

# CODING

## The 7 Deadly Sins of Infusion Center Documentation

by Cindy Parman, CPC, CPC-H, RCC

Medical record documentation takes the form of paper records, electronic medical records (EMRs), and blended or hybrid records that incorporate elements of both paper and electronic records. While it seems obvious that the medical record must include all necessary data, some infusion services require careful attention to ensure complete documentation.

In addition to detailed written physician orders, documentation of medical necessity, complete diagnosis information, and patient-specific treatment planning, freestanding and hospital-based infusion centers may want to review the following documentation issues.

### 1. Documenting Venipuncture

Many patients who receive drug administration services require regular laboratory testing to ensure that treatment is working or to assess the patient's physical reaction to the drug regimen. The venipuncture procedure code is **36415**: Collection of venous blood by venipuncture.

Nursing staff typically document blood samples obtained via implanted port (code **36591**) or PICC line (code **36592**), but staff who obtain a blood sample via venipuncture, such as phlebotomists or medical assistants, also need to document this service in the individual patient medical record. The medical record should include the site accessed, the condition of the access site, presence of erythema or inflammation, and patient complaints of pain or discomfort.

### 2. Recording Wasted Drugs

Medicare encourages providers to schedule patients in such a way that drugs are used in the most clinically efficient manner. However, if the provider must discard the remainder of a single use vial after administering a dose of the drug to a Medicare patient, the Medicare contractor will pay for the amount of drug discarded along with the amount administered, up to the amount of the drug indicated on the vial or package label. Some Medicare contractors require the following modifier to be reported on the claim form—**JW**: Drug amount discarded or not administered to any patient.

It is essential that the individual patient medical record include documentation of both the amount of drug administered and the wasted drug amount billed to the patient. Although drug waste is tracked by the pharmacy, the individual chart must contain documentation to support all services, drugs, and supplies charged to the patient.

### 3. "Rounding" Drug Administration Time

Official coding guidance from the American Medical Association (AMA) states that the actual time over which the infusion is administered determines the number, type, and sequencing of administration codes for which infusion time is a factor.

While busy infusion centers often find it difficult to accurately capture the exact start and stop time for each medication delivered, evidence illustrates that "rounding" drug administration times may result in lost revenue.

In this situation, infusion centers have a tendency to "round down," which may eliminate the use of an "each additional hour" drug administration code.

For example, if the patient receives 5FU administered intravenously for 92 minutes, infusion centers should report two administration codes—**96413** (initial hour of IV chemotherapy) and **96415** (each additional hour of IV chemotherapy). However, if the time is "rounded" to 90 minutes, the only code that can be charged is **96413**, a revenue loss of approximately \$37 in the outpatient hospital setting. This number may seem like a small reimbursement loss, but if "rounding down" of administration times occurs frequently, lost revenue increases exponentially. (Remember, the "each additional" hour code can only be added if there is *more than* 30 minutes beyond the first hour. In other words, at least 91 minutes of infusion time must elapse before the "each additional" hour code can be reported.)

### 4. Documenting in Five-Minute Increments

As indicated above, when reporting codes for which infusion time is a factor, the actual time over which the infusion is administered is reported. Very few drug administration services begin exactly on the hour; most often the administration begins at 9:36 am, 10:02 am, 4:11 pm, or a similar time.

Although the pumps used in the infusion center to administer the drugs can be programmed for a specific time period, bag overfill and individual patient considerations generally mean that the infusion did not last exactly 30 minutes, 45 minutes, or other specified 5-minute time increments. The reimbursement concern in this situation is that the infusion center may either consistently lose revenue because the actual administration time has not been accurately reported, or may inappro-

propriately receive additional reimbursement by inflating the administration time to ensure that all infusions are reported in five-minute increments.

For example, an intravenous chemotherapy infusion begins at 9:58 am and ends at 10:14 am, a total of 16 minutes. However, the administration time is recorded in the patient chart as 10:00 start time and 10:15 end time, a total of 15 minutes. Based on the time recorded, this service would be billed as an IV push. (An intravenous or intra-arterial push is defined as either an injection during which the healthcare professional who administers the drug is continuously present to administer the injection and observe the patient, or an infusion of 15 minutes or less.) However, the actual administration time supports an IV infusion code—a potential loss of approximately \$93 in the hospital outpatient setting. In other words, report an infusion of 15 minutes or less using the code for IV push. Report an infusion of 16 minutes or more using the code for an IV infusion.

