INFUSION BILLING UPDATE: 2006
Opportunities to Ensure Proper Reimbursement and Program Success

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One of the services that many Neurologists have begun to explore in the last couple of years is infusion service. Infusion services can be an important adjunct to treating Multiple Sclerosis (MS), and a variety of other neuromuscular disorders such as Myasthenia Gravis (MG), Stiff Persons Syndrome (SPS), Multifocal Motor Neuropathy (MMN) and Chronic Inflammatory Demyelinating Polyneuropathy (CIDP).

Starting this type of a service in an office based practice can be a valuable tool in the spectrum of care for these chronically ill patients and can also provide an opportunity to become involved in clinical trials of infusions medications, thus offering patients choice in participating in therapy that may otherwise not be available to them.

There is considerable risk in this type of program due to the many constraints placed on coverage of drugs for a given condition, due to volatility of the cost of some drugs in the marketplace, and due to availability concerns of drugs commonly used to treat neurologic disease. Neurologists considering this type of program need to be well equipped to adapt to rapidly changing regulations, significant reimbursement considerations and supplier constraints if they decide to offer these services. Practices that can walk the tightrope of providing these services to their patients may be able to improve their bottom line while offering a value added service experience in their practice.

In 2006 significant changes were implemented to the CPT® codes for drug administration and infusion billing as well as the HCPCS codes for the billing of the drug. The result in CPT® is that where there had been 2 codes to report a variety of infusion services, now there are 2 new categories of infusion services, and 11 new codes to replace the codes used previously. The chemotherapy section remains, but has also undergone significant revision. In HCPCS 2006, new J codes for some commonly used drugs (IVIG) have been established and the old codes have been deleted. Making sure that you are selecting the proper CPT® codes to report your services, accurately selecting the proper HCPCS codes to report all of the drugs that are being infused, and billing the drugs in proper quantities are all integral to ensuring that your services are billed correctly and that your practice is properly maximizing its reimbursement.

The 2 new categories of drug administration/infusions are 1) Hydration and 2) Therapeutic, Prophylactic, and Diagnostic Injections and Infusions. The Chemotherapy section has also been revised with new codes and the explanatory notes in this section now clarify that these codes may be used when administering chemotherapy or monoclonal antibodies or other biologicals to patients with a non-neoplastic disease.

CPT® now clarifies what is included in the services provided when utilizing these drug administration codes. The following services are always included and therefore not

separately billable when performing services from the 90760-90779 and 96401-96549 series of codes: Use of local anesthesia, IV start, access to indwelling IV, subcutaneous catheter or port, flush at conclusion of infusion, and standard tubing, syringes or supplies. In addition, if administering chemotherapy, preparation of the chemotherapy agent(s) is bundled to the infusion code(s). The instructions also tell us when multiple drugs are administered, report each service, and the materials or drugs for each. We now must report one "initial" service code, and it should be the initial code that best describes the reason for the encounter, and not necessarily the code that describes the first service performed. Any subsequent drug administration services, even if they chronologically precede the initial service that is the main reason for the encounter, are reported using the subsequent services codes. As in the past, CPT® makes clear that if a separately identifiable e/m service occurs on the same date as the infusion, these services can be separately reported with the appropriate e/m code with modifier 25. CPT® also specifies also that the e/m service does not require a different diagnosis.

The 2006 Coding Changes: Hydration

New Codes	Description	Old Codes
90760	Initial IV infusion, up to 1 hour	90780, G0345 (MC)
90761	each additional hour, up to 8 hours (list separately in addition to code for primary procedure)	90781, G0346 (MC)

The hydration codes should only be used to report hydration services (i.e. pre-packaged electrolytes or other fluids such as normal saline, 5% dextrose etc.). These services require direct physician supervision for consent, safety oversight or intra-service direction of staff. Staff that does not have advanced practice training may typically perform these services. These are considered low risk and require little patient monitoring as a result. In order to bill for the subsequent hour code 90761, you must provide at least and additional 31 minutes beyond the preceding 1-hour. The 90761 can be used to report hydration services subsequent to other therapeutic, prophylactic, and diagnostic injections and infusions and chemotherapy. Codes 90760 or 90761 may not be used to report incidental hydration or services where saline or sterile water is used as a diluent to accomplish infusion of another drug. In these circumstances however, the saline solution can be billed, and may be paid according to the payer's policy. A 15-minute hydration infusion is billed as 90774- initial IV Push with the appropriate J code.

