



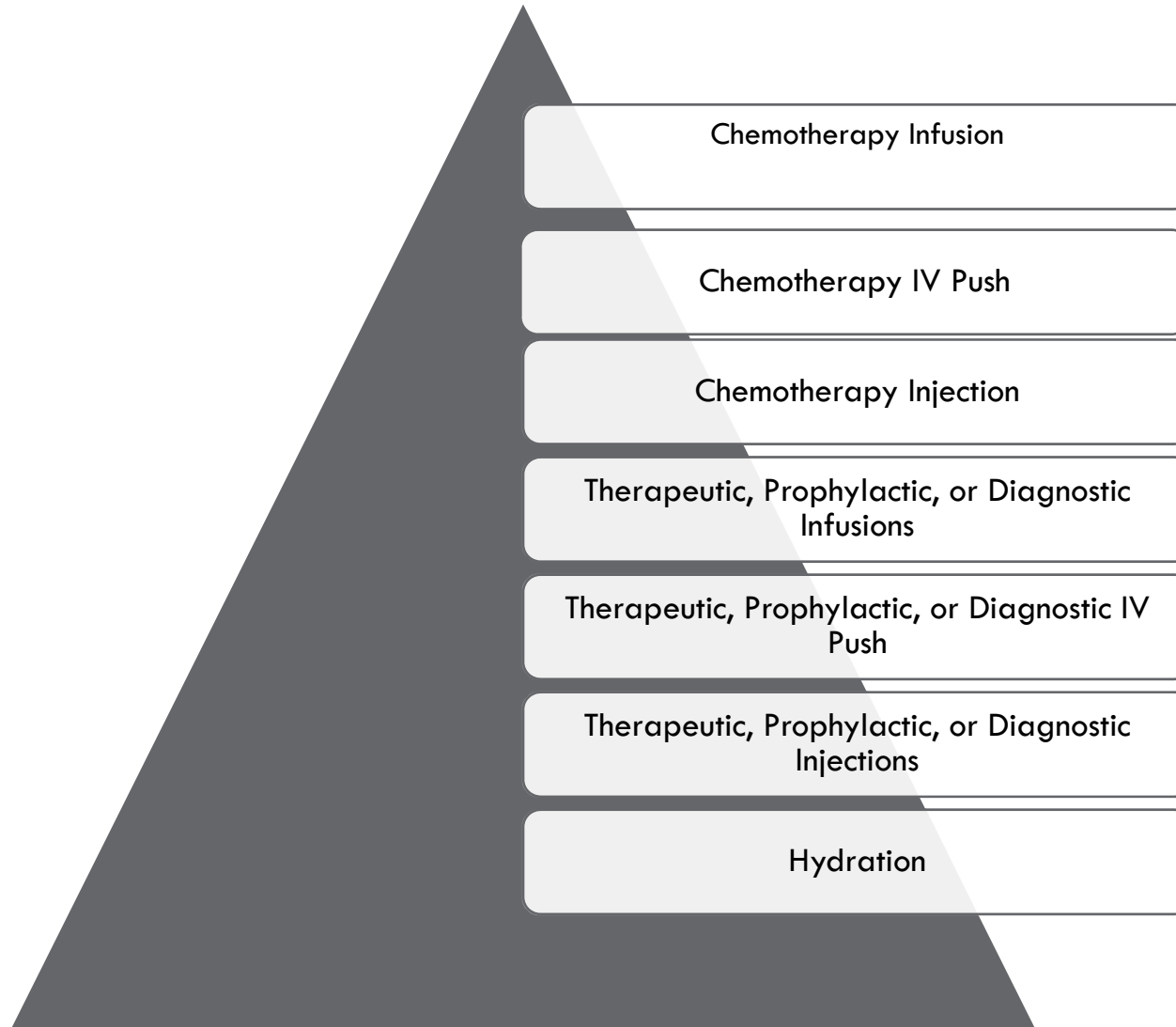
**CPAs & BUSINESS ADVISORS**

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# **INFUSION/INJECTION CODING EDUCATION**

