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Certified Hematology & Oncology Coder

STUDY GUIDE

2026

2026

Specialty Study Guide: CHONC™

HEMATOLOGY AND ONCOLOGY

AAPC

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2026 Specialty Study Guide: CHONC™ Introduction

The *Study Guide: CHONC™* is designed to help hematology and oncology coders, billers, and other medical office professionals prepare for the CHONC™ examination. This guide is by no means comprehensive. Your primary resource for the exam will be your years of hands-on experience in coding for hematology and oncology.

Healthcare in the 21st century is complex and requires expertise in proper coding to obtain payment for procedures, services, equipment, and supplies. Becoming a CHONC™ shows your expertise in hematology and oncology coding. Membership in AAPC lends integrity to your credentials, provides a large network of coders for support, and allows you access to continuing education opportunities. The *Study Guide: CHONC™* provides an overall review of coding and compliance information for the more experienced coder, as well as for someone preparing for the CHONC™ examination.

We will review the importance of using the coding guidelines in ICD-10-CM and CPT® as well as emphasize the importance of correct evaluation and management (E/M) leveling. You will need 2026 versions of ICD- 10-CM, CPT®, and HCPCS Level II code books. These are the books you will need for the study guide and the CHONC™ exam.

ICD- 10-CM Coding

Proper diagnostic coding not only reports the medical necessity of procedures performed, but also contributes to data that determines health policies for tomorrow. Because physicians have traditionally been paid by CPT® code values, coders have sometimes given little importance to correct ICD-10-CM coding. Regulatory trends show that diagnoses will play a larger role in future reimbursement. It is important to code correctly now, so that you can be prepared for that day.

We will discuss the major topics of diagnosis coding for hematology and oncology. The examinee must become familiar with the ICD-10-CM Official Coding Guidelines for Coding and Reporting and must know how to select the appropriate ICD-10-CM codes; as well as the proper sequencing of diagnosis codes when more than one diagnosis code is required to report a patient's condition(s). This year's guidelines can be found at https://www.cms.gov/files/document/fy-2026-icd-10-cm-coding-guidelines.pdf. The examinee must understand the conventions, general coding guidelines, and chapter specific guidelines in the ICD-10-CM code book.

Evaluation and Management Coding

Office visits consume a lion's share of the physician's time in most practices, and consequently represent the largest revenue source. Compliance is an increasing concern at practices, and the E/M material will focus on the E/M services for hematology and oncology and underscore the importance of modifier use. An understanding of the E/M guidelines and subsection notes is an important foundation for accurate code selection. The AMA E/M guidelines are provided in your CPT® codebook.

An E/M calculator is provided for the online exam (https://www.aapc.com/codes/em-calculator) and your CPT® code book provides a Medical Decision Making (MDM) table to level an E/M service.

CPT® Coding

Surgical procedures specific to hematology and oncology will be discussed in this section. Special attention will be given to the guidelines and parenthetical phrases associated with procedures. Understanding CPT® coding conventions will be helpful as well. The examinee must be able to select the appropriate CPT® codes and sequence the codes correctly when multiple procedures are performed. CPT® codes are sequenced based on the most complex or labor-intensive procedures. The codes with the highest RVUs (Relative Value Units) are sequenced first.

Top 10 Missed Coding Concepts

We will review the Top Ten Missed Coding Concepts for the CHONC™ certification exam. The list is not presented in any specific order. The information is determined after an evaluation by the AAPC exam department of the commonly missed questions on the exam.

Practice Exam

The practice exam and the exam itself were written by coders with extensive experience in hematology and oncology. The practice exam mimics the format and structure of the CHONC™ certification exam.

AAPC has developed specialty credentials to enable coders to demonstrate superior levels of expertise in their respective

specialty disciplines. Here is information on the CHONC™ credential:

- CHONC™ stands alone as a certification with no prerequisite that the examinee holds a CPC® or COC® credential.
- Exams aptly measure preparedness for "real world" coding by being entirely operative/physician-note based. These operative (op) notes are redacted op notes from real hematology and oncology practices.

The CHONC™ examination tests your knowledge of coding concepts, anatomic principles, and coding guidelines only. When you take the exam, remember that individual payer rules are not a consideration when choosing the right answer. Unless it is specifically stated in the case note or exam question that Medicare covers the patient, you should follow the CPT® coding guidelines.

