Welcome to Coding Guidelines Presentation Focusing on Oncology Billing

E&M Coding

The Centers for Medicare/Medicaid Services has provided 2 guidelines for Evaluation and Management Coding,

1995 Documentation Guidelines
for Evaluation and Management Services

And

1997 Documentation Guidelines
for Evaluation and Management Services

**Keep in mind the 1997 Guidelines did NOT replace the earlier 1995 Guidelines, you may choose to use either set of rules. Here we will focus on "Best Practices".

LEVELS OF E&M Coding

Key Components

History

Physical Exam

Medical Decision Making

Since the majority of all Visits in Oncology will be level 3 or 4 – we will focus the basic E&M Coding portion on the requirements for these higher level services.

E&M Coding

Maximize Revenue BUT Stay Compliant

Evaluation & Management or E&M –

- Office Visit – Level 4 instead of Level 3 increases revenue by about 40%
- Hospital Visit – Level 3 instead of Level 2 increases revenue by about 40%

E&M - HPI

Elements of HPI for General Visit

Location

Severity

Quality

Context

Timing

Duration

Modifying Factors

Associated Signs & Symptoms

Except in the academic setting the billing provider MUST complete the HPI – it cannot be completed by a Clinical Assistant/Medical Assistant/Nurse

E&M - HPI

Elements of HPI focused on Oncology

Location - “Where is the cancer located?”

Severity – “What stage is the cancer or what is the extent of disease progression?”

Quality – “What is the tumor type/pathology?”

Context – “Is there any relevant personal or family history that could lend to the cancer diagnosis?”

Timing – “Has there been any delays with establishing diagnosis or beginning a treatment plan?”

Duration – “Time lapse since diagnosis?”

Modifying Factors – “Are there any co-morbidities that must be considered for treatment?” “Are there any personal or family limitation or expectations with regard to treatment?”

Associated Signs & Symptoms – “Is the patient experiencing any signs or symptoms related to the cancer diagnosis?”

E&M - HPI

HPI for Oncology

- Focus on the Patient's Specific "Cancer Story" and not the steps taken to obtain the diagnosis
- Include Patient's emotional status and state of mind
- Include relevant social, family or past medical history that has an impact on the cancer diagnosis and potential treatment
- Include signs and symptoms related to disease state and possible treatment complications.

E&M - HPI

Sample

Ms. “Patient” is a 71 year old female, with a recently diagnosed Metastatic Anaplastic Carcinoma of the Thyroid Gland. She is currently on palliative chemotherapy and presents today for an early follow up.

At last visit, she was here with right arm swelling and pain. I obtained a stat venous US and it showed DVT. On Eliquis since then. Patient says the swelling and pain in the arm are better.

5 Elements of HPI Met

Location – Thyroid Gland

Severity – Metastatic

Quality – Anaplastic Carcinoma

Duration - recently

Associated Signs/Sx – Right arm swelling and pain

E&M – Review of Systems

- **Constitutional**
- **Eyes**
- **Ears, nose, mouth, throat (ENT)**
- **Cardiovascular**
- **Respiratory**
- **Gastrointestinal**
- **Genitourinary**
- **Musculoskeletal**
- **Integumentary**
- **Neurological**
- **Psychiatric**
- **Endocrine**
- **Hematologic/Lymphatic**
- **Allergic/Immunologic**

Common area to be templated into an Electronic Note – Be VERY Careful that this is reviewed each visit, WITH comment on change from visit to visit

Common Shortcut for ROS
"All other systems reviewed and are negative"

- MUST be documented exactly as above. MANY variations are NOT compliant
- Be VERY careful that all relevant clinical findings are documented separately
- Double check to make sure Shortcut is accepted by your local CMS carrier

E&M – Past/Family/Social History

Past Medical History – Major Illnesses, operations, current medication, allergies

For Cancer Dx – Focus on history that may be relevant to disease progression or ability to tolerate treatment plan

Family History – Specific disease related to the problems identified in the chief complaint or the HPI

For Cancer Dx – Focus on family history that may show a genetic component

Social History – Marital Status, current employment, occupational history, alcohol use or drug abuse.