Examples:

Patient with MS comes in for 3 month follow up visit and during visit is determined to be severely dehydrated. After full exam and assessment patient is infused for 120 minutes with 1500cc of normal saline.
Coding: E/M as appropriate with 25 modifier 90760, 90761 and J7050 X 6.

The 2006 Coding Changes: Therapeutic, Prophylactic, and Diagnostic Infusions

New Codes	Description	Old Codes
90765	Intravenous Infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); up to 1 hour	90780, (G0347 MC)
90766	each additional hour, up to 8 hours	90781, G0348 (MC)

	(list separately in addition to code for primary procedure)	
90767	Additional sequential infusion , up to 1 hour	90781, G0349 (MC)
90768	Concurrent infusion, up to 1 hour	G0350 (MC)
G0332	New TEMPORARY Medicare Code effective 1/1/06-Add on code. Billed once per IVIG infusion session. Only to be used in conjunction with IVIG infusion bills. $69.00 per infusion. Rationale: Compensation for administrative burdens associated with IVIG infusion services (sourcing etc.)	

Again, these services require direct supervision for patient consent, safety, oversight or intra-service direction of staff. Unlike hydration services, these services require periodic assessment and monitoring of patient vital statistics and typically require that staff have specific training and competencies in administering such infusions. Fluids such as saline or sterile water that are combined with the drug to facilitate administration are not separately reportable. An infusion that lasts 15 minutes or less should be reported using the IV Push codes 90774 and or 90775 as appropriate. Codes 90767 and 90768 are reported only once per encounter per infusate mix.

The importance of documenting time cannot be overstated here. The reportable time that must be used to determine which codes can be billed and whether the add-on codes can be used is the actual infusion time only. Prep time, patient assessment time, time spent waiting for the pharmacy to deliver medication, time spent flushing the port in between subsequent infusions, post-service monitoring and patient time in the waiting room cannot be counted towards billable infusion time. Now more than ever, it is important that practices fine tune their protocols for properly documenting beginning and ending times for each phase of a patient's infusion. All times should be documented to the exact minute, because failing to do so may mean the difference between being able to bill for additional services or not. It may also mean the difference between being able to bill for an hourly infusion or a lower reimbursed IV push code. Multiple drugs infused from one bag over the course of 120 minutes would be billed as 90765, 90766 with the appropriate J codes.

Examples:

68 yr old patient (MC Elig) diagnosed with acute MG presents for scheduled infusion of IVIG. Pt. Receives 75 grams of Gammunex® non-lyophilized (liquid) over 4 hours and 17 minutes.

Coding: 90765, 90766 x 3, G0332, J1567 x 150

60-year-old patient with MG reports for infusion of IVIG followed by 8 g. IV Solumedrol. Pt receives 75 grams Gammagard® over 4 hours and then 1 gram Solumedrol® over 35 minutes.

Coding: 90765, 90766x3, 90767, J1567 x 150, J2930 x 8

The 2006 Coding Changes: Therapeutic, Prophylactic, and Diagnostic Injections

New Codes	Description	Old Codes
90772	Therapeutic, Prophylactic or Diagnostic Injection (specify substance or drug): IM or subcutaneous	90782, (G0351 MC)
90773	Intra-arterial	90783, G0352 (MC)
90774	Intravenous push, single or initial substance/drug	90784, G0353 (MC)
90775	Each additional sequential IV Push of a new drug or substance. (list separately in addition to code for primary procedure)	G0354 (MC)

The injection codes are to be reported when a physician is directly supervising the staff. In the absence of direct physician supervision, injections should be billed using CPT® code 99211. Code 90774 may be used to report an infusion of less than 15 minutes or an initial IV push service.