The exam tests competency. The candidate most qualified to pass the exam will be proficient in understanding:

- Medical terminology and anatomy
- Medical physiology
- Teaching physician guidelines
- Incident-to guidelines
- Split/Shared services
- HIPAA regulations
- Proper use of the Advance Beneficiary Notice (ABN)
- CMS drug wastage policy
- Clinical trial services
- ICD-10-CM coding
- E/M code selection using the AMA CPT® E/M guidelines
- CPT® coding for common procedures
  - 30000 Series
  - Laboratory and Pathology
  - Radiology
  - Medicine
  - Category III codes
- CPT® and HCPCS Level II modifier usage
- HCPCS Level II coding

Familiarity with practical coding and the code books is essential, as time is an important element in successfully completing the exam. Approach the exam as you would approach your work—by demonstrating coding abilities essential to success. This is not a general aptitude test, and each question has a specific goal for measuring your competency. The practice exam in the *Specialty Study Guide: CHONC™* course is highly representative of the subject matter and level of difficulty you will encounter in the full-length exam.

Test Answers and Rationales

The final chapter in the book contains the answers to the practice exam. Accompanying each answer is a rationale that explains the coding guidelines contributing to selecting the right answer. These rationales should help you understand what is needed to successfully approach and answer questions on the real exam, because they allow you a glimpse into the minds of the test's creators.

Examinees passing the CHONC™ certification examinations will receive recognition in AAPC's monthly magazine, *Healthcare Business Monthly* and receive a diploma suitable for framing.

About AAPC

AAPC was founded in 1988 in an effort to elevate the standards of medical coding by providing training, certification, ongoing education, networking, and recognition.

AAPC provides medical coding certification exams for coders in physician practices and the outpatient/facility environment. Listen carefully while the proctor reads the instructions. Ask questions before the examination begins if you do not understand the instructions given. The purpose of AAPC coding certifications is to test an examinee's knowledge of coding principles and proficiency in coding accurately and efficiently. AAPC examinations measure a coder's skill of both coding accuracy and efficiency.

AAPC Member Code of Ethics

Members of AAPC shall be dedicated to providing the highest standard of professional service for the betterment of healthcare to employers, clients, vendors, and patients. Professional and personal behavior of AAPC members must be exemplary.

It shall be the responsibility of every AAPC member, as a condition of continued membership, to conduct themselves in all professional activities in a manner consistent with ALL of the following ethical principles of professional conduct:

- Integrity
- Respect
- Commitment
- Competence
- Fairness
- Responsibility

Adherence to these ethical standards assists in assuring public confidence in the integrity and professionalism of AAPC members. Failure to conform professional conduct to these ethical standards, as determined by AAPC's Ethics Committee, may result in the loss of membership with AAPC.

Introduction to ICD-10-CM Coding Guidelines

The National Center for Health Statistics (NCHS) developed ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification) in consultation with a technical advisory panel, physician groups, and clinical coders to assure clinical accuracy and utility. ICD-10-CM coding guidelines are developed by the Centers for Medicare & Medicaid Services (CMS) and the National Center for Health Statistics. Healthcare providers must begin using the most recent ICD-10-CM code revisions on Oct. 1 of each year, with no "grace period" to transition to the changes.

All versions of the ICD-10-CM code book typically include the ICD-10-CM Official Guidelines for Coding and Reporting. These guidelines are an invaluable source for diagnosis coding information and provide instruction supplemental to that found in the Tabular List and the Alphabetic Index of the ICD-10-CM code book.

ICD-10-CM codes utilized to facilitate payment of health services, to evaluate utilization patterns, and to study the appropriateness of healthcare costs. Case-by-case success in achieving these goals requires an open line of communication between the coder and the documenting physician.

The Official Guidelines note, "A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures." Each ICD-10-CM code assigned must be supported by documentation linked to that particular claim (individual dates of service must stand alone), and coders must be mindful not to assume or extrapolate information from the medical record (for instance, coding a condition as "acute" when it isn't documented as such).

The Official Guidelines are divided into four sections:

- Section I lists ICD-10-CM Conventions, General Coding Guidelines, and Chapter Specific Guidelines.
- Section II explains the Selection of Principal Diagnosis. The Uniform Hospital Discharge Data Set (UHDDS) defines the principal diagnosis as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."
- Section III gives rules for Reporting Additional Diagnoses (diagnoses, in addition to the principal diagnosis, that affect the patient's care).
- Section IV provides Diagnostic Coding and Reporting Guidelines for Outpatient Services. These include information about coding signs and symptoms, when to report chronic diagnoses, ambulatory surgery, routine outpatient prenatal visits, and more.

