



E/M Services and Drug Infusion Codes

Statement of the Problem

Recently, the American College of Gastroenterology (ACG), American Gastroenterological Association (AGA) and American Society for Gastrointestinal Endoscopy (ASGE) have become aware of several insurance companies that have denied payment for Evaluation and Management (E/M) services when provided on the same day as drug infusion services.

While the stated reasons seem to vary, one common theme is the apparent belief by the payer that all physician work is encompassed by the reimbursement structure of the drug infusion codes regardless of level of physician work involved in the patient visit. With the exception of E/M service code 99211 (level one, office or other outpatient visit, established patient) which is bundled with and should not be coded on the same day as drug infusion codes, this is an *incorrect interpretation* of the valuation of the drug infusion codes.

This background document serves to review the history surrounding the development of the drug infusion codes by the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel, as well as the physician work and practice expense valuation of these codes by the AMA / Specialty Society Relative Value Update Committee (RUC). It concludes with a review of the specific language taken from the CPT® manual, which provides instruction regarding reporting of drug infusion services in conjunction with E/M services.

Development of the Drug Infusion Codes: Historical Perspective

The Medicare Modernization Act of 2003 (MMA) mandated substantial changes in the way physicians are reimbursed for outpatient drug infusion services. Prior to MMA, drug pricing was based on the Average Wholesale Price (AWP) of the drug, which was an industry published pricing structure. At the time, there was a limited menu of drug infusion codes available in the CPT manual, with restrictions placed upon the number and types of codes that could be reported during a single drug infusion encounter. While seldom explicitly stated, it was widely understood - and directly expressed in Congressional hearings - that the pricing structure of the drugs provided some revenue which was necessary to subsidize

Medicare's underpayment for the costs of actually administering the drugs to the patient.

MMA mandated a new drug pricing structure based on Average Sales Price (ASP), which resulted in substantial decreases in reimbursement for drugs. Along with this new drug pricing mechanism, the MMA instructed the AMA CPT Editorial Panel to revise the coding structure for drug infusion services. The goal was to provide more complete and accurate reporting of services provided by physicians at each encounter. The perceived "drug profits" were removed from the equation, with expressed goal of basing physician reimbursement on work actually performed.

During 2004, the CPT Editorial Panel established a Drug Infusion Workgroup, which met via conference calls and in-person to develop a new series of CPT codes for office-based infusion services. The goal was to develop a comprehensive code set that would accurately describe the work as performed. The "granularity" of the resulting coding system is reflective of the complexity of drug regimens delivered in outpatient settings, the range of agents administered, and potential toxicities involved.

The workgroup divided codes into three groups: Hydration (codes 96360-96361), Therapeutic, Prophylactic, and Diagnostic Injections and Infusions (codes 96365-96379), and Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration (codes 96401-96549). [Please note, the code numbers listed are from the 2010 edition of the CPT manual, and have undergone minor changes since their original development in 2004-2005.] The nature of the substance or drug administered, the route of drug administration, and the primary reason for the patient encounter all play a role in the selection of the codes for description of a given outpatient drug administration service. Instructions in the preamble language of the given section of the CPT manual are quite explicit in this regard.

Immediately after completion of the descriptive work by the CPT Editorial Panel, the drug infusion code set was sent to the RUC for valuation. Total RVU value for each code was determined by a complex series of calculations, with a large part of the data coming from physician work and practice expense surveys conducted by the physician specialties which performed these services (Hematology, Oncology, Rheumatology, Gastroenterology, Urology and Infectious Diseases) as well as input from the Oncology Nursing Society. A detailed description of the components used in the valuation of this code set is beyond the scope of this article.

The revised drug infusion code set was approved by AMA CPT Editorial Panel in late 2004. In 2005, the Centers for Medicare and Medicaid Services implemented these codes and physician payment using a set of temporary "G-codes" for Medicare beneficiaries. The new drug infusion codes were published

by the AMA in the 2006 CPT coding manual. Since 2006, there have been several minor revisions to the code set, and renumbering of several codes.