For Cancer Dx – Focus on activity that could the contributory to diagnosis or impact treatment

May be completed by Questionnaire or Ancillary Staff

E&M Coding Rules – 1995 Guidelines Physical Exam

Physical Exam – 1995 Guidelines

- Guidelines indicate a number of organ systems and body areas that must be examined to meet level of care
- Does NOT require provider to examine specific elements – Provider's Discretion
- Provider MUST document Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented
- Provider MUST document Abnormal or unexpected findings of the examination of unaffected or asymptomatic body area(s) or organ system(s

Due to Vague Nature of the Guidelines – there are Generally Accepted Rules to help identify the Number of Organ Systems and Body Areas to Meet Level of Care

Physical Exam

The levels of E/M services are based on four types of examination:

- Problem Focused – A limited examination of the affected body area or organ system.
- Expanded Problem Focused – A limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ systems.
- Detailed – An extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body areas or organ systems.
- Comprehensive – A general multi-system examination or complete examination of a single organ system (and other symptomatic or related body area(s) or organ system(s) – 1997 documentation guidelines.

An examination may involve several organ systems or a single organ system. The type and extent of the examination performed is based on clinical judgment, the patient's history, and nature of the presenting problem(s).

Important points to keep in mind

Here are some important points to keep in mind when documenting general multi-system and single organ system examinations (in both the 1995 and the 1997 documentation guidelines)

Document **specific** abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s). A notation of "abnormal" without elaboration is not sufficient.

Describe abnormal or unexpected findings of the examination of any asymptomatic body area(s) or organ system(s).

It is sufficient to provide a brief statement or notation indicating "negative" or "normal" to document normal findings related to unaffected area(s) or asymptomatic organ system(s).

E&M Coding Rules – 1997 Guidelines Physical Exam

14 Organ Systems with Specific Bullet Requirements

Constitutional
- Three Vital Signs
- General Appearance

Eyes
- Inspection of conjunctivae and lids
- Examination of pupils and irises (PERRLA)
- Ophthalmoscopic examination of discs and posterior segments

Ears, Nose, Mouth and Throat
- External appearance of the ears and nose
- Otoscopic exam of the external auditory canals and TMs
- Assessment of hearing
- Inspection of nasal mucosa, septum and turbinates
- Inspection of lips, teeth and gums
- Examination of oropharynx, oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx

Neck
- Exam of neck (masses, symmetry, tracheal position, crepitus)
- Exam of thyroid (masses, nodules, tenderness)

Respiratory
- Assessment of respiratory effort
- Percussion of chest
- Palpitation of chest

Cardiovascular
- Palpitation of the heart
- Auscultation of the heart
- Assessment of lower extremity/edema
- Examination of carotid arteries
- Examination of abdominal aorta
- Examination of the femoral pulses
- Examination of the pedal pulses

Gastrointestinal
- Examination of the abdomen
- Examination of the liver and spleen
- Examination for the presence or absence of hernias
- Examination of anus, perineum and rectum
- Obtain stool for occult blood testing if indicated

E&M Coding Rules – 1997 Guidelines Physical Exam

14 Organ Systems with Specific Bullet Requirements

Male Genitourinary
- Examination of the scrotal contents
- Examination of the penis
- Digital rectal Exam

Female Genitourinary
- Examination of the external genitalia
- Examination of the urethra
- Examination of the bladder
- Examination of the cervix
- Examination of the uterus
- Examination of the adnexa

Lymphatic
- Palpitation of lymph nodes in 2 or more areas

Skin
- Inspection of skin and subcutaneous tissue
- Palpitation of the skin and subcutaneous tissue