General Tips for Using ICD-10-CM

Use the Alphabetic Index and Tabular List of the ICD-10-CM code book together to determine the diagnosis code. When attempting to select an ICD-10-CM diagnosis code, begin by searching for the main term—such as lesion, burn, etc. —in the Alphabetic Index. Follow all cross-references and "see also" entries. When you have located the code you are seeking, turn to that code in the Tabular List. Be sure to pay close attention to disease definitions, footnotes, color-coded prompts, and other instructions. Read all supplemental information completely to be certain you are choosing the correct code. Always select a diagnosis to the highest level of specificity supported by the available documentation.

The first-listed diagnosis should describe the most significant reason for the procedure or visit. Generally speaking, the first-listed diagnosis will be reflective of the patient's chief complaint. Relevant co-existing diseases and conditions, as well as related history or family history conditions, are reported as secondary diagnoses. When coding preexisting conditions, make sure the assigned diagnosis code identifies the current reason for medical management. Do not report conditions that no longer exist, or do not pertain to the visit.

Many patients will have numerous chronic complaints. Report a chronic complaint diagnosis only when that chronic condition is treated or becomes an active factor in the patient's care.

Always select ICD-10-CM codes to the highest level of specificity supported by documentation. For example, diagnosis coding for fractures of the wrist and hand requires a 5th code character (which specifies location), a 6th code character (which specifies the laterality and whether the fracture is displaced or nondisplaced), and a 7th code character (which specifies the episode of care). If this information is not documented, appropriate code selection is impossible. You should work with your provider to ensure that the information necessary for proper coding is always noted.

Diagnostic Coding in Hematology and Oncology

The goal of this chapter is to review diagnosis codes for hematology and oncology. It is important to select the correct diagnosis codes for many reasons. The diagnosis codes inform payers of the reason for the services provided to our patients. Payment determination often depends on medical necessity, which is supported by the diagnosis that is documented in the medical record and reported on the claim form. Failure to report the correct diagnosis can lead to claim denials.

If diagnoses are reported incorrectly, the patient's ability to obtain insurance coverage in the future may be affected. For example, reporting a code for breast cancer when a patient has a lump in her breast that has not been clinically confirmed as cancer.

Merkel Cell Carcinoma

Merkel Cell Carcinoma (MCC) is a rare and aggressive form of skin tumor. MCC is classified as a neuroendocrine tumor because it begins in the neuroendocrine cells called Merkel cells. When stimulated by the nervous system they release hormones into the blood stream and play a role in skin sensitivity.

MCC is most commonly seen in older people who have had significant sun exposure, and the most common site for MCC is the head and neck. The American Academy of Dermatology (AAD) requested codes specific to MCC, which has been reported with the codes used for common skin cancers like basal cell or squamous cell carcinomas. Because MCC is more aggressive than these forms of skin cancer, it was argued MCC should be tracked separately. In the United States, 1,500 new cases of MCC are reported every year; triple the incidence of MCC occurring 20 years ago. The prognosis for recovery depends upon the stage of the cancer when it is discovered and treated. Overall, the five-year survival rate for MCC is 64 percent, making it more lethal than melanoma.

Neuroendocrine Tumors

Merkel cell tumors are among many different kinds of neuroendocrine tumors. Neuroendocrine tumors have their genesis in the endocrine and neuroendocrine cells found throughout the body. These tumors are biologically different from adenocarcinomas and benign tumors and are significant in that they may alter the flow of hormones from the endocrine gland affected, creating complications that may be life-threatening or the first evidence of disease. M.D. Anderson Cancer Center requested that codes for secondary neuroendocrine tumors be added to the classification to allow for reporting of metastatic spread of the hormone-producing tumor to sites distant from the primary site. Report any functional activity—typically a clinically significant release of hormone—secondarily.

Retina and Choroid Neoplasms

Physicians sometimes monitor suspicious dark spots or freckles on the retina or choroid, suspecting a retinal or choroidal melanoma that may be primary or secondary. Because it is difficult and risky to biopsy the retina, these areas are monitored to determine any changes.

Tumor Lysis Syndrome

Code E88.3 is for tumor lysis syndrome, which describes a group of metabolic complications that may occur after cancer therapy, caused by a breakdown of products of dying cancer cells. It most commonly occurs in treatments of leukemias or lymphomas but can occur with other cancers like melanomas. Complications can include hyperkalemia, hypouricemia, hypocalcemia, and acute renal. When reporting tumor lysis syndrome, use a code to identify the complication and an additional external cause code to identify the antineoplastic drug that caused the reaction if appropriate. The drug is usually the chemotherapeutic agent, but this syndrome has been known to occur with steroid treatment, and occasionally, spontaneously.