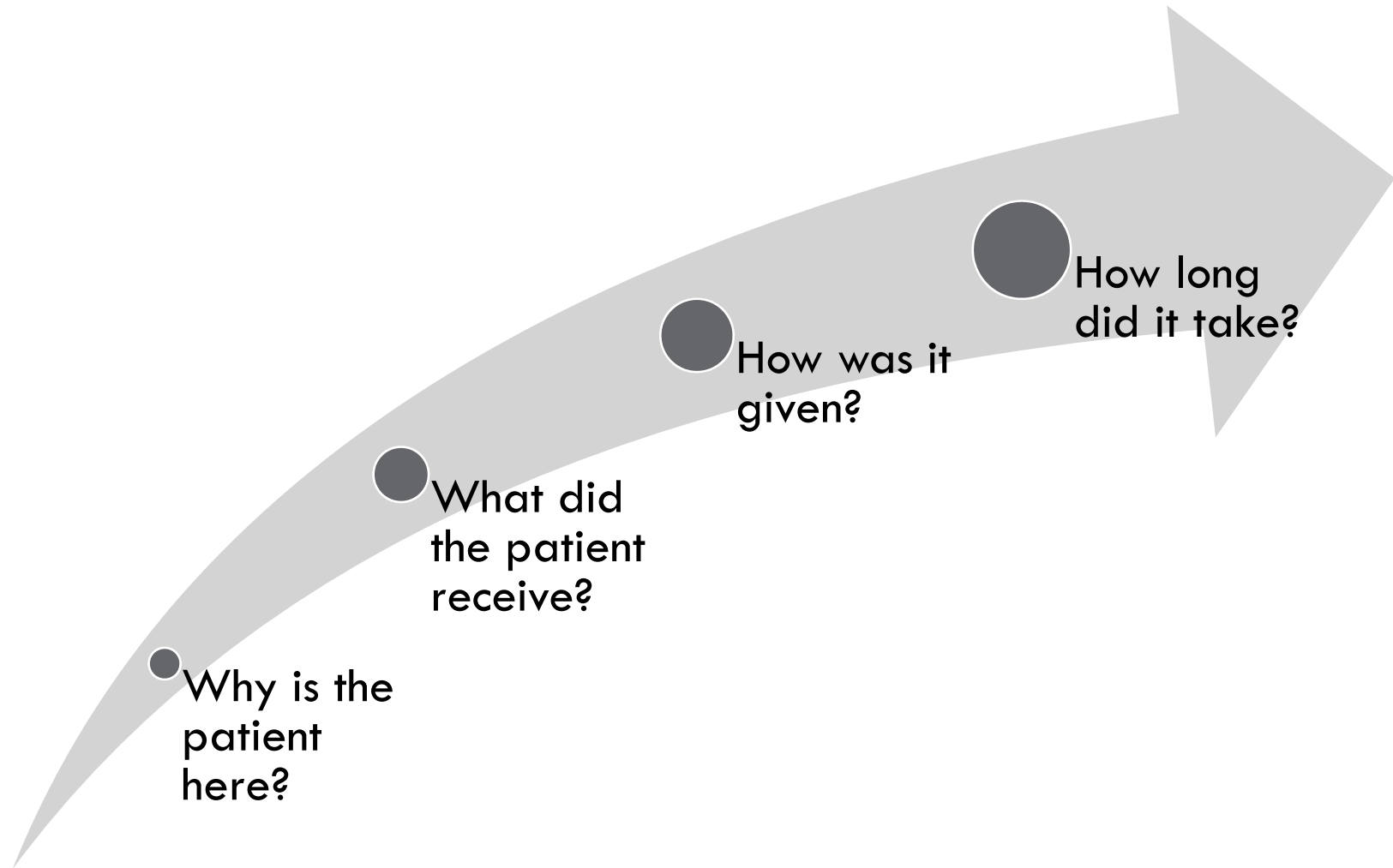
# INJECTION/INFUSION HIERARCHY FOR FACILITY REPORTING