Musculoskeletal
- Examination of gait and station
- Inspection and/or palpitation of digits and nails
- Examination of joints, bones and muscles of 1 or more of –
  - Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions
  - Assessment of range or motion with notion of any pain, crepitation or contracture
  - Assessment of stability with notation of any dislocation, subluxation or laxity
  - Assessment of muscle strength and tone with notation of any atrophy or abnormal movement

Neurological
- Test cranial nerves with notation of any deficits
- Examination of DTRs with notation of abnormal reflexes
- Examination of sensation

Psychiatric
- Description of patient's judgement and insight
- Brief assessment of mental status, including –
  - Orientation to time, place and person
  - Recent and remote memory
  - Mood and affect

E&M – Medical Decision Making

Elements of Medical Decision Making

1. Problems – the number of Problems/Assessments being evaluated during the Visit
2. Data – the amount of data being reviewed for the Visit; this could include lab results, imaging results, consultation notes…
3. Risk – the level of risk associated with the patient's condition

E&M - History

Level of Visit	99213	99214 99203	99215 99204/05
History of Present Illness (HPI)	Brief (1 -3 elements)	Extended (4 + elements)	Extended (4 + elements)
Review of Systems (ROS)	1	2-9	10
Personal/Family/Social History	1 of 3	2 of 3	3 of 3

E&M – Physical Exam

	Expanded Problem Focused	Detailed	Comprehensive
Level of Visit	99213	99214 99203	99215 99204/05
1995 Guidelines – Exam Requirements	Limited to Affected Area and Body Systems	Extended or Related Organ Systems	8 or More Organ Systems
1995 Guidelines – General Accepted Guidelines	2-3 Organ Systems	5-7 Organ Systems	8 or More Organ Systems
1997 Guidelines – Exam Requirements	6-11 Bullets	12 Bullets	2 bullets from 9 Organ Systems

E&M – Medical Decision Making

	Expanded Problem Focused	Detailed	Comprehensive
2 out of 3 Required	99213	99214	99215
Number of Diagnosis	Limited	Multiple	Extensive
Data Reviewed	Limited	Moderate	Extensive
Risk	Low	Moderate	High

Chemotherapy Administration, Non-Chemotherapy Injections and Infusions

Infusion Suite Coding

Maximize Revenue BUT Stay Compliant

"Incident to" billing is used when a clinical staff member other than the billing provider is providing services. In the Infusion Suite this refers to the RN, LPN or other clinical staff member provides and injection to a patient or administers IV medication to a patient.

- The Physician MUST be physically present within the Facility

START and STOP Time – is critical to ensuring that your maximizing revenue, but also remaining compliant. If you are still utilizing a paper superbill, it is important to review the Medication Administration Record to look at START and STOP time to ensure accurate coding.

Don't "Fudge" your Numbers – consistently entering stop time exactly on the hour or half hour are a red flag to auditors that your MAR is inaccurate. Also, consistently going over the 30 or 60 minute mark by 1-2 minutes is also a red flag you may trying to "up-code" or take advantage of the system.

Administration and Nonchemotherapy Injections, Infusions Coding

Codes for Chemotherapy administration and nonchemotherapy injections 3 Categories of CPT,

1. Hydration;

2. Therapeutic, prophylactic, and diagnostic injections and infusions (excluding chemotherapy);

3. Chemotherapy administration.

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
5. Standard tubing, syringes and supplies.

Payment for the above is included in the payment for the chemotherapy administration or non-chemotherapy 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 antineoplastic drugs; and also to anti-neoplastic agents provided for treatment of non-cancer 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.

Coding Rules for Chemotherapy Administration and Non-chemotherapy Injections and Infusion Services

Administration of multiple infusions, injections or combinations

1. 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.
2. 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.

Other Specific Rules

30 Minute Rule

Infusion Administration (including Hydration, Chemotherapy & Non-chemotherapy) is coded based on time.

Do NOT bill for an additional increment of time unless you have exceeded the Initial 1 hour by OVER 30 minutes.