Autoimmune Lymphoproliferative Syndrome (ALPS)

ALPS is a very rare disease caused by a genetic defect causing a proliferation of lymphocytes in body tissue. Typically, it is first diagnosed in childhood. In ALPS, lymphocytes persist in the spleen and lymphatic nodes, and immune cells attack the body's own tissue. The liver, spleen, and lymph nodes become enlarged, and anemia, thrombocytopenia, and neutropenia may result. Treatment may include splenectomy, steroid, or cyclosporine treatment and blood transfusions. Presence of ALPS increases a patient's lifelong risk of lymphoma.

Antineoplastic Chemotherapy Induced Anemia

There is a code specific to anemia caused by antineoplastic chemotherapy. Anemia is one of the most common side effects of antineoplastic chemotherapy, as this treatment can inhibit production of bone marrow and reduce the supply of red blood cells. Up to 60 percent of patients undergoing chemotherapy experience anemia, which can cause fatigue and an inability to perform or enjoy work or leisure activities. The MD Anderson Cancer Center requested a code specific to antineoplastic chemotherapy induced anemia. Previously, D61.1 *Drug-induced aplastic anemia* or D64.9 *Anemia, unspecified* were reported with T45.1X5- *Adverse effect of antineoplastic and immunosuppressive drugs* to report anemia secondary to

Evaluation and Management Coding for Hematology and Oncology

This chapter examines the documentation requirements for the evaluation and management (E/M) codes used by physicians and non-physician practitioners (NPPs) to bill for their services.

The E/M documentation requirements chapter is designed to provide a detailed approach to the accurate identification of documentation elements as they are defined by the American Medical Association (AMA) Guidelines for E/M services. The goal of this material is to offer the necessary insight to develop proficiency and correct technique to accurately select levels of E/M services for the exam. This material is not meant to influence policy, rather to refer to as coding guidelines for the CHONC™ exam.

This chapter should be reviewed with the CPT® guidelines for E/M services found in the current CPT® code book. This guide is a general summary that explains commonly accepted aspects of selecting E/M codes. The goal is that, after completing your training, you will be confident that you will not under or over code a visit.

An Introduction to the Documentation Requirements Associated with E/M Services

The E/M Documentation Guidelines (DGs) have perhaps inspired more discussion than any other non-clinical topic based in the industry. In an ever-increasing effort to ensure that correct payments are made for visits and consultations, Medicare and the AMA have been working together for well over a decade. In 1992, Medicare transitioned to the Resource-Based Relative Value Scale (RBRVS) physician payment system and the AMA introduced E/M codes in CPT® to report visits and consultations.

By 1994, in response to confusion and the inaccurate interpretation of the codes, the Office of Management and Budget mandated that Medicare adopt DGs to expand the definition that was, at that time, only provided by CPT®. Medicare and the AMA jointly developed this initial set of E/M DGs which were deployed in 1995 and became known as the 1995 Documentation Guidelines or DGs. As auditing showed a pattern of continued misuse of the E/M Codes, the 1995 DGs were criticized as unfair to specialists because they seem to account for extended single system examinations with as much weight as limited multiple system exams.

Within two years, the E/M DGs were revised to improve physician and provider understanding and payment accuracy by extending the definitions to include specialty specific guidance. This set of DGs was scheduled to replace the 1995 DGs and became known as the 1997 DGs. The only problem was that the physician community loudly objected to the 1997 DGs. They were criticized as burdensome with documentation requirements that were too detailed and very difficult to achieve. Medicare decided to not replace the 1995 DGs but to instead allow physicians and providers to choose between the 1995 and the 1997 DGs.

In 2021, in an attempt to simplify the guidelines, the AMA changed the descriptions of the Office or Other Outpatient E/M Services codes 99202-99215. In addition, guidelines for the use of these codes were printed in the CPT® code book. The guidelines added in the 2021 CPT® code book were specific to Office or Other Outpatient E/M Services. In 2023, the AMA expanded the use of the guidelines introduced in 2021 to other E/M categories, eliminating the need for the 1995 and 1997 DGs.

Documentation Guidelines

There are three general principles regarding documentation to ensure credit can be thoroughly verified. It is important to follow these rules of thumb:

1. Documentation should be legible to someone other than the documenting physician or provider and their staff.
2. The date of service, name of the patient, and the name of the provider of service should be easily demonstrated by the documentation.
3. The documentation should support the nature of the visit and the medical necessity of the services rendered.