Example:

New Pt. with MS presents for initial visit and is deemed to be eligible for Interferon therapy. After office visit, Avonex ® 33mcg is injected under direct supervision of the physician.

Coding: 99201-99205-25 as appropriate, 90772, J1825

The 2006 Coding Changes: Chemotherapy- Codes commonly used for NRO patients

New Codes	Description	Old Codes
96413	Chemotherapy administration, IV infusion tech. up to 1 hour (single/initial drug or substance)	96410, (G0359MC)
96415	each additional hour, 1- 8 hours (list separately in addition to code for primary procedure)	96412, (G0360 MC)
96417	each additional sequential infusion(diff subs/drug) up to 1 hour (list separately in addition to code for primary procedure) Report only once per sequential infusion.	96412,(G0362 MC)

Example:

New Pt. with MS presents for initial visit and is deemed an appropriate candidate for Tysabri® infusion therapy. After office visit, Tysabri® 1 gram is infused over the course of one hour and 10 minutes.

Codes: 99201-99205-25 as appropriate, 96413, Q4079, J7050 (J code pending)

Drug Coding-

One of the most important factors in successfully running an infusion practice is ensuring that the drugs that are administered are properly accounted for on the physician's bill. The drug supplies that are used during infusion/injection services are found in the HCPCS book, in the J section and much like CPT®, the codes are revised periodically as

drugs are introduced to or removed from the market. Most, but not all drugs have an established J code. Those drugs that are too new to have a dedicated J code may be billed using the J3490 or J3590 code, which are unclassified J codes. They function much in the way unlisted CPT® codes function- as a catch all for any drug or biological that has does not yet have an established code.

In 2006 HCPCS updated the IVIG drug codes to facilitate the reporting of lyophilized (powdered) vs. non-lyophilized (liquid) IVIG. In addition, the dosage information associated with the new IVIG codes changed from 1 gram to 500 milligrams. In 2005 in order to bill 75 grams of IVIG, the J1563 code would be billed with a quantity of 75. In 2006 the quantity billed for 75 grams of either the J1566 of J1567 would be 150 units. Disregarding this important bit of information has the potential to seriously undermine the finances of your practice and cause you to significantly under report the quantities of drugs being infused.

The 2006 Coding Changes: HCPCS- Codes commonly used for NRO patients

New Code	Description	Old Code
J1566	Inj., Immune Globulin, IV, lyophilized (e.g. powder) **500 mg**	J1563 per G
J1567	Inj., Immune Globulin, IV, non- lyophilized (e.g. liquid) **500 mg**	J1563 per G

Selecting the proper drug codes from HCPCS requires that staff have a knowledge of both trade names and generic names for the drugs being billed, the route of administration of the drug (IV, IM, SC) and that they have the ability to convert metric measurements to determine proper billing units. A mistake on either the code selection or the quantity of units billed may mean significant reduction in reimbursement. In the short time since the Medicare Part D drug benefit plan has been released, there have been questions about what impact the Part D benefit would have on medications administered in the office. Currently, for Medicare beneficiaries, medications that are administered in a physician’s office incident to a service must be provided by the physician and billed to Medicare Part B. The patient cannot be asked to purchase these drugs through their Part D benefit and bring them to the Physician's office. If a patient brings their own medication to a physicians office where it is administered, the drug and the services itself are deemed to be non-covered by Medicare. Drugs that are routinely self-administered are never covered under Part B. In addition, the drugs that would commonly be covered through Part B are not a part of the Part D formulary.

The Competitive Acquisition Program

CMS is currently working on a proposal to start a program called the Competitive Acquisition Program (CAP), whereby physicians could contract with a regional pharmacy vendor to ship certain specified Part B covered drugs directly to the physicians office for a given patient, and have the pharmacy bill the patient’s Part B coverage directly, eliminating the need for the physician to have to purchase and bill for these supplies. CMS hopes to help eliminate cash flow problems that arise periodically even in the best-run infusion practices. Unfortunately, IVIG has been statutorily excluded from the CAP program and given its cost, the Cap program will not help with cash flow shortages related to the purchase of IVIG. This program is still under development and CMS has delayed its implementation until many of the issues that were raised during the

comment period by specialty societies including the AAN can be ironed out, at least until 7/2006. At the time of this writing, no vendors had yet applied to be included in the program.