Audit Proof – keep in mind if 90% of your infusion treatments last 91 minutes, this is a red flag for a auditor to look for issues in your documentation.

Usage of Initial code Rule

Drug administration codes include an “initial” service code that best describes the key reason for the patient encounter. It does not reflect the order that the infusions or injections occur.

If a patient is admitted for the primary purpose of chemotherapy but receives other infusions prior to the chemotherapy, the chemotherapy “initial” code is the only “initial” code used. For example, if a patient receives Zofran and Dexamethasone prior to the chemotherapy, the “initial” service code billed would be for the chemotherapy as it is the key reason for the encounter.

There is only one “initial” drug administration code per encounter. The only exceptions are if the protocol requires two separate IV sites or if the patient comes back for a second encounter on the same date of service. These services are identified with modifier 59. Medical documentation is required to justify the use of the modifier.

Hydration

<u>Hydration CPT Codes</u>

96360 – Intravenous infusion, hydration; initial, 31 minutes to 1 hour

96361 – Each additional hour

Can you give Hydration on the SAME day as Chemo or Non-Chemo Infusion?

YES – Use a 59 Modifier, but MAKE SURE that you have separate documentation indicating that Hydration as a Separate Service

CPT Code	CPT Description	Notes
Hydration		
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	Do not report if performed as concurrent infusion service; do not report hydration infusion of 30 minutes or less).
		Use for infusions of 31-90 minutes.
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	Report for intervals of greater than 30 minutes beyond one-hour increments; also report for secondary or subsequent service after a different initial service through same IV access.

Chemo Admin

Chemotherapy CPT Codes

96413 – Intravenous (IV) infusion; up to 1 hour, single or initial chemotherapy substance/drug

96415 – Intravenous (IV) infusion; each additional hour (1-8 hours)

96417 – Intravenous (V) infusion; each additional sequential infusion, up to 1 hour

96409 – Intravenous (IV) push technique; single or initial chemotherapy drug

96411 – Intravenous (IV) push technique; each additional chemotherapy drug

CPT Code	***CPT Description***	***Notes***
	Chemo admins	
96413	**Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug**	**Report for infusions of 16–90 minutes.** **Report 96361 to identify hydration as a secondary service through the same IV access.** **Report 96366, 96367, or 96375 to identify therapeutic infusion/injection as secondary service through same IV access.**
96415	**Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure)**	**Report in conjunction with 96413.** **Report for infusion intervals of greater than 30 minutes beyond one-hour increments.**
96417	**Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug) up to 1 hour (List separately in addition to code for primary procedure)**	**Report in conjunction with 96413.** **Report only once per sequential infusion.** **Report 96415 for additional hour(s) of sequential infusion.**
96409	**Chemotherapy administration; intravenous, push technique, single or initial substance/drug**	
96411	**Chemotherapy administration; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure)**	**Report with 96409 or 96413.**

Non-Chemo Admin

Non-Chemotherapy CPT Codes

96365 – Intravenous (IV) infusion for therapy, prophylaxis or diagnosis; up to 1 hour; single or initial drug/substance

96366 – Intravenous (IV) infusion for therapy, prophylaxis or diagnosis; each additional hour

96367 – Intravenous (IV) infusion for therapy, prophylaxis or diagnosis; each additional sequential drug/substance

96374 – Intravenous (IV) push technique; single or initial drug/substance

96375 – Intravenous (IV) push technique; each or additional drug/substance

CPT Code	***CPT Description***	***Notes***
	Non chemo admin	
96365	**Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour**	**Report for IV infusions of 16-90 minutes.**
96366	**Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)**	**Report for intervals of greater than 30 minutes beyond one-hour increments; also report for secondary or subsequent service after a different initial service through same IV access.**
96367	**Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)**	**Report in conjunction with 96365, 96374, 96409, or 96413 if provided as secondary service after a different initial service is administered through the same IV access.** **Report only once per sequential infusion of same infusate mix (multiple drugs mixed together in one bag is one infusate mix).**
96368	**Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure)**	**Report only once per encounter.** **Report in conjunction with 96365, 96366, 96413, 96415, or 96416.** **Used for infusions running at the same time via the same IV access—must be hung in separate bags.**
96374	**Therapeutic, prophylactic or diagnostic injection (specify substance or drug);** **intravenous push, single or initial substance/drug**	
96375	**Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each** **additional sequential intravenous push of a new substance/drug (List separately in** **addition to code for primary procedure)**	