For most E/M visits, the provider performs three main components: history, exam, and medical decision making (MDM). The history directs the provider to troubleshoot the chief complaint based on an interview with the patient. The exam portion is the provider's physical exam and evaluation of the patient. The MDM includes the provider's assessment and plan.

The guidelines for E/M Services, along with the code descriptors, indicate that a "medically appropriate history and/or physical examination, when performed" is included in the service. While the history and exam should be documented, they are not used in the determination of the level of the code.

The guidelines also include pertinent definitions for terms necessary to understand when determining the level of MDM. You should read through the definitions provided in your CPT® code book and refer back to them as we go through the MDM components below.

The E/M guidelines provide instructions for selecting the appropriate level of service based on either of the following:

1. The level of the MDM as defined for each service; or
2. The total time for E/M services performed on the date of the encounter.

The provider can determine to support the E/M level of the visit based on MDM or time on a case-by-case basis. Regardless of which element is used to determine the level of visit, documentation should support the medical necessity of the visit. Payers may also have regulations on when MDM or total time is used.

Determining the Medical Decision Making (MDM)

The MDM most accurately reflects the amount of work a provider performs during an E/M service. Four levels of MDM are recognized: straightforward, low, moderate, and high. The level of MDM directly correlates to a level of service.

EXAMPLE: OFFICE VISIT MDM TO CODE CORRELATION

New Patient Code	Established Patient Code	Level of MDM
	99211	N/A 99211 is reported for services that typically do not require the presence of a provider. As such, the concept of MDM does not apply to code 99211.
99202	99212	Straightforward
99203	99213	Low
99204	99214	Moderate
99205	99215	High

To adequately determine the level of visit, the MDM is selected based on three components:

1. The number and complexity of problems addressed at the encounter;
2. The amount and complexity of data to be reviewed and analyzed; and
3. The risk of complications and/or morbidity or mortality of patient management.

To determine the levels of these components appropriately, the definitions provided in your CPT® code book must be understood. Using a grid method, we will discuss each component. Be sure to refer back to the definitions listed in the E/M Guidelines as needed.

Number and Complexity of Problems

The number and complexity of problems identifies the nature of the presenting problem and is based on the relative difficulty level in making a diagnosis. For the problem to be considered in the number of problems, the problem must be addressed within that encounter.

Per CPT®, symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Multiple problems of lower severity may, in aggregate, create higher risk due to interaction.

The final diagnosis alone does not determine the complexity or risk to the patient. The documentation should be reviewed for comorbidities or underlying diseases that are addressed that increase the level of risk to the patient. Simply listing a chronic illness in the documentation is not sufficient. The documentation should indicate that the provider addressed the conditions during the encounter or that the condition contributed to the severity of the case.

When a patient sees multiple providers for different aspects of their care, you may see a physician document the condition is being managed by another provider. When the documentation only states that the patient has the condition and that it is being treated by another provider, it is not considered for the leveling of the visit. If there is additional documentation showing assessment or care coordination regarding that diagnosis, other than the statement of the condition being treated by another provider, it is then considered toward the level of service.

TESTING TECHNIQUE

Read through the entire note to get an understanding of the conditions that are addressed and analyzed during the visit. Simply relying on the chief complaint will not always give an accurate description of the number and complexity of problems for the encounter.

There are four levels identified under the number and complexity of problems addressed; minimal, low, moderate, and high. As demonstrated by the table below, the level of Number/Complexity of Problems Addressed increases as the difficulty of the patient's health increases.

CPT® Coding for Hematology and Oncology

Introduction

Procedures commonly performed in hematology and oncology practices will be discussed in this chapter. The CPT® coding guidelines are covered as well as the HCPCS Level II codes and modifiers.

Bone Marrow Procedures

Bone marrow has a fluid part and a solid part. In a bone marrow aspiration, an injection is made to withdraw the fluid part of the bone marrow. In a bone marrow biopsy, a needle is used to withdraw the solid part of the bone marrow. The procedures are performed on the posterior iliac crest or the sternum. Both procedures allow providers to diagnose and monitor blood and bone diseases such as cancer.

The following codes are used to report these procedures.

38220 Diagnostic bone marrow; aspiration

38221 Diagnostic bone marrow; biopsy

The provider must document a procedure note that includes the description of the procedure. This will include the anatomical site of the procedure, the preparation of the surgical site, the instruments used, the sample that is obtained and the dressing applied to the site following the procedure.