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# INFUSION/INJECTION DECISION TREE

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# TIME DOCUMENTATION IS CRITICAL

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- **Time Documentation is Critical**

- Drug administration codes are services that reference time and are “time-based” codes
- Documentation should support the services reported

	Therapeutic Infusions	Hydration
• 1 <sup>st</sup> Hour	16-90 minutes	31-90 minutes
• 2 <sup>nd</sup> Hour	91-150 minutes	91-150 minutes
• 3 <sup>rd</sup> Hour	151-210 minutes	151-210 minutes

- **Best Practice – document “start” and “stop” times for infusions**

- Noridian Drugs, Biologicals, and Injections Documentation Requirements indicate:
  - Medication Administration Record (MAR) from date(s) of service that include name of medications(s), dose, route of administration and infusion start and stop times, if applicable

# INITIAL SERVICE

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- “Initial” service is described as “the service that best describes the key or primary reason for the encounter”
- Order of service delivery does not determine what is “initial” service
- Hierarchy does not apply to Subcutaneous/Intramuscular injections
- Only one per patient encounter UNLESS:
  - Two separate IV sites are medically used/necessary
  - Patient returns for a separate and medically necessary and reasonable encounter on the same day
  - These may be reported with two initial services with a modifier -59 (XE) on the second IV or second encounter

# INITIAL SERVICE

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- IV Push with Hydration – What is the “initial” service?
- When you bill IV hydration along with IV pushes, always report the IV push as the initial code. According to the CPT hierarchy, the initial code must be 96374.
- Following that code, 96361 must be assigned for the hydration.
- The CPT hierarchy is based on the instructional notes found in the CPT book. Please see parenthetical notes following both 96374 and 96361

# “SEQUENTIAL” ADMINISTRATION

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- Sequential” is when multiple drugs are infused “back to back” or one after the other
- Must be a DIFFERENT drug through the same IV access
- Must be a clinical reason for doing sequential versus concurrent
- 96367 (additional sequential infusion) – report once per drug
  - If additional hours of infusion, report 96366

# “CONCURRENT” ADMINISTRATION

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- “Concurrent” is when multiple therapeutic or diagnostic medications (not hydration fluids) are infused simultaneously through separate bags through the same IV line
- Concurrent codes are not to be used for multiple drugs within the same bag
- Typically concurrent is used for “gravity drip” infusion methods
- 96368 (concurrent infusion) - report once per date of service
  - If additional hours of infusion, report 96366



# HYDRATION

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2018 CODES	DESCRIPTION
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour
96361	Intravenous infusion, hydration; each additional hour (list separately in addition to primary code)

# HYDRATION

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## What is Hydration

- Hydration is defined as the replacement of necessary fluids via an IV infusion which consists of pre-packaged fluid and electrolytes. Some of the solutions utilized in administration of hydration services are:
  - Saline solutions,
  - D5W (dextrose 5% water),
  - Hypotonic solution,
  - Ringer Lactate, and
  - DW ( Distilled water)

# HYDRATION

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## Medical Necessity

Noridian addressed hydration in 2010:

- Necessity should be supported within medical documentation
- Routine administration of IV fluids without documentation of supporting signs/symptoms such as dehydration or fluid losses is not supported as medically necessary
- Medical necessity is supported in the evaluation performed by provider  
Documentation of assessment should describe symptoms warranting hydration, such as:
  - Inability to ingest fluids
  - Abnormal fluid losses – (i.e. Dehydration)
  - Abnormal vital signs
  - Abnormal laboratory studies - elevated BUN, creatinine, glucose or lactic acid
  - Note: Nausea alone does not implicate fluid volume depletion nor support necessity of fluid repletion

# HYDRATION

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## Medical Necessity

- The rate of infusion is important in determining hydration therapy
  - Typically at least 100 - 125/cc – up to wide open IV flow
- If it ordered below 100/cc, physician documentation must indicate that it is hydration and why a slower rate is ordered
  - Patient with Congestive Heart Failure
  - Elderly patient in which hydration needs to be administered slowly