Pumps & Injections

IV Pump CPT - Codes

Day 1: 96416 – Initiation of prolonged chemo infusion (more than 8 hours) requiring use of a portable or implantable pump

Day 2: 96521 – Refill and maintain portable pump

Day 3: 96523 – Irrigation of implanted venous access device for drug delivery

96401 – Intramuscular administration (IM) of Chemotherapy Agent

96402 – Intramuscular administration (IM) of Hormonal or Anti-neoplastic agent

96372 - Subcutaneous (SubQ) or Intramuscular (IM) administration of therapeutic, prophylactic or diagnostic injection

CPT Code	***CPT Description***
PUMPS	
96416	**Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (> 8 hours), requiring use of a portable or implantable pump.**
96521	**Refilling and maintenance of portable pump**
96523	**Port flush**
	(Irrigation of implanted venous access device for drug delivery systems)
96401	**Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic**
96402	**Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic**

Administration Coding - Realistic scenarios

Sample Flow sheet for CHEMO, NON CHEMO& INJECTION

Patient Name	XXX, YYY	Practice	ZZZZZ	Provider	AAA
DOB	99/99/9999	Visit date	5/30/2017	PATINET ID	11111

MEDICATION ADMINISTRATION IN DETAIL

Start	Stop	Min.*	Drug	Waste	Route	Admin. code	Description
11:07 AM	11:09 AM	2	Palonosetron hcl, inj 0.25 mg	0 mg	IV Push	96375x1	IVP Therapeutic - Sequential
11:11 AM	11:40 AM	29	Bevacizumab, inj 600 mg	0 mg	IVPB	96413x1	IV Chemotherapy - Initial
11:42 AM	12:04 PM	22	Dexamethasone sod phosphate, inj 20 mg	0 mg	IVPB	96367x1	IV Therapeutic - Sequential
12:05 PM	12:20 PM	15	Diphenhydramine hcl, inj 50 mg	0 mg	I.V.	96375x1	IVP Therapeutic - Sequential
12:05 PM	12:20 PM	15	Zantac, inj (ranitidine hcl) 50 mg	0 mg	I.V.		
12:21 PM	01:55 PM	94	Paclitaxel, inj 60 mg	0 mg	IVPB	96415x1 96417x1	IV Chemotherapy - Additional hr. IV Chemotherapy - Sequential
01:57 PM	02:27 PM	30	Carboplatin, inj 92 mg	0 mg	IVPB	96417x1	IV Chemotherapy - Sequential
			Epoetin alfa, inj 40000 Units	0 Units	sub-Q	96372x1	SQ/IM Therapeutic
			Neulasta, syringe (pegfilgrastim) 6 mg	0 mg	Sub-Q, with wearable injector	96372x1	SQ Therapeutic

Administration Coding - Realistic scenarios

Sample Flow sheet for CHEMO, NON CHEMO& INJECTION

Patient Name	XXX, YYY	Practice	ZZZZZ	Provider	AAA
DOB	99/99/9999	Visit date	5/30/2017	PATINET ID	11111