When a bone marrow aspiration and biopsy are performed during the same surgical encounter, code selection is determined by the sites of the procedure. When a bone aspiration and bone marrow biopsy are performed on the same site through the same skin incision report 38222. If the procedures are performed on separate sites or through separate incisions, both services are reported with 38221, 38220-59. Modifier 59 is appended to report that a distinct service was performed.

Both procedures are minor procedures that have 0 global days. When performed during a significant and separately identifiable E/M service, modifier 25 is appended to the E/M code.

Hydration, Injections, Infusions, and Chemotherapy Administration

Codes for hydration, injections, infusions, and chemotherapy are determined based on route and time. The actual time the infusion is administered must be documented. CPT® defines an intravenous or intra-arterial push as "(a) an injection in which the healthcare professional who administered the substance/drug is continuously present to administer the injection and observe the patient, or (b) an infusion of 15 minutes or less."

The following services are included when performed to facilitate an injection or an infusion service:

- Use of local anesthesia
- Starting the IV
- Access to indwelling IV, subcutaneous catheter or port
- Flush at conclusion of infusion
- Standard supplies

Multiple Drug Administrations

When multiple drug administrations are performed during the same encounter, only one service is reported as the "initial" service. Selecting the correct initial code will depend on whether you are coding for a physician or a facility. More than one initial code can only be selected if the protocol requires that two separate IV sites be used.

When coding for a physician, the initial code is selected to describe the primary reason for the encounter, not the order in which the medications are administered. For example, if a patient presents for IV chemotherapy and prior to the chemotherapy an antihistamine is administered, select the IV chemotherapy code as the initial service and the administration of the antihistamine as a sequential service.

The codes reported by a facility are determined by a hierarchy. The hierarchy for facilities supersedes the parenthetical instructions for the CPT® codes. Report the services in the following order when coding for a facility:

1. Chemotherapy administration
2. Therapeutic, prophylactic, and diagnostic services
3. Hydration services

When different routes of administration are performed, the hierarchy is as follows:

1. Infusions
2. Intravenous or intra-arterial pushes
3. Injections

For example, if a patient presents for chemotherapy and hydration, code the chemotherapy as the initial service followed by the code for hydration.

Hydration

Hydration codes are reported when pre-packaged fluids and electrolytes are infused. Examples include normal saline and D5-1/2 normal saline+30mEq KCL/liter. When saline is used to administer a medication, a hydration code is not reported, and neither is the supply. According to CPT®, "when fluids are used to administer drug(s), the administration of the fluid is considered incidental hydration and is not separately reported."

Hydration codes are not reported by physicians when the service is performed in a facility setting. There are two codes for hydration services which are selected based on infusion time.

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

96361 Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)

There are important parenthetical notes associated with these codes in the CPT® code book. Hydration services that are 30 minutes or less are not reported. Code 96360 should not be coded if hydration is performed as a concurrent infusion service. Although an administration is not reported, select the appropriate HCPCS Level II code to report the substance administered.

CODING EXAMPLE

The patient is severely dehydrated. Hydration is performed for one hour and 15 minutes. The correct code is 96360 to report the first hour. The additional 15 minutes is not reported because a minimum of 31 minutes beyond the first hour is required to report 96361.

Therapeutic, Prophylactic, and Diagnostic Injections and Infusions

This category of codes is used for the administration of drugs and substances that are not chemotherapy drugs or highly complex biologic agents. The codes are determined based on route and time. Infusion codes are also selected based on whether it is initial, sequential, or concurrent. There are important parenthetical notes associated with these codes in the CPT® code book.

These codes are not reported for the IV administration of contrast for radiology procedures. The contrast administration is included in the radiology service when you select the "with contrast" codes. Do not report these codes for a physician when the services are performed in a facility setting.

Codes 96365-96368 are reported for intravenous infusions. This type of infusion is administered by inserting an intravenous catheter into a patient's vein or by injection or infusion through an existing port. Codes 96369-96371 are reported for subcutaneous infusions. This type of infusion is administered under the skin. The most common sites are the upper arm, shoulder, abdomen, and thigh. Codes 96372-96373 are reported for injections. The route of the injection determines the correct code. Intravenous push is reported with 96374 and 96375. Review the coding guidelines and all the parenthetical notes for the codes in this category.

