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E&M Services and Drug Infusion Codes

Statement of the Problem

Recently, several carriers have denied payment for Evaluation and Management (E&M) services when provided on the same day as drug infusion services. Stated reasons seem to vary, but one common theme is the apparent belief by the carrier that all physician work is encompassed by the reimbursement structure of the 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 valuation of these codes by the AMA Relative Value Update Committee (RUC). It concludes with a review of the specific language taken from the CPT® manual, which gives 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 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, 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

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from the equation, with expressed goal of basing physician reimbursement on work they actually performed.

During 2004, the CPT Editorial Panel established a Drug Infusion Workgroup, which met in person and via conference call several times over that year to develop a new menu 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 current 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 practice expense surveys conducted by the specialty societies which would be impacted by these codes, as well as with 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 brief article, but is maintained by the AMA RUC committee.

The drug infusion code set was approved by AMA CPT Editorial Panel in late 2004, and implemented in 2005 by the Medicare program using a set of temporary "G-codes." The drug infusion codes were published in the 2006 AMA CPT coding manual. There have been only minor revisions to the code set since 2006.

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The bulk of the makeup of the total RVU value is 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 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 directly 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. 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, and gave explicit instructions in the preamble language regarding how this should be done. Recall that chemotherapy administration is considered an "incident to" service, and requires the direct presence of the physician during the provision of the service to ensure safety, given the potentially toxic nature of the therapy that is being administered.

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

Often, an office visit which includes the provision of drug infusion services will also involve a visit with the physician. The work of the physician in providing these "face-to-face" services may include taking a history, conducting a physical examination, reviewing laboratory and radiology data, making decisions about the proper course of action, discussing these recommendations with the patient and family, and obtaining consent if required. If the plan is to proceed with the administration of chemotherapy or other therapeutic agents in the outpatient setting, the patient then goes to the drug infusion suite where the actual therapeutic is administered, often on the same day. Therefore: the work provided by the physician *during the direct face-to-face encounter* may appropriately be coded by using the E&M code that most accurately describes the level of service provided.

For purposes of coding, the entire visit may be considered in two parts. The first part is the actual physician visit, 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

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in existence since the mid 1990's, and are published in the first section of the CPT coding manual.)

The second 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. When an E&M service is provided on the same day as a drug infusion service, the CPT manual clearly states that "the appropriate E/M service code should be reported using modifier 25 in addition to 96360-96549." The next sentence in the CPT manual indicates 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.

Conclusion

The CPT manual language regarding same-day E&M visits in conjunction with drug infusion services is clear and unequivocal. As described above, the work of the E&M visit can be seen as separate and distinct from the drug infusion service, properly coded using modifier 25. The history and documentation suggest it is incorrect for payers to deny these codes when submitted together with the correct modifier, or to alter the level of reimbursement for either of these codes when submitted together.

This background paper is not intended to be and should not be viewed as coding or billing advice. Coding and billing are done by health care providers in their independent judgment and in light of the specific circumstances and relevant payer standards.

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