CAPTURED CODES BASED ON ADMINISTRATION

Code	Units	Description	ICD	Comment(s)
J0885	40	Epoetin alfa, inj (Non-ESRD) 1,000 Units	C34.90, Z51.11, Z51.12	D/W: 40000/0 Units
J1100	20	Dexamethasone sod phosphate, inj 1 mg	C34.90, Z51.11, Z51.12	D/W: 20/0 mg
J1200	1	Diphenhydramine hcl, inj 50 mg	C34.90, Z51.11, Z51.12	D/W: 50/0 mg
J2469	10	Palonosetron hcl, inj 25 mcg	C34.90, Z51.11, Z51.12	D/W: 0.25/0 mg
J2505	1	Neulasta, syringe (pegfilgrastim) 6 mg	C34.90, Z51.11, Z51.12	D/W: 6/0 mg
J2780	2	Zantac, inj (ranitidine hcl) 25 mg	C34.90, Z51.11, Z51.12	D/W: 50/0 mg
J9035	60	Bevacizumab, inj 10 mg	C34.90, Z51.11, Z51.12	D/W: 600/0 mg
J9045	2	Carboplatin, inj 50 mg	C34.90, Z51.11, Z51.12	D/W: 92/0 mg
J9267	60	Paclitaxel, inj 1 mg	C34.90, Z51.11, Z51.12	D/W: 60/0 mg
96367	1	IV Therapeutic - Sequential	C34.90, Z51.11, Z51.12	
96372	2	SQ/IM Therapeutic	C34.90, Z51.11, Z51.12	
96375	2	IVP Therapeutic - Sequential	C34.90, Z51.11, Z51.12	
96413	1	IV Chemotherapy - Initial	C34.90, Z51.11, Z51.12	
96415	1	IV Chemotherapy - Additional hr.	C34.90, Z51.11, Z51.12	
96417	2	IV Chemotherapy - Sequential	C34.90, Z51.11, Z51.12	

Administration Coding - Realistic scenarios

Sample Flow sheet for PUMP, PUSH & HYDRATION

Patient Name	XXX, YYY	Practice	ZZZZZ	Provider	AAA
DOB	99/99/9999	Visit date	5/30/2017	PATINET ID	11111

MEDICATION ADMINISTRATION IN DETAIL

Start	Stop	Min	Drug	Wate	Route	Admin	Description
11:31 AM	12:01 PM	30	Bevacizumab, Inj 600 mg	0 mg	IVPB	96413x1	IV Chemotherapy - initial
12:05 PM	12:08 PM	3	Morphine sulfate, inj 8 mg	2 mg	IV push	96375x1	IVP Therapeutic - Sequential
12:08 PM	12:09 PM	1	Palonosetron hcl, inj 0.25 mg	0 mg	IV Push	96375x1	IVP Therapeutic - Sequential
12:09 PM	12:29 PM	20	Dexamethasone sod phosphate, inj 1	0 mg	I.V	96367x1	IV Therapeutic - Sequential
12:29 PM	12:33 PM	4	Atropine sulfate, inj 0.4 mg	0 mg	IV push	96375x1	IVP Therapeutic - Sequential
12:34 PM	1:58 PM	84	Irinotecan hcl, inj 240 mg	0 mg	IVPB	96417x1	IV Chemotherapy - Sequential
1:59 PM	2:37 PM	38	0.9 % sodium chloride, inj 500 mL	0 mL	IV infusion	96361x1	IV Hydration - Additional hr.
2:37 PM	4:37 PM	115	Leucovorin calcium, inj 660 mg	40 mg	IVPB	96366x1 96367x1	IV Therapeutic - Additional hr. IV Therapeutic - Sequential
4:39 PM	4:41 PM	2	Fluorouracil, inj 500 mg	0 mg	IV Push	96411x1	IVP Chemotherapy - Ea.
			Fluorouracil CIV, inj 2970 mg	0 mg	CIV	96416x1	Chemo extended IV infusion w/pump (Medicare may use G0498

Administration Coding - Realistic scenarios

Sample Flow sheet for PUMP, PUSH & HYDRATION

Patient Name	XXX, YYY	Practice	ZZZZZ	Provider	AAA
DOB	99/99/9999	Visit date	5/30/2017	PATINET ID	11111