“Will hydrate the patient” should not be your only determining statement

# HYDRATION

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- Is NOT:
- Not used when purpose of IV fluid is to “keep open” an IV line
  - Sole purpose of the IV fluid administration is to keep vein open or maintain vascular access, this should not be separately reported.
- Not used when fluid is the vehicle in which drug is administered
- Not used when used to accommodate a therapeutic IV piggyback through the same IV access as a free flowing IV to safely infuse the agent
- Not used for routine administration of IV fluids, pre/post operatively while patient is NPO for example, without documentation supporting signs and/or symptoms including those of dehydration or fluids loss
- Concurrent hydration is not billable via a HCPCS code and not separately payable

# HYDRATION

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- CPT code 96360 is for initial service of hydration when hydration is the only service performed
  - A minimum of 31 minutes of hydration is required to report the service. Hydration provided for less than 30 minutes would not be reportable.
- Use CPT 96361 in conjunction with CPT 96360
- Report 96361 for hydration intervals of greater than 30 minutes beyond 1 hour increments
  - More than 90 minutes of total infusion time must elapse before the “additional hydration” code may be billed
    - > 91-150 minutes 96361 – 1 unit
    - > 151-210 minutes 96361 – 2 units
- Report 96361 to identify hydration if provided as a secondary/subsequent service after a different initial service (96360, 96365, 96374, 96409, 96413) is administered through the same IV access
- Remember Emergency Department through Observation is all one encounter, so if hydration began in ED and is the only injection/infusion service, only bill the initial hydration once

# HYDRATION

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## Example:

A patient is seen at our facility because of dehydration due to continuous nausea with vomiting. She is given a prepackaged solution of 1,000 cc's of normal saline with potassium added to the bag which was prepared by the pharmacy. The hydration is administered for an hour and 15 minutes.

**CPT code 96360, Intravenous infusion, hydration; initial, 31 minutes to 1 hour,** would be reported for this encounter because there was no other intravenous infusion service performed during this encounter and the primary reason for the encounter was to administer the fluids and electrolyte(s) due to fluid loss from the patient's continuous nausea with vomiting. The additional 15 minutes would not be reported due to the hydration services not being greater than 30 minutes past the initial hour.

# HYDRATION

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## Example

A 55 year-old diabetic female is brought to the emergency department due to acute altered level of consciousness. Blood glucose level initially is 42 mg/dL. The patient is promptly administered dextrose 50% (D50) 25g IV push for the altered level of consciousness at 08:29 am. Her blood glucose at 08:37 is 219 mg/dL. What is the correct CPT code for the D50?

No code for the administration of hydration would be reported in this case. Based on the information provided, this patient received an intravenous push of dextrose 50% (D50). Guidelines for reporting hydration services specifically state that if hydration is 30 minutes or less it would not be reported.



# INFUSION

2018 CODES	DESCRIPTION
96365	Intravenous infusion, for therapy, prophylaxis, or diagnostic (specify substance or drug); initial, up to 1 hour
96366 *add on code *Report 96366 in conjunction with 96365, 96367 *Report 96366 for additional hour(s) of sequential infusion *Report 96366 for infusion intervals of greater than 30 minutes beyond 1 hour increments *Report 96366 with 96365 to identify each subsequent infusions of the same drug/substance	Intravenous infusion, for therapy, prophylaxis, or diagnostic (specify drug/substance);each additional hour (list separately in addition to primary code)

# INFUSION

2018 CODES	DESCRIPTION
<p><b>96367 * add on code</b></p> <p>*Report 96367 in conjunction with 96365, 96374, 96409, 96413 to identify infusion of a new drug/substance provided as a secondary or subsequent service after a different initial service is administered through the same IV access.</p> <p>*Report 96367 only once per sequential infusion of same infusate mix</p>	<p>Intravenous infusion, therapy, prophylaxis or diagnostic (specify drug/substance); additional sequential infusion of a new drug/substance, up to one hour (list separately in addition to primary code)</p>
<p><b>96368 *add on code</b></p> <p>*Report 96368 only once per date of service</p> <p>*Report 96368 in conjunction with 96365, 96366, 94613, 96415, 96416</p>	<p>Intravenous infusion, for therapy, prophylaxis, or diagnostic (specify drug/substance); concurrent infusion (list separately in addition to primary code)</p>