## 5. Recording all Mini-Bag Infusions as Requiring 16 Minutes

As mentioned above, an intravenous or intra-arterial push is defined as either an injection during which the healthcare professional who administers the drug is continuously present to administer the injection and observe the patient, or an infusion of 15 minutes or less.

This means that if a nurse is present for a drug administered by push technique that requires 20 minutes of face-to-face time, the service is coded as an IV push administration. In addition, if the nurse hangs a mini-bag of medication that requires 13 minutes of administration time, this service is also reported with an IV push code.

To borrow a current phrase, it is what it is. Infusion centers should document the exact time of the infusion and report the appropriate code for the service provided. This practice may mean that some mini-bag administrations are coded as infusions and others are reported with the code for an intravenous push. Make certain to avoid bad charting habits, such as automatically recording each mini-bag infusion with 16 minutes of

infusion time in order to bill a higher-paying administration code.

## 6. Assigning Drug Administration Codes by Protocol

In an effort to improve efficiency and ensure that all relevant codes are captured and charged, some providers develop a list of administration codes to be reported “per protocol.” Unfortunately, this practice may also result in lost revenue. For example, codes reported for a standard FOLFOX protocol include:

- **96413:** Chemotherapy administration, IV, up to 1 hour
- **96411:** Chemotherapy administration, each additional IV push
- **96416:** Chemotherapy administration, prolonged infusion requiring pump
- **96368:** Therapeutic drug administration, IV, concurrent infusion
- **96375:** Therapeutic drug administration, each additional IV push.

However, if the pre-medications in the mini-bag required more than 15 minutes to administer and the Oxaliplatin required more than 90 minutes to deliver, the resulting administration codes would be:

- **96413:** Chemotherapy administration, IV, up to 1 hour
- **96415:** Chemotherapy administration, IV, each additional hour
- **96411:** Chemotherapy administration, IV push
- **96416:** Chemotherapy administration, prolonged infusion requiring pump
- **96368:** Therapeutic drug administration, IV, concurrent
- **96367:** Therapeutic drug administration, IV sequential drug.

While many patients may require 15 minutes or less for the infusion of the pre-medications and may receive the chemotherapy administration in 90 minutes or less, additional time required for either service increases the drug administration reimbursement for the FOLFOX regimen.

## 7. “Cloned” Notes

Templated medical record documentation has increased with the advent of electronic medical records.

Medicare and other payers have stated that “cloned” medical record documentation does not support medical necessity for an individual patient. While CMS has not taken a formal position on templates, the agency has conveyed that templates are meant to prompt medical record documentation, not include pre-printed paragraphs of general information.

In addition, documents that include pre-populated information may not accurately describe the care provided to an individual patient or reflect the procedures performed on a given date of service. Medicare contractors generally publish newsletters or other documents to remind providers that information in the medical record must support the medical necessity of the services rendered and the appropriateness of the service provided.

For example, PBSI Medicare Services states that the detection of cloned medical records may lead to an investigation of potentially fraudulent practices.

## A Word to the Wise

Medical record documentation supports the number of drug administration services, the method of administration, and the length of drug delivery. In an era of increased Medicare audits and scrutiny by other insurers, infusion centers must maintain complete and accurate medical record documentation. Incomplete charting, such as rounded administration times, omitting documentation for venipuncture or wasted medications, coding by drug protocol, or the use of cloned documentation templates may decrease reimbursement and/or elevate the possibility of refunds in a payer audit. ❏

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## References

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- <sup>2</sup>CPT® Assistant, November 2005.
- <sup>3</sup>Medicare Claims Processing Manual, Chapter 17. Available online at: <http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf>.
- <sup>4</sup>PBSI Medicare Services. Available online at: <http://www.lamedicare.com/provider/viewarticle.aspx?articleid=6194>.