

Documentation Summary for Chemotherapy Administration, Nonchemotherapy Injections and Infusions

Documentation to Support Medical Necessity of Chemotherapy Services

Date: April 23, 2012
Source Information: Medicare Policy

Purpose

The United Mine Workers of America Health and Retirement Funds (the Funds) processes and pays Medicare claims as a Health Care Prepayment Plan contracted through the Centers for Medicare and Medicaid Services (CMS). The purpose of this summary is to provide education about Medicare documentation guidelines to improve the quality of records needed to support the payment of Medicare claims paid by the Funds on behalf of CMS.

Requirement & Retrospective Audits

Medicare requires documentation which is legible, complete, appropriately authenticated and supports medical necessity for services reported on the insurance claim form. You may be audited retrospectively by the Funds or CMS to ensure that you have complied with all Medicare payment policies.

Documentation of Treatment Plan

You should maintain documentation of a Treatment Plan or Plan of Care in the record that includes at least the following:

- Progress note providing history, exam and medical decision-making components of a face-to-face encounter to evaluate the patient's condition.
- Results of diagnostic tests to support the diagnosis used to support medical necessity.
- Written order(s) for chemotherapy treatment, including route of administration, dosage, drug, frequency and length of treatment.

Chemotherapy Administration (or Nonchemotherapy Injection and Infusion) and Evaluation and Management Services Furnished on the Same Day

Evaluation & Management with Modifier -25

Physicians providing a chemotherapy administration service or a nonchemotherapy drug infusion service and evaluation and management services, other than CPT code 99211, on the same day must bill in accordance with §30.6.6 using modifier 25.

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If a chemotherapy service and a significant separately identifiable evaluation and management service are provided on the same day, a different diagnosis is not required.

Incident To

If the RN, LPN or other auxiliary personnel furnishes the injection in the office and the physician is not present in the office to meet the supervision requirement, which is one of the requirements for coverage of an incident to service, then ***the injection is not covered***. The physician would also not report 99211 as this would not be covered as an incident to service.

Administration and Nonchemotherapy Injections, Infusions

Codes for Chemotherapy administration and nonchemotherapy injections and infusions include the following three categories of codes in the American Medical Association's Current Procedural Terminology (CPT):

1. Hydration;
2. Therapeutic, prophylactic, and diagnostic injections and infusions (excluding chemotherapy); and
3. Chemotherapy administration.

Documentation must meet applicable CPT and Medicare coding guidelines for medical necessity. Physician work related to hydration, injection, and infusion services involves the affirmation of the treatment plan and the supervision (pursuant to incident to requirements) of nonphysician clinical staff.

Hydration

The hydration codes are used to report a hydration IV infusion which consists of a pre-packaged fluid and /or electrolytes (e.g. normal saline, D5-1/2 normal saline +30 mg EqKC1/liter) but are not used to report infusion of drugs or other substances.

Therapeutic, prophylactic, and diagnostic injections and infusions (excluding chemotherapy)

A therapeutic, prophylactic, or diagnostic IV infusion or injection, other than hydration, is for the administration of substances/drugs. The fluid used to administer the drug(s) is incidental hydration and is not separately payable. If performed to facilitate the infusion or injection or hydration, the following services and items are included and are **not separately billable**:

1. Use of local anesthesia;
2. IV start;
3. Access to indwelling IV, subcutaneous catheter or port;
4. Flush at conclusion of infusion; and

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5. Standard tubing, syringes and supplies.

Payment for the above is included in the payment for the chemotherapy administration or nonchemotherapy injection and infusion service. Documentation of the agent, route, dose given, and the duration of the administration may be required to be in the medical record.

Chemotherapy Administration

Chemotherapy administration codes apply to parenteral administration of non-radionuclide anti-neoplastic drugs; and also to anti-neoplastic agents provided for treatment of noncancer diagnoses (e.g., cyclophosphamide for auto-immune conditions) or to substances such as monoclonal antibody agents, and other biologic response modifiers. The following drugs are commonly considered to fall under the category of monoclonal antibodies: infliximab, rituximab, alemtuzumb, gemtuzumab, and trastuzumab.

Drugs commonly considered to fall under the category of hormonal antineoplastics include leuprolide acetate and goserelin acetate. The drugs cited are not intended to be a complete list of drugs that may be administered using the chemotherapy administration codes.

The administration of anti-anemia drugs and anti-emetic drugs by injection or infusion for cancer patients is not considered chemotherapy administration. If performed to facilitate the chemotherapy infusion or injection, the following services and items are *included and are not separately billable*:

1. Use of local anesthesia;
2. IV access;
3. Access to indwelling IV, subcutaneous catheter or port;
4. Flush at conclusion of infusion;
5. Standard tubing, syringes and supplies; and
6. Preparation of chemotherapy agent(s).

Payment for the above ***is included*** in the payment for the chemotherapy administration service. Documentation of the agent, route, dose given, and the duration of administration may be required to be in the medical record.

Coding Rules for Chemotherapy Administration and Nonchemotherapy Injections and Infusion Services

Administration of multiple infusions, injections or combinations

When administering multiple infusions, injections or combinations, the physician should report only one "initial" service code unless protocol requires that two separate IV sites must be used.

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Documentation of the agent, route, dose given, the duration of administration and the type of vascular access device filled or maintained (if any) may be required to be in the medical record and available to Medicare on request.

The ***initial code is the code that best describes the key or primary reason for the encounter*** and should always be reported irrespective of the order in which the infusions or injections occur.

If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code should be reported. For example, the first IV push given subsequent to an initial one-hour infusion is reported using a subsequent IV push code.

If more than one “initial” service code is billed per day, the second initial service code will be denied unless the patient has to come back for a separately identifiable service on the same day or has two IV lines per protocol. For these separately identifiable services, report with modifier 59.

The CPT includes a code for a concurrent infusion in addition to an intravenous infusion for therapy, prophylaxis or diagnosis. Medicare permits only one concurrent infusion per patient per encounter. Payment will not be allowed for the concurrent infusion billed with modifier 59 unless it is provided during a second encounter on the same day with the patient and is documented in the medical record.

For chemotherapy administration and therapeutic, prophylactic and diagnostic injections and infusions, an ***intravenous or intra-arterial push*** is defined as:

1. an injection in which the healthcare professional is continuously present to administer the substance/drug and observe the patient; or
2. an infusion of 15 minutes or less.

The physician may report the infusion code for “each additional hour” only if the infusion interval is greater than 30 minutes beyond the 1 hour increment. For example if the patient receives an infusion of a single drug that lasts 1 hour and 45 minutes, the physician would report the “initial” code up to 1 hour and the add-on code for the additional 45 minutes.

Payment for code 96523, “Irrigation of implanted venous access device for drug delivery systems,” is allowed if it is the only service provided that day. If there is a visit or other chemotherapy administration or nonchemotherapy injection or infusion service provided on the same day, payment for 96523 is included in the payment for the other service.

Recommended Medicare Resources & References (not all inclusive)

Medicare Claims Processing Manual Chapter 12, Section 30.5

Medicare Benefit Policy Manual Chapter 15, Section 50.4.1

National and Local Coverage Determinations

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