# INFUSION

2018 CODES	DESCRIPTION
<b>96372</b> *Not used for administration of vaccines *Use for <u>non-antineoplastic</u> hormonal therapy injections *Do not use for <u>anti-neoplastic</u> non-hormonal or hormonal injections *Do not use for allergen immunotherapy	Therapeutic prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
<b>96373</b>	Therapeutic prophylactic, or diagnostic injection (specify substance or drug); intra-arterial

# INFUSION

2018 CODES	DESCRIPTION
96374	Therapeutic prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug
96375 *add on code *Use in conjunction with 96365, 96374, 96409, 96413 *Report 96375 to identify IV push of a new substance/drug after an initial service is administered	Therapeutic prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug

# INFUSION

2018 CODES	DESCRIPTION
<p><b>96376 *add on code</b></p> <p>*Report 96376 in conjunction with 96365, 96374, 96409, 96413</p> <p>*Push of same substance/drug</p> <p>*Do not report 96376 for a push performed within 30 minutes of a reported push of the same substance or drug</p>	<p>Therapeutic prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided</p>

# INFUSION

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**Bolus** – A ‘bolus’ is defined as a single, large dose of medication usually injected into a blood vessel over a short period of time and is billed as an intravenous (IV) push per CPT guidelines.

**“Banana Bag” or rally pack**

Considered therapeutic administration – 96365 category  
Bag of IV fluids containing vitamins and minerals

**If the drug is considered self-administrable, the injection is not covered**

# INFUSION

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Included in the CPT codes – do not bill separately

Local anesthesia

IV start

Access to subcu catheter or port

Flush at the conclusion

Standard tubing

Syringes

Supplies

Infusion time is calculated from the time the administration commences (i.e., the infusion starts dripping) to when it ends (i.e., the infusion stops dripping). Services leading up to the infusion and following the infusion have been included in the infusion code services and are not reported separately. *Source: CPT Assistant September 2007*

# INTRAVENOUS PUSH

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- Health care professional continuously present
  - Administer the drug
  - Observe the patient

OR

- Infusion of 15 minutes or less



# INITIAL SERVICE – PER ENCOUNTER

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CMS Pub 100-04 Medicare Claims Processing

Transmittal 2141, change request 7271

January 24, 2011

## **10. Clarification of Coding for Drug Administration Services**

CMS revised Pub. 100-04, Medicare Claims Processing Manual, chapter 4, section 230.2, to clarify the correct coding of drug administration services. Drug administration services are to be reported with a line-item date of services on the day they are provided. In addition, beginning in CY 2007, **hospitals should report only one initial drug administration service, including infusion services, per encounter for each distinct vascular access site, with other services through the same vascular access site being reported via the sequential, concurrent or additional hour codes**. Although new CPT guidance has been issued for reporting initial drug administration services, Medicare contractors are to continue to follow the guidance given in this manual.

# INITIAL SERVICE – PER ENCOUNTER

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From the CMS Billing Manual Instructions

## **230.2 - Coding and Payment for Drug Administration**

**(Rev. 2141, Issued: 01-24-11, Effective: 01-01-11, Implementation: 01-03-11)**

### **Billing for Infusions and Injections**

Drug administration services are to be reported with a line item date of service on the day they are provided. In addition, only one initial drug administration service is to be reported per vascular access site per encounter, including during an encounter where observation services span more than 1 calendar day.

Only one initial infusion or injection for the entire outpatient encounter (Emergency Room and Observation Care)

# INITIAL SERVICE – PER ENCOUNTER

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## FAQ - Infusion, Injection, and Hydration Services

This FAQ supersedes all prior articles published within the year 2008.