CAPTURED CODES BASED ON ADMINISTRATION

Code	Units	Description	ICD	Comment(s)
J0461	40	Atropine sulfate, inj 0.01 mg	C20, Z51.11, Z51.12	D/W: 0.4/0 mg
J0640	14	Leucovorin calcium, inj 50 mg	C20, Z51.11, Z51.12	D/W: 660/40 mg
J1100	10	Dexamethasone sod phosphate, inj 1 mg	C20, Z51.11, Z51.12	D/W: 10/0 mg
J2270	1	Morphine sulfate, inj 10 mg	C20, Z51.11, Z51.12	D/W: 8/2 mg
J2469	10	Palonosetron hcl, inj 25 mcg	C20, Z51.11, Z51.12	D/W: 0.25/0 mg
J7040	1	0.9 % sodium chloride, inj 500 mL	C20, Z51.11, Z51.12	D/W: 500/0 mL
J9035	60	Bevacizumab, inj 10 mg	C20, Z51.11, Z51.12	D/W: 600/0 mg
J9190	7	Fluorouracil CIV, inj and Fluorouracil, inj, 500 mg	C20, Z51.11, Z51.12	D/W: 3470/0 mg
J9206	12	Irinotecan hcl, inj 20 mg	C20, Z51.11, Z51.12	D/W: 240/0 mg
96416	1	Chemo extended IV infusion w/pump (Commercial payors may use G0498)	C20, Z51.11, Z51.12	
96361	1	IV Hydration - Additional hr.	C20, Z51.11, Z51.12	
96366	1	IV Therapeutic - Additional hr.	C20, Z51.11, Z51.12	
96367	2	IV Therapeutic - Sequential	C20, Z51.11, Z51.12	
96375	3	IVP Therapeutic - Sequential	C20, Z51.11, Z51.12	
96411	1	IVP Chemotherapy - Ea. Additional	C20, Z51.11, Z51.12	
96413	1	IV Chemotherapy - Initial	C20, Z51.11, Z51.12	
96417	1	IV Chemotherapy - Sequential	C20, Z51.11, Z51.12	
99214	1	Established patient, moderate complexity	C20	

Administration Coding - Realistic scenarios

Sample Flow sheet for CONCURRENT INFUSION

Patient Name	XXX, YYY	Practice	ZZZZZ	Provider	AAA
DOB	99/99/9999	Visit date	5/30/2017	PATINET ID	11111

MEDICATION ADMINISTRATION IN DETAIL

Start	Stop	Min	Drug	Wate	Route	Admin	Description
10:26 AM	10:56 AM	0	Decadron, inj (dexamethasone sod phosphate) 5 mg	0 mg	IV infusion	96368x1	Concurrent infusion
10:26 AM	10:56 AM	30	Zofran, inj (ondansetron hcl) 16 mg	0 mg	IV infusion	96365x1	IV Therapeutic - Initial
10:59 AM	1:25 PM	146	Infuvite adult, inj (multivit infusn,adult 4,vit k) 10 mL	0 mL	IV infusion	96366x1 96367x1	IV Therapeutic - Additional hr IV Therapeutic - Sequential

Administration Coding - Realistic scenarios

Sample Flow sheet for CONCURRENT INFUSION

Patient Name	XXX, YYY	Practice	ZZZZZ	Provider	AAA
DOB	99/99/9999	Visit date	5/30/2017	PATINET ID	11111

CAPTURED CODES BASED ON ADMINISTRATION

Code	*Units*	*Description*	*ICD*	*Comment(s)*
J1100	5	Decadron, inj (dexamethasone sod phosphate) 1mg	C18.7, C18.9, C79.89	D/W: 5/0 mg
J2405	16	Zofran, inj (ondansetron hcl) 1 mg D/W: 16/0 mg	C18.7, C18.9, C79.89	D/W: 16/0 mg
J3490	1	Infuvite adult, inj (multivit infusion, adult 4,vit k) 10 mL D/W: 10/0 mL	C18.7, C18.9, C79.89	D/W: 10/0 ml
96365	1	IV Therapeutic - Initial	C18.7, C18.9, C79.89	
96366	1	IV Therapeutic - Additional hr.	C18.7, C18.9, C79.89	
96367	1	IV Therapeutic - Sequential	C18.7, C18.9, C79.89	
96368	1	Concurrent infusion	C18.7, C18.9, C79.89	
99214	1	Established patient, moderate complexity C18.7, C18.9, C79.89	C18.7, C18.9, C79.89	