When reporting add-on codes for each additional hour, an interval of greater than 30 minutes is required beyond one-hour increments. The codes include:

96366 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)

96370 Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)

Coding Example

A patient receives 250 mg of Solu-Medrol by IV infusion over two hours. The correct codes are 96365 for the first hour, 96366 for the second hour, and two units of J2930 *Injection, methylprednisolone sodium succinate, up to 125 mg.*

Chemotherapy and Other Highly Complex Drugs or Biologic Agent Administration

These services are highly complex due to higher incidents of severe adverse reactions. The codes include the administration and the preparation of the drugs. When saline is used to administer chemotherapy, the hydration is incidental and is not reported separately. There are important parenthetical notes that pertain to these codes. Do not report the codes for a physician if the services are performed in a facility.

The codes in this section are determined based on route and time. Some codes are also determined based on the type of medication. An example is 96401 *Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic.*

Codes 96405–96406 are reported for intralesional chemotherapy administration. This procedure is performed

AAPC continuously evaluates and enhances our certification exams throughout the year. As AAPC continues to enhance the certification exams, we are beta testing the inclusion of a fill-in-the-blank item type on our certification exams. To prepare you for both item types (multiple choice and fill-in-the-blank), we have provided two versions of this practice exam. The same questions are on both versions of the Test Your Knowledge practice exam; however, the last three cases on this version of the practice exam are fill-in-the-blank. If you prefer to test using the multiple-choice item type for all the cases, use practice exam B.

The following questions will test your comprehension of the information covered in this study guide. The answer key is used for both versions of the Test Your Knowledge practice exams.

Version A

CASE 1

Date: November 14, 20XX

RE: Patient

DOB: 01/23/XX

Wt: 156

BP: 138/24

Pulse: 82

The patient presents today for her weekly injection of Aranesp. Dr. X ordered the Aranesp to treat the patient's anemia, which she developed as a result of her chemotherapy treatments for lymphoma. Patient states she feels well today. Dr. X ordered a CBC and ferritin every two weeks. Her next appointment is in two months.

Administered Aranesp 500 mcg SQ L Arm

Signed: BE, RN

The patient is covered by Medicare.

The following policy applies:

LCD Article A57628:
J0881 Erythropoiesis stimulating agents
J0881 ICD-10 Codes that Support Medical Necessity

Group 1 Paragraph: J0881 List 1

The diagnosis codes listed below require the use of the EC modifier (ESA administered to treat anemia not due to anti-cancer radiotherapy or anti-cancer chemotherapy) when submitting claims for J0881. In addition, diagnosis codes marked with an * require a dual diagnosis. The dual diagnosis rule is outlined below.

ICD-10

Codes Description

C88.00 Waldenstrom macroglobulinemia not having achieved remission

D46.0-D46.22 Refractory anemia without ring sideroblasts, so stated - Refractory anemia with excess of blasts 2

D46.A-D46.C Refractory cytopenia with multilineage dysplasia - Myelodysplastic syndrome with isolated del(5q) chromosomal abnormality

D46.4 Refractory anemia, unspecified

D46.Z Other myelodysplastic syndromes

D46.9 Myelodysplastic syndrome, unspecified

D47.0 Mast cell tumors of uncertain behavior

D47.3 Essential (hemorrhagic) thrombocythemia

D47.Z9 Histiocytic tumors of uncertain behavior

D63.1* Anemia in chronic kidney disease

I12.0* Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease

I13.11 -I13.2* Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease - Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease

N18.1 -N18.5* Chronic kidney disease, stage 1 - Chronic kidney disease, stage 5

N18.9* Chronic kidney disease, unspecified

Group 1 Medical Necessity ICD-10 Codes Asterisk Explanation: *Dual Diagnosis Rule:

Examples of dual diagnosis codes which include etiologic specificity, as well as, stage of ESRD are indicated by an *.

1) I12.0, I13.11, I13.2, N18.1, N18.2, N18.30, N18.31, N18.32, N18.4, N18.5, OR N18.9, AND D63.1 MUST BE BILLED TOGETHER.

Group 2 Paragraph: J0881 List 2

The following diagnosis codes require the use of the EA modifier (ESA administered to treat anemia due to anti-cancer chemotherapy) when submitting claims for J0881. In addition, ALL diagnosis codes listed below require a dual diagnosis. The dual diagnosis is outlined below.