Off Label Use of Drugs in Your Practice

On occasion physicians may prescribe drugs for conditions that have not been approved by the FDA. Off label drug usage is common in Neurology. Rituxan has been prescribed for patients with MS. IVIG is currently not FDA approved for any neurological disease, yet it is frequently prescribed and administered to treat Polymyositis, CIDP and MG and MMN. Making sure your patient has insurance coverage for their infusion is very important in eliminating denials for medical necessity, especially when you have incurred expense for the drug. It is essential that each patient undergo thorough benefit verification prior to initiating infusion treatment to ensure that you are not at risk for non-payment of the service.

Many payers list their coverage criteria for high cost drugs/therapies on their websites. It is important to review the payer's clinical guidelines if they are available online so that you will know ahead of time whether the payer will cover the treatment. In many instances payers may refuse to cover off label infusions because they consider them investigational or not proven safe and effective. These denials may result in the patient being responsible for the entire bill, or if your contract with the payer does not permit balance billing the patient, you may have to write off the cost of the therapy. Both situations are unpleasant and disruptive to the effective running of an infusion practice.

If the payer's clinical guidelines and coverage criteria are not available online, write a pre-determination of benefits letter to the payer stating explicitly that you are seeking coverage for off label use of a drug. Include the name of the drug, the condition for which it is being prescribed and the dosage. Use appropriate CPT® and HCPCS codes when describing the services. Be prepared to provide peer reviewed articles and or supporting documentation from any of the compendia to support your request. Before infusing the patient, make sure you have the predetermination of coverage in writing. Even this may not prevent a denial, but it will make the appeal much easier to handle.

Medicare has established Local Coverage Decisions (LCD's) in many localities for chemotherapy and other drugs and biologicals such as IVIG. You need to review your fiscal intermediary's website to make sure that your Medicare carrier will cover the drugs you intend to infuse for your patient's diagnosis. LCD's can be researched by J code on your intermediary's website or at www.cms.hhs.gov. If the services are non-covered by Medicare based on the coverage criteria in an LCD, you must obtain an Advanced Beneficiary Notice ABN from the patient, indicating they have been told that the services (drugs and procedures) are not covered, and indicating the approximate cost of the non covered services. Failure to obtain a properly executed ABN from the patient will result in the patient being held harmless, and your practice will be forced to write the charges off. If a properly executed ABN is obtained, the patient can be billed for the non-covered services.

Infusion Center Start-Up

Equipment	Quantity	Approximate Cost
Chairs	2	$1500 ea.
Infusion Pumps	2	$1700 ea.
B/P Machines (1)	1	$1500-$1800 ea.
Pt. comfort equipment (2)	Variable	$2500
Leasehold improvements (3)	Variable	$7,000
Refrigerator (4)	1	$1500.00
Total approximate startup costs:		**$17,400-$17,700**

1. BP Machines are highly variable in cost- this cost is based on automated machines that include automated BP printout.
2. Pt. comfort equipment includes TV/DVD player, DVDs, Walkmans, Microwave, and Pt. refrigerator for snacks/drinks.
3. Leasehold improvements include installing privacy curtains between chairs, installing windowed wall at nurse's station, painting and relocating existing light fixtures.
4. Refrigerator may or may not be necessary depending on what types of drugs you will be administering. Some drugs require refrigeration in a dedicated (drug only) refrigerator.