**Q2.** How many initial services may be billed per day?

A2. Only one *initial* code is allowed per patient **encounter** unless two separate IV sites are medically reasonable and necessary (use modifier 59). If the patient returns for a separate and medically reasonable and necessary visit (encounter) on the same day, another *initial* code may be billed for that visit with modifier 59.

# OTHER RULES AND REGULATIONS

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- Do not report injections and infusions given during the course of outpatient surgery and recovery
- Therapeutic IVs and injections given beyond the “normal” recovery time may be separately billable
- Expected recovery time is considered 4-6 hours
- Physician documentation is essential to reporting of infusions and injections prior to surgery and in recovery. Documentation of medical necessity above and beyond normal treatment is necessary for reporting.

# CHEMOTHERAPY

2018 CODES	DESCRIPTION
96401	Chemotherapy administration, subcutaneous or intramuscular; <b>non-hormonal</b> anti-neoplastic
96402 *Firmagon    *Lupron Depot 7.5	Chemotherapy administration, subcutaneous or intramuscular; <b>hormonal</b> anti-neoplastic
96405	Chemotherapy administration; intralesional, up to and including 7 lesions
96406	Chemotherapy administration, intralesional, more than 7 lesions
96409	Chemotherapy administration; intravenous, push technique, single or initial substance/drug

# CHEMOTHERAPY

2018 CODES	DESCRIPTION
96411	Chemotherapy administration, intravenous, push technique, each additional substance/drug (list separately in addition to primary procedure)
96413	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug
96415	Chemotherapy administration, intravenous infusion technique; each additional hour (list separately in addition to code for primary procedure)
96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemo infusion (more than 8 hours), requiring use of a pump

# CHEMOTHERAPY

2018 CODES	DESCRIPTION
96417	Chemotherapy administration, intravenous infusion, each additional sequential infusion (different substance/drug) up to 1 hour (list separately in addition to primary procedure)
96420	Chemotherapy administration, intra-arterial; push technique
96422	Chemotherapy administration; intra-arterial; infusion technique, up to 1 hour
96423	Chemotherapy administration; intra-arterial; infusion technique, each additional hour (list separately in addition to primary procedure)

# CHEMOTHERAPY

2018 CODES	DESCRIPTION
96425	Chemotherapy administration; intra-arterial, infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis
96446	Chemotherapy administration into peritoneal cavity via indwelling port or catheter
96450	Chemotherapy administration; into CNS (e.g., intrathecal), requiring and including spinal puncture



# CHEMOTHERAPY

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2018 CODES	DESCRIPTION
96542	Injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents
96549	Unlisted procedure

# CHEMOTHERAPY TIPS

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- Report one initial service CPT code
- Specific drug(s) or biological(s) used
  - HCPCS codes
  - Dosage
  - J code value = units reported
- Unless protocol requires two separate IV sites
  - Modifier 76 if simultaneously
  - Modifier 59 if different encounter
- Saline, anti-nausea, or non-chemo drugs
  - Same day sequentially – report separately
    - Medically necessary before or after chemotherapy
  - Same day same time – bundled into chemo administration

# CHEMOTHERAPY TIPS

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- HCPCS Level II establishes “Chemotherapy Drugs” as those in the range of codes J9000-J9999. Infusion of drugs with assigned HCPCS codes in this range are accepted as appropriately billed using the chemotherapy administration codes.
- Example of administration of hormonal anti-neoplastic drug
  - Degarelix (Firmagon) – classified as an injectable chemotherapy drug
  - J9155
  - Report with CPT administration code 96402
- Noridian has indicated use of an appropriate chemotherapy administration code for an infusion or IV push of certain drugs (because of documented increased infusion reactions and/or other reasons necessitating increased administration practice expense)
  - Example of a common drug is:
    - Remicade                      J1745

