs administered
- Look for "outliers"
  - Drugs don't match specialty
- Example:
  - Medical oncologist
  - IV phenytoin (neurology)
  - IV linezolid (antibiotic)
  - IV Orencia (rheumatoid arthritis)

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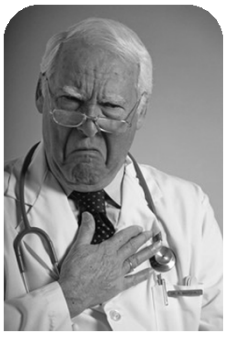
Cherry Picking

Freestanding center administers all but one drug and sends the patient to the hospital for this one unprofitable medication…

Independent oncologist transfers patients to hospital during a course of treatment when insurance is lost…



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How do you know?

- Analyze drugs administered by service date; look for:
  - Multiple providers
  - Multiple sites of service
  - Same service date

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Laboratory Testing

Excessive laboratory testing without documentation of medical necessity…

Comparison Reports

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Appropriate Supervision

- Hospital Infusion Center
  - Must be physician who can direct patient care
  - Hospitalist?
  - Midlevel provider?
- Office/Freestanding
  - *Always* supervision?
  - Early? Late?

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How do you know?

- Analyze number of administrations per day, per individual physician
  - Compare to same specialty
  - Aggregate with other payors, when possible

AUDIT

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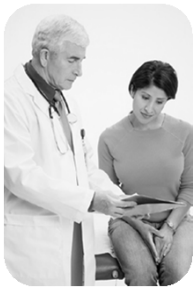
Patient Visits

Excessive Consultations



- Most medical oncology encounters are *not* consultations
- The plan is for the physician to take over care and perform treatment incident-to

AMA Guideline

Transfer of care is the process whereby a physician who is providing management for some or all of a patient's problems relinquishes this responsibility to another physician who explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services.

The physician transferring care is then no longer providing care for these problems though he or she may continue providing care for other conditions when appropriate.

Consultation codes should not be reported by the physician who has agreed to accept transfer of care before an initial evaluation but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial consultation evaluation, regardless of site of service.

Multiple New Patient Codes

A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

2012 = Different sub-specialty

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High Number of High Level Visits

- Established patient visits
  - Taking credit for MDM that is managed by another physician

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How do you know?

- Review use of consultation codes
  - 99241 – 99245
  - 99251 – 99255
- > 1 new patient code in 3 years
  - 99201 – 99205
- Analyze established patient visits
  - 99214 or 99215
  - With *one* diagnosis code

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Education Charges

Billing separately for chemotherapy education

- Nurse
- Midlevel provider

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99211 PRIOR TO CHEMO

It is not now, nor has it ever been, a "nurse visit."

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Abuse of Incident-to

- Midlevel providers
  - New patient visits cannot be "shared"
  - New medical conditions must be billed in the name of the nonphysician practitioner

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How do you know?

- Analyze number of charges per physician per day
  - Compare to number of treatment hours
  - Aggregate with other payors, when possible

AUDIT

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This *can* be fixed…

- Non-Medicare Payors
  - Credential mid-level providers
  - Insist all services performed by midlevel be billed in name of performing practitioner

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Additional Services

- Billed Medical Nutrition Therapy because chemotherapy patient also had diabetes…
- Billed Physical Therapy for "chair massages" in the waiting room…

Analyze: ALL Outliers

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Drug Administration

There Can Be Only One…

Cannot bill more than one "initial" code during a single patient encounter.

Initial Drug Administration Codes

Code	Descriptor
96360	Initial hour of IV hydration
96365	Initial hour of IV therapeutic infusion
96413	Initial hour of IV chemotherapy infusion
96374	Initial therapeutic IV push
96409	Initial chemotherapy IV push

Multiple Hospital Departments

- Hospitals billing multiple "initial" codes on the same day in different departments

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Drug Administration Time

Medical record documentation should include an accurate start and stop time.

- 90 minute infusion = 1 code
- 91 minute infusion = 2 codes

- 15 minute minibag = push
- 16 minute minibag = infusion

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Generally Requires a Chart Audit

- Automatically chart 91 minutes to bill 2 infusion codes
  - 90 minutes = 96413
  - 91 minutes = 96413 + 96415
- Automatically chart all minibag infusions as 16 minutes
  - 15 minute minibag = 96375
  - 16 minute minibag = 96367

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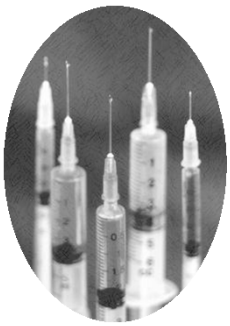
Overuse of Medications



- Change in administration
  - Benadryl IV *push*
  - Now, Benadryl IV *infusion*

Comparison Reports

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Chart Review

- Watch for "rounded" administration times
  - Infusion begins 9:00
  - Infusion ends 9:35

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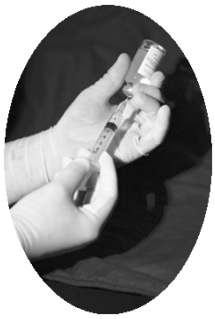
Multiple Pushes



- Office/Freestanding
  - Multiple pushes
  - Same drug
  - *One* administration code
- For example:
  - Benadryl pushed at 10:04
  - Benadryl pushed at 11:52
  - One unit code 96374 or 96375

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How do you know?