Proforma Infusion Center Profit and Loss		
Income		
Services/Chair	Year 1, 2 chairs	Year 2, 3 Chairs
IVIG @ 3 hours, 40G, J1567 (liquid)	$60,230 $1,400,000	$90,345 2,100,000
3 Solumed @ 1/hr, 1G J2930/ pt.	$106,590 $36,480	$214,605 $54,720
Gross Annual Income	$1,603,300	$2,459670
Expenses		
Personnel: Physician @ 50% effort Nurse Secy @ 50% effort	 $90,000 $65,000 $13,500	 $90,000 $65,000 $13,500
Depreciation:	$3,540	$4,540
Supplies (Non Drug-med) **Supplies (Drug)** **Supplies (Office)**	$8,000 $1,175,000 $1,000	$12,000 $1,762,500 $1,500
Billing Costs @ 9%	$144,297	$221,370
Professional Svcs. (Tax/Legal)	$2,500	$2,500
Rent @350 sq. feet **Phone**	$12,250 $1,000	$12,250 $1,000
Insurance: WC GL Malpractice @50%	 $700 $500 $7,500	 $700 $500 $7,500
Total Expenses:	$1,524,787	$2,194,860
Net Income:	$78,513	$264,810
Capital Expense:	$17,700	$5,000
Net Cash Flow:	$60,813	$259,810

Notes:

1) Utilization based on 5 days per week, 50 weeks per year with 2 chairs (6 Hours per day)
2) Assumes Commercial/HMO/PPO utilization only- No Medicare/ Medicaid pts infused.
3) Rent Based on 350 square feet @ $35/sq.ft
4) Depreciation is calculated at 20% over 5 years.
5) Billing costs are estimated to be 9% of gross collections
6) Model assumes physician is directly supervising staff but may have other patients in the suite.

Scheduling Patients

In the infusion center setting, the chairs must be scheduled as resources and must be scheduled for an approximate number of hours with appropriate down time for discharge activities (discontinuation of infusion and clean up between patients). For this reason, at least initially it is best not to schedule patients for the maximum daily hours available per chair, in case the infusion takes longer than projected, or clean up time is more intense than projected. In our experience, it has proved extremely beneficial during our start up phase to stagger patient start times so that the nursing staff is not bombarded at the beginning of the day. Paying close attention to scheduling concerns will also allow you to start your program with one dedicated nurse and still allow for breaks and lunch. An experienced infusion nurse should be able to comfortably assess 3-4 patients at a time. In the Proforma model, in year one the nurse monitors 2 patients at the most at any given time. In year 2, the potential is for one nurse to monitor 4 patients simultaneously. For greater ease, part time nursing coverage for lunch, breaks and QA activities should be considered when additional chairs are added**.** It is imperative that you do whatever you can to keep your chairs filled on a daily basis.

Inventory Management

It is very important to keep your chairs filled, and that you adopt a "Just in Time" inventory management system. We found that reviewing the schedule each week for the coming week was helpful in projecting drug needs and limiting carrying costs. In recent months obtaining the quantity of drug we needed has become difficult due to shortage of drug. Purchasing large quantities of drug once a month is not cost effective and will have a serious impact on cash flow. Make sure that you research your drug vendor carefully. Any contract with a drug vendor should guarantee availability and competitive pricing, but also allow you to terminate the agreement without penalty.

Monitoring Your Costs

By far the largest expense in an infusion center is the cost of the drugs. The costs and availability of drug must be continually monitored in order to ensure success of your program. Over the past couple of years, the cost of purchasing IVIG has increased dramatically as a shortage of supply has encouraged vendors to sell to the highest bidder. Allocation of the drug by vendors to individual practices has become a common practice. Reimbursement from 3rd party payers should be reviewed carefully to ensure that you are being paid according to your payer contract. If your contracts do not include adequate reimbursement for the drugs you are providing to your patients, you need to re-evaluate the contract or potentially source the drug from a different vendor. Some practices have chosen to end their infusion service due to their inability to obtain adequate reimbursement for the drug supply. In recognition of the complexities associated with sourcing IVIG, Medicare developed HCPCS code G0332, which may be billed once per infusion session, and which provides an additional $69.00 per IVIG infusion per Medicare beneficiary. In developing the code, Medicare did not acknowledge any shortage in the marketplace and indicated it's pricing for IVIG was appropriate.

Infusion service reimbursement and management continue to challenge administrators and practice managers alike. Infusion services can be profitable and an increased source of revenue for a practice that is able to continually and rapidly evaluate and adapt to the changing reimbursement environment. Advanced screening of benefits, review of Local Coverage Decisions and continual scrutiny of reimbursement levels are keys to success in any infusion practice.

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