The bulk of the total RVU value of the drug infusion codes is the actual practice expense. Items such as the space and equipment used, nursing time required for the provision of the service, and routine supplies were carefully examined and were included in the valuation. In addition, some physician work was recognized during the valuation of the drug infusion codes, and was included in the total RVU valuation for each code. This work, as stated in the CPT manual, “predominantly involves affirmation of the treatment plan and direct supervision of the staff.”

The Drug Infusion Workgroup never intended that the physician work component included in the valuation of the drug infusion codes would include the physician work of providing E/M services beyond a minimal amount of service time and low intensity work such as in E/M code 99211, which may be supervisory and according to the descriptor, “may not require the presence of a physician.” Stated another way, physician work included in the valuation of the drug infusion codes is primarily related to provision of oversight for the nursing staff who directly administer the drugs. The panel recognized the need to report both E/M codes and infusion codes on the same day when a separately identifiable E/M service does take place and gave explicit instructions in the preamble language regarding how this should be done.

Use of Drug Infusion Codes in Conjunction with an E/M Visit

Appropriate reporting of a same-day separately identifiable E/M service in concert with a drug infusion must reflect:

- 1) That there is a medical necessity for the visit.
- 2) That the purpose of the visit/evaluation is to assess either the condition for which the patient is receiving an infusion or the need to assess other conditions.

If these two conditions are not met and the patient simply "presents for infusion" no additional E/M code is needed or should be reported.

For purposes of coding, the entire visit in these cases may be considered in two parts. The first part of the visit relates to the actual administration of the fluids, therapeutics, or chemotherapy. Proper coding includes the J-code for the agent or agents themselves, as well as the code or combination of codes which accurately describes the manner of administration of the agent(s). Clear instructions for coding drug infusion encounters are provided in the preamble language of the appropriate section of the CPT manual.

At times, an office visit which includes the provision of drug infusion services may also involve a separate “face-to-face” visit with the physician. The physician may need to indicate that on the day a drug administration 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 drug infusion service provided. Examples include the situation where the physician performs a significant, separately identifiable E/M service at the same encounter, but **unrelated** to the initial presenting problem, or the physician provides services beyond the usual preoperative and postoperative care **associated** with the procedure that was performed. 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. The physician visit is reported using the E/M code which most accurately reflects the level of work performed by the physician.

(Documentation guidelines regarding the proper level of E/M coding have been in place since the mid 1990’s, and are published in the CPT coding manual.)

When an E/M service is provided on the same day as a drug infusion service, the CPT manual clearly states that, “If a significant, separately identifiable Evaluation and Management service is performed, the appropriate E/M service code should be reported using modifier 25 in addition to 96360-96549.” The next sentence in the CPT manual clearly states that, “For same day E/M service, a different diagnosis is not required.” It is important to note that the addition of modifier 25 only serves to clarify the coding, and does not alter the valuation of the codes.

Thus, on the days the physician is providing a physician service and the patient is receiving an in-office infusion at the same time, documentation might reflect the following:

“Mr. X presents today for follow-up of Y...”

As the infusion is “incident to” the E/M service, the nurses' notes are used to document the infusion service.

When a patient comes in for an infusion only, the physician’s notes might say:

“Mr. X is here today for Y infusion. Please see nurses' notes.”

In this way the physician explicitly identifies the primary reason for the visit and the medical necessity for the E/M service, when provided.

Conclusion

The CPT manual language regarding same-day E/M visits in conjunction with drug infusion services is clear. As described above, the work of an E/M visit can

be seen as separate and distinct from the drug infusion service, and is properly coded using modifier 25. It is incorrect for payers to uniformly or routinely deny E/M services when submitted with the correct modifier 25, or to alter the level of reimbursement for the drug administration or E/M service when performed on the same date of service and submitted together.

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