Administration Coding - Realistic scenarios

Sample Flow sheet for PUMP REFILLING

Patient Name	XXX, YYY	Practice	ZZZZZ	Provider	AAA
DOB	99/99/9999	Visit date	5/30/2017	PATINET ID	11111

MEDICATION ADMINISTRATION IN DETAIL

Start	*Stop*	*Min**	*Drug*	*Waste*	*Route*	*Admin code*	*Description*
			Fluorouracil CIV, inj 2450 mg	**0 MG**	**CIV**	**96521*1**	**Refilling and maintenance of Portable PUMP**

CAPTURED CODES BASED ON ADMINISTRATION

Code	*Count*	*Description*	*ICD*	*Comment(s)*
J9190	**5**	**Fluorouracil CIV, inj 500 mg**	**C20, Z51.11**	**D/W: 2450/0 mg**
96521	1	Refilling and maintenance of portable pump	C20, Z51.11	

Administration Coding - Realistic scenarios

Sample Flow sheet for INTRAMUSCULAR - HORMONAL

Patient Name	XXX, YYY	Practice	ZZZZZ	Provider	AAA
DOB	99/99/9999	Visit date	5/30/2017	PATINET ID	11111

MEDICATION ADMINISTRATION IN DETAIL

Start	Stop	Min*	Drug	Waste	Route	Admin code	Description
			Fulvestrant, syringe 500 mg	0 mg	IM	96402x1	SQ/IM Chemotherapy Hormona
			Xgeva, inj (denosumab) 120 mg	0 mg	Sub-Q	96372x1	SQ/IM Therapeutic

CAPTURED CODES BASED ON ADMINISTRATION

Code	Count	Description	ICD	Comment(s)
J0897	120	Denosumab, inj, 1 mg (Apply payor instructions for administration charge)	C50.412, C50.919, Z17.0, Z51.11,C79.51	D/W: 120/0 mg
J9395	20	Fulvestrant, syringe 25 mg	C50.412, C50.919, Z17.0, Z51.11,C79.51	D/W: 500/0 mg
96372	1	SQ/IM Therapeutic	C50.412, C50.919, Z17.0, Z51.11,C79.51	
96402	1	SQ/IM Chemotherapy Hormonal	C50.412, C50.919, Z17.0, Z51.11,C79.51	
99213	1	Established patient, low complexity	C50.412, C50.919, Z17.0, Z51.11,C79.51	

Administration Coding - Realistic scenarios

Sample Flow sheet for INTRAMUSCULAR - NONHORMONAL

Patient Name	XXX, YYY	Practice	ZZZZZ	Provider	AAA
DOB	99/99/9999	Visit date	5/30/2017	PATINET ID	11111

MEDICATION ADMINISTRATION IN DETAIL

Start	Stop	Min.*	Drug	Waste	Route	code	Description
			Bortezomib, inj 2.6 mg	0.9 mg	Sub-Q	96401x1	SQ/IM Chemotherapy Non-Hormonal

CAPTURED CODES BASED ON ADMINISTRATION

Code	Count	Description	ICD	Comment(s)
J9041	26	Bortezomib, inj 0.1 mg	C90.00, Z51.12	D/W: 2.6000001/0 mg
J9041 - JW	9	Bortezomib, inj 0.1 mg	C90.00, Z51.12	D/W: 0/0.9 mg
36415	1	Routine venipuncture		
96401	1	SQ/IM Chemotherapy Non-Hormonal	C90.00, Z51.12	

Thank you