- Compare number of drug administration codes to number of drugs charged

AUDIT

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Site of Service

- Hospital inpatient treated at freestanding center
- Physician tries to bill for infusions in the hospital outpatient department
  - No professional component

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WWYT

- Patient admitted to hospital observation, but transported to a freestanding center for scheduled chemotherapy.
- Analyze if charges received from 2 different sites of service during the same time period.

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Site of Service

- OIG Report July 2010
  - 90 out of 100 claims reviewed – wrong POS
  - Estimated $13.8 million overpayments
    - Calendar year 2007
- If patient is inpatient – POS 21
  - Not office!

How do you know?

- Analyze drugs administered by service date; look for:
  - Multiple providers
  - Multiple sites of service
  - Same service date

Drug Units Billed

Drug Overfill

- CMS clarified that "intentional overfill" of a drug is not covered by Medicare.
  - Overfill is defined as the amount of product in excess of FDA labeled amount.
- Since excess does not represent a cost to the provider, it is not separately paid.

Medicare Coverage – Wasted Drugs

If the hospital or physician office must discard the remainder of a single use vial after administering the dose to the Medicare patient, the program provides payment for the amount discarded as well as the dose administered, up to the amount of the drug as indicated on the package label.

Wasted Modifier

JW
Drug amount discarded/not administered to any patient

Modifier JW

- Modifier JW on separate line
- With the amount of discarded drug
- Each insurer can determine if required
  - And claim filing guidelines
- Wasted drug amount must *always* be documented

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Modifier JW Example

Claim Line #1
- HCPCS code for drug given
- No modifier
- Number of units administered to the patient
- Calculated submitted price for drug administered

Claim Line #2
- HCPCS code for "discarded" drug
- HCPCS modifier JW to indicate waste
- Number of units discarded
- Calculated submitted price for discarded drug amount

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Example

A patient receives 316 mg of Avastin, available in either 100 mg or 400 mg SDV.

Claim Line #1

J9035, 32 units (320 mg) administered

Claim Line #2

J9035-JW, 8 units (80 mg) discarded

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Multi-Dose Vials

- Herceptin
  - J9355, per 10 mg
  - Available in 440 mg MDV
- Carboplatin
  - J9045, per 50 mg
  - Available 50 mg, 150 mg, 450 mg MDVs

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How do you know?

- Watch for:
  - Every patient billed 44 units of Herceptin (440 mg)
  - Every patient billed 3 units (150 mg) or 9 units (450 mg) of Carboplatin

Comparison Reports

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amednews, September 7, 2009

A 2006 study in the *Archives of Internal Medicine* found that unapproved use accounted for 21% of an estimated 725 million scripts written in 2001 for 160 frequently prescribed drugs.

More than 70% of these off-label prescriptions were for indications in which the drug had little or no scientific support.

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Supporting Documentation

Documentation such as a reference to supporting literature should be maintained in the medical record for the use of a drug for a purpose not included in the FDA approved labeling or the compendia.

Informed Consent

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Off-Label Use

2012 OIG Work Plan

The OIG will review Medicare payments for drugs and biologicals used on an off-label basis in anticancer chemotherapeutic regimens to determine whether patients with particular indications were prescribed anticancer drugs not approved for those indications. If so, they will determine whether there were improvements in the patients' medical conditions before the use of off-label drugs. If the beneficiaries' medical conditions improved before the use of off-label drugs, they will determine how much Medicare could have saved had anticancer drugs continued to be used.

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How do you know?

- Set edits for diagnosis to HCPCS Drug Code
  - Include only approved diagnoses
  - Monitor use of off-label diagnoses

Comparison Reports

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Cloned Documentation

Cloned Notes

- Considered misrepresentation of the medical necessity requirement
- Documentation must be patient specific

Cloned Notes

Templates
- Dictation prompts
- ROS or PFSH form

Cloning
- Considerable amount of identically prepared text

Check Off Boxes

Progress notes seem to be the area in need of most improvement. While most of them do document service modalities and interventions, they do not document clinical relevance. This frequently occurs when utilizing a note format that consists of mainly check-off boxes.

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www.justcoding.com

Another big mistake some practices make when designing templates is not watching for medical record cloning – the use of the same, pre-entered documentation (also known as "canned documentation") across different patient populations.

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Modern Medicine – May 7, 2010

If you use an electronic record system, avoid the overuse of templates that automatically document services that were not provided. False documentation can be every bit as serious, if not more serious, than under-documentation.

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Epocrates Insights

The fact that providers need to record much of the same information, in the same way, patient after patient, is part of the appeal of EHRs.

Those benefits are starting to look like problems.

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Articles on Compliance Strategies

Physicians love electronic medical record (EMR) templates because they make documentation faster and easier, but abuses, such as cloning and "exploding" notes, are jeopardizing reimbursement and compliance…

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Final Thoughts

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Clinical Trials

- Insurance Coverage?
  - Require V70.7 diagnosis code
  - Require Q0 and Q1 modifiers
- "We just send all the charges to insurance and file whatever they don't pay with the trial sponsor."

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Oncologists With a PET Scanner

- Here a PET, there a PET…
  - Monitor frequency
  - Request medical necessity
  - Preauthorize
    - Diagnostic PET, MRI, CT
  - NAME of referring physician
    - Should be *oncologist*
    - Not original referring physician

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Thank You!

Questions?

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