# CHEMOTHERAPY TIPS

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- Noridian published a list of drugs for which the administration of the drugs in their subcutaneous or intramuscular forms should not be billed using a chemotherapy administration code.
- Instead, unless listed in Noridian's Self-Administered Drugs article, these should be billed using CPT code 96372.
  - Denosumab (Prolia/Xgeva) J0897
  - Abatacept (Orencia) J0129
  - Pegfilgrastim (Neulasta) J2505 \*Note Effective 01/01/2018 providers are instructed to use 96377 for the on-body application injector for Neulasta Onpro Kit
- See Noridian Local Coverage Article on Chemotherapy Administration (A52991)

# CODING EXAMPLE

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## Scenario:

Patient with diagnosis of bacterial enteritis and dehydration is admitted to outpatient department with orders for infusion of IV Levaquin over two hours. Also has orders for Demerol and Reglan IV push. After the above medications were infused, Nursing contacts the physician due to patients low blood pressure and lack of urine output. MD orders three hours of intravenous fluids of Ringer's lactate for documented dehydration

# CODING EXAMPLE

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## Code Assignment:

96365 – first hour of IV Levaquin

96366 – additional hour of IV Levaquin

96375 – sequential IV push of Demerol

96375 – sequential IV push of Reglan

96361 – IV infusion hydration each additional hr

96361 – IV infusion hydration each additional hr

96361 – IV infusion hydration each additional hr

# CODING EXAMPLE

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## Scenario:

Patient arrived in the emergency department and received an intravenous hydration infusion with Vancomycin for over 1 hour. How would the hydration and administration of Vancomycin be reported?

# CODING EXAMPLE

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## Code Assignment:

Report CPT code 96365, Intravenous infusion, for therapy, prophylaxis, or diagnosis; (specify substance or drug) initial, up to 1 hour, for the service provided. This hydration service would be considered integral to the drug administration and not separately reported



# CODING EXAMPLE

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## Scenario:

A patient was seen at our facility for low potassium level. He received 1 hour of intravenous hydration fluid mixed with potassium for treatment of the patient's low potassium level. What would the correct CPT code be for this encounter?

# CODING EXAMPLE

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## Code Assignment:

Report CPT code *96365, Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour*, for the intravenous infusion of potassium.

It would be inappropriate to report the hydration code for this encounter because the infusion was provided primarily for treatment of the patient's low potassium level.

# CODING EXAMPLE

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## Scenario:

A patient with Congestive Heart Failure with given an IV bolus of Amiodarone at 0700. At 0800, an infusion of Lasix was started and ended at 1020.

# CODING EXAMPLE

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## Code Assignment:

Report CPT code *96365, Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour*, for the intravenous infusion of Lasix.

Report CPT code *96366, Intravenous infusion, for therapy, Prophylaxis, or diagnosis; each additional hour times one for the additional hour of infusion*.

Report CPT code *96375, Intravenous push, each additional sequential push of a new substance or drug*, for the IV bolus of Amiodarone.

# PRIORITY FOR COMPLIANCE

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- **Chargemaster**
  - Updated with correct CPT codes and descriptions of codes for infusion/injection services
  - Updated with correct J codes for drugs
  - Correct Pharmacy value reflecting J code value
- **Billing**
  - Final claim reconciliation
  - Correct units of services
  - Appropriate Modifiers
  - Correct from and through dates of service



# MODIFIERS

# MODIFIER 25

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Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

- It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

# MODIFIER 25 SCENARIO

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A healthy male presents to the clinic after cutting his finger on a knife while cooking at home. The patient has no chronic medical conditions, is not on any medications, and has no other complaints. A nurse assessed and cleaned the wound, and the physician performed a simple laceration repair (CPT code 12001). The wound was dressed and the nurse provided routine discharge instructions.

- Is this outside of the usual pre-/post-operative work for the laceration repair, and are there significant and separately identifiable E/M services?



# MODIFIER 25 SCENARIO

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A male presents to the clinic after falling and cutting his finger on a knife in the barn. The patient has chronic medical conditions such as type II diabetes, hypertension, past history of a cerebrovascular accident, and indicates some dizziness prior to the fall. The nurse took a detailed medical history as well as a detailed medication review. The nurse then assessed and cleaned the laceration, and the physician performed a simple laceration repair (CPT code 12001).

