



Featured Article:

Auditing IV Hydration Documentation and Coding

As published in August 13, 2009 issue of RACMonitor's – Special 4 Part Series

Ashley Brandon, MBA, RHIA, CCS

Since the launch of the Recovery Audit Contractor (RAC) demonstration project apprehension over the targets for review has continued to increase among medical facilities as well as associated physicians and rightfully so! Preparedness offers the best results, with hospitals and physicians encouraged and recommended to be proactive rather than reactive in their approach. Conducting internal audit reviews to evaluate areas of concern, establishing baseline policies and procedures to assure proper coding and billing, and commencing investigative actions for those problems found, provides a solid foundation as providers adjust to the Centers for Medicare and Medicaid Services (CMS) recovery initiative.

The appointed RAC for Region C, Connolly Consulting, recently announced a list of seven (7) issues that they intend to target initially. This list includes IV hydrations. For this service, significant code changes and corresponding coding and billing guidelines were put into place effective January 1, 2006. Drug administration codes G0345 – G0363 were replaced by CPT codes 90760 – 90779. These codes were again revised January 1, 2009 to 96360 – 96549, including codes 96360 – 96361 for IV hydration. These changes in codes and billing guidelines can be a source of billing errors. In addition, problems can occur with use of the codes and supporting documentation. As presented below, an internal audit can help a provider identify areas that might be vulnerable to RAC audits.

With the scope already defined (CPT codes 96360 and 96361 for records billed in 2009 and codes 90760 and 90761 for records billed from Jan. 1, 2006 – Dec. 31, 2008) the first step of an internal audit would be gathering a sufficient audit sample of IV hydration cases. The size of the sample depends on the volume of these services provided, the complexity, the number of providers, and whether there is any suspicion or prior evidence of issues with billing IV Hydration services (all of these factors serve to increase sample size). At a minimum, no fewer than 30 records should be reviewed. The sample should include old cases (cases billed between Oct 1, 2006 and Dec 31, 2009), recently billed cases (Jan 1, 2009 – July 31, 2009), and pre-billed cases. By selecting these three types of cases, the provider can determine if the coding/billing rule changes effective Jan 1, 2006 were correctly implemented (old cases); whether the coding/billing rule changes effective Jan 1, 2009 were correctly implemented (recently billed cases); and whether the most recent cases are being coded/billed correctly.

The criteria for the audit should keep in mind the focus of the recovery audit reviews: to detect payments for services for which providers failed to provide documentation when requested or failed to submit sufficient documentation to support claims; payments for services that are not coded properly; and payment errors including claims paid twice due to duplicate submission.

Documentation

Since coding and billing of IV hydration is solely dependent upon accurate and legible medical record documentation, this should be the starting point of internal audits. Clear notation of actual start and stop times for each bag, the route of administration, and sufficient documentation to decipher whether a flush versus hydration is performed. If only a flush (clearing of lines) is performed, the procedure is not coded unless the flush occurs with a medication (referred to as an "IV push"). An IV push may be coded. Documentation such as "Over 1 hour" in an order; 600cc infused with no start or stop times; medically unlikely amounts of medications versus route e.g. "NS 400cc per hour flush;" "Initial line (INT) removed/hep-

lock discharged”; administration times that are marked through and/or illegible; and times recorded that do not make sense (i.e. start time 10:09 with stop time 9:19) cannot be coded, thus should not be billed. The lack of clear documentation could result in lost revenue initially or the issuance of a RAC demand letter for repayment of the reimbursement received.

As referenced in AMA’s CPT 2009, IV hydration infusions typically require direct physician supervision for purposes of consent, safety oversight, or intra-service supervision of staff. The physician should document his/her supervision of IV hydration procedures performed by nursing staff.

Coding and billing

After documentation has been reviewed, internal auditors should turn the focus to the specifics of IV hydration coding and billing guidelines. Drug administration codes G0345 – G0363 were replaced by CPT codes 90760 – 90779 in January 2006. These codes were revised January 1, 2009 to 96360 – 96549, including codes 96360 – 96361 for IV hydration. If these changes were not implemented in a timely manner, charge masters and/or charge sheets might have incorrect codes listed. Internal auditors should review these areas to be sure all changes were made timely and accurately. Claims billed with improper codes may result in incorrect reimbursement.

Using the same audit sample, auditors should validate the following for each case (based on coding guidelines taken from AMA-CPT 2009 and unchanged since 2006):

- Only one “initial” service code [96360] may be reported per patient per day, unless protocol or circumstances require that two separate IV sites must be used.
 - On a rare occasion a patient can have two initial IV hydration procedures if, for example, the IV in left arm blows out or has complications and another IV is started in the right arm. Clear documentation of start and stop times are a must for both IV services. Notations as to the reason(s) for the failure of the first initial hydration must be stated in the record. Additional documentation must describe the second initial hydration procedure in other arm.
 - The time for the first initial hydration service must be indicated as 31+ minutes. If the initial hydration started at 9:00 and stopped at 9:30, the provider cannot bill for this service! The second initial hydration can be coded only if it goes beyond 31 minutes. If neither the first nor second initial hydration lasts longer than 31 minutes, neither one should be coded or billed.
 - If a second “initial” administration code is appropriate the code should be coded with modifier 59 appended.
- For all IV Hydrations, start and stop times must be documented for proper coding and/or billing .
- IV hydrations of 30 minutes or less are not reported. For hydration infusion intervals of greater than 30 minutes and beyond 1 hour increments, each additional hour is coded with 96361 No modifier is required.
- IV Hydration codes should only be billed with chemotherapy codes if the hydration is given before or after the chemotherapy (if chemotherapy is given simultaneously with an IV hydration, the provider should not bill for the IV hydration). Look at claims that contain a Chemotherapy CPT code together with an IV hydration code for documentation of start and stop times in the record.
- IV Hydration codes should only be billed with Therapeutic Infusion codes if the hydrations are given before or after the therapeutic infusion (if both infusions given simultaneously, the provider should not bill for IV hydration). Look at claims that contain a Therapeutic Infusion CPT code together with an IV hydration code for documentation of start and stop times in the record.
- IV hydrations ARE NOT coded and/or reported with blood transfusion codes, regardless of when the IV hydration is administered.

Charge Process Audit

The audit sample should be further reviewed in collaboration with charge entries on the claims to assure that there is no duplication of charges from improper coding of services (i.e. duplication of codes on one claim). If this is occurring, the provider should review its charging processes to assure that IV hydration charges aren’t being captured on the floor (e.g. by the charge nurse) followed by retrospective capture by the medical record coder resulting in double billing of the same service.

Internal audits can provide excellent insight into a facility's and/or physician's practices, drawing attention to those errors of concern that can be successfully addressed prior to external corrective action. Again, this can be achieved by first thoroughly examining the medical record documentation used to code, followed by validating whether coding guidelines are being followed, and finally comparing coding summaries and charge entries to avoid double billing. This proactive approach allows for potential liabilities to be determined and corrected; additional education to be provided where needed; revisions of policies and procedures to be made where necessary; overpayment to be returned with supporting documentation and explanation for the refund; appeals to be submitted for facility underpayment (if found within 30 days of discharge) or in response to RAC demand letters with supporting documentation and explanation.

References:

American Medical Association. 2009. *Current Procedural Terminology*, 2009 edition. Chicago: AMA
Ingenix. 2008. *Recovery Audit Contractor Audit High Risk Areas*. USA