Group 2 Codes:

C00.0 - C43.9 Malignant neoplasm of external upper lip - Malignant melanoma of skin, unspecified

C4A.0 - C4A.9 Merkel cell carcinoma of lip - Merkel cell carcinoma, unspecified

C44.00 -C49.9 Unspecified malignant neoplasm of skin of lip - Malignant neoplasm of connective and soft tissue, unspecified

C50.011 -C75.9 Malignant neoplasm of nipple and areola, right female breast - Malignant neoplasm of endocrine gland, unspecified

C7A.00 -C7B.8 Malignant carcinoid tumor of unspecified site - Other secondary neuroendocrine tumors

C76.0 - C79.9 Malignant neoplasm of head, face and neck - Secondary malignant neoplasm of unspecified site

After reviewing the answers and rationales, if you have further questions, please send them to: mct@aapc.com

CASE 1

Date: November 14, 20XX

RE: Patient

DOB: 01/23/XX

Wt: 156

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Administered Aranesp 500 mcg SQ L Arm

Signed: BE, RN

The patient is covered by Medicare.

The following policy applies:

LCD Article A57628:

J0881 Erythropoiesis stimulating agents

J0881 ICD-10 Codes that Support Medical Necessity

Group 1 Paragraph: J0881 List 1

The diagnosis codes listed below require the use of the EC modifier (ESA administered to treat anemia not due to anti-cancer radiotherapy or anti-cancer chemotherapy) when submitting claims for J0881. In addition, diagnosis codes marked with an * require a dual diagnosis. The dual diagnosis rule is outlined below.

ICD-10 Codes Description

C88.00-C88.01 Waldenstrom macroglobulinemia

D46.0 -D46.22 Refractory anemia without ring sideroblasts, so stated - Refractory anemia with excess of blasts 2

D46.A -D46.C Refractory cytopenia with multilineage dysplasia - Myelodysplastic syndrome with isolated del (5q) chromosomal abnormality

D46.4 Refractory anemia, unspecified

D46.Z Other myelodysplastic syndromes

D46.9 Myelodysplastic syndrome, unspecified

D47.0 Mast cell tumors of uncertain behavior

D47.3 Essential (hemorrhagic) thrombocythemia

D47.Z9 Histiocytic tumors of uncertain behavior

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I12.0* Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease

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Group 1 Medical Necessity ICD-10 Codes Asterisk Explanation: *Dual Diagnosis Rule:

Examples of dual diagnosis codes which include etiologic specificity, as well as, stage of ESRD are indicated by an*.

1) I12.0, I13.11, I13.2, N18.1, N18.2, N18.30, N18.31, N18.32, N18.4, N18.5, OR N18.9, AND D63.1 MUST BE BILLED TOGETHER.

Group 2 Paragraph: J0881 List 2

The following diagnosis codes require the use of the EA modifier (ESA administered to treat anemia due to anti-cancer chemotherapy) when submitting claims for J0881. In addition, ALL diagnosis codes listed below require a dual diagnosis. The dual diagnosis is outlined below.

Group 2 Codes:

C00.0 - C43.9 Malignant neoplasm of external upper lip - Malignant melanoma of skin, unspecified

C4A.0 - C4A.9 Merkel cell carcinoma of lip - Merkel cell carcinoma, unspecified

C44.00 -C49.9 Unspecified malignant neoplasm of skin of lip - Malignant neoplasm of connective and soft tissue, unspecified

C50.011 -C75.9 Malignant neoplasm of nipple and areola, right female breast - Malignant neoplasm of endocrine gland, unspecified

C7A.00 -C7B.8 Malignant carcinoid tumor of unspecified site - Other secondary neuroendocrine tumors

C76.0 - C79.9 Malignant neoplasm of head, face and neck - Secondary malignant neoplasm of unspecified site

C80.0 -C84.79 Disseminated malignant neoplasm, unspecified - Anaplastic large cell lymphoma, ALK-negative, extranodal and solid organ sites

C84.A0 -C84.Z9 Cutaneous T-cell lymphoma, unspecified, unspecified site - Other mature T/NK-cell lymphomas, extranodal and solid organ sites

C84.90 -C84.99 Mature T/NK-cell lymphomas, unspecified, unspecified site - Mature T/NK-cell lymphomas, unspecified, extranodal and solid organ sites

C85.10 -C86.61 Unspecified B-cell lymphoma, unspecified site - Primary cutaneous CD30-positive T-cell proliferations

C88.20 -C91.62 Heavy chain disease - Prolymphocytic leukemia of T-cell type, in relapse

C91.A0 -C91.Z2 Mature B-cell leukemia Burkitt-type not having achieved remission - Other lymphoid leukemia, in relapse

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