In addition to the laceration repair, the physician ordered lab and a head CT, which were normal. The wound was dressed and the nurse provided detailed discharge instructions, including a prescription for antibiotics based on the dirty environment where the laceration occurred.

- Is this outside of the usual pre-/post-operative work for the laceration repair, and are there significant and separately identifiable E/M services?

# MODIFIER 59

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## Distinct Procedural Service

- Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

# MODIFIER 59 MAC GUIDANCE

## Appropriate Uses:

- A different session
- Different procedure or surgery
- Different site or organ system: If two procedures are performed at separate anatomical sites or at separate patient encounters on the same date of service separate incision or excision
- Separate lesion, or separate injury (or area in injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual
- Second initial injection procedure when protocol requires two separate sites or when the patient has to come back for a separately identifiable service
- No other appropriate modifier is available. Evaluate other modifiers such as the RT/LT identifying right and left, F1 - F0 to identify fingers, T1-T0 to identify toes and E1-E4 to identify eyelids
- Evaluate additional modifiers to determine appropriate usage
- Centers for Medicare & Medicaid Services (CMS) established four new HCPCS modifiers (XE, XS, XP, and XU) to provide greater reporting specificity in situations where modifier 59 was previously reported
  - XE – “Separate encounter, a service that is distinct because it occurred during a separate encounter;” use this modifier only to describe separate encounters on the same date of service
  - XS – “Separate Structure, a service that is distinct because it was performed on a separate organ/structure”
  - XP – “Separate Practitioner, a service that is distinct because it was performed by a different practitioner”
  - XU – “Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service”

# MODIFIER 59 SCENARIO

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17000 – Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (e.g., actinic keratosis) other than skin tags or cutaneous vascular proliferative lesions; first lesion

11100 – Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

- Modifier 59 may be reported with 11100 if the procedures are performed at different anatomic sites on the same side of the body and a specific anatomic modifier does not apply.
- If the procedures are performed on different sides of the body, modifiers RT and LT or another pair of anatomic modifiers should be used.
- Modifier 59 is reported for different anatomic sites during the same encounter only when procedures, not ordinarily performed or encountered on the same day, are performed on different organs, different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.

# MODIFIER 59 SCENARIO

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47370 – Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency

76942 – Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation

- Modifier 59 should not be reported with 76942 if the ultrasonic guidance is for needle placement for the laparoscopic liver tumor ablation procedure.
- Modifier 59 may be reported with 76942 if the ultrasonic guidance for needle placement is unrelated to the laparoscopic liver tumor ablation procedure.

# MODIFIER 59 SCENARIO

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Arthroscopic treatment of structures in adjoining areas of the same shoulder constitutes treatment of a single anatomic site.

29827 – Arthroscopy, shoulder, surgical; with rotator cuff repair

29820 – Arthroscopy, shoulder, surgical; synovectomy, partial

- Modifier 59 should not be reported with 29820 if both procedures are performed on the same shoulder during the same operative session because the shoulder joint is a single anatomic structure.
- If the procedures were performed on different shoulders, modifiers RT and LT should be used.
- Modifier 59 may be reported when the procedures are performed in different encounters on the same day.

# PRIORITY FOR COMPLIANCE

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- **Do not hard code modifier 25 and 59 in the Chargemaster**
  - The assignment of these modifiers requires documentation review
- **Assignment should only be performed by coding**
  - Coding clinic and CPT Assistant issue guidance regarding these modifiers and the coders will have access to the most current and accurate information
  - Coders are trained to read the medical record documentation and determine the appropriate use of these modifiers
- **Develop a modifier assignment policy**
  - A policy for the organization that defines who can assign these modifiers and any audit processes should be developed
- **Periodic chart reviews should be conducted**
  - This will identify any training and education needs
  - Will validate that the organization's policies and coding guidelines are being followed

# QUESTIONS?

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# THANK YOU

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