CMS Manual System

Pub. 100-20 One-Time Notification

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 129 **Date: DECEMBER 10, 2004**

CHANGE REQUEST 3631

SUBJECT: 2005 Drug Administration Coding Revisions

I. SUMMARY OF CHANGES: This one time notification provides clarification on the 2005 drug administration coding revisions. In the final physician fee schedule rule published in the **Federal Register** on November 15, 2004, we announced that we would adopt G-codes for 2005 that correspond to the new CPT drug administration codes that will become effective in 2006. The new G-codes are interim until 2006. While we are adopting the G-codes, we are also adopting, in 2005, the CPT coding rules that will not officially appear until the CPT 2006 is published.

The CPT drug administration codes approved by the CPT Editorial Panel are grouped into three categories of codes: hydration (i.e., codes G0345 and G0346); therapeutic or diagnostic injections and intravenous infusions other than hydration (i.e., codes G0347 to G0354 and CPT codes 90783, 90788); and chemotherapy administration (i.e., codes G0355 to G0363, CPT codes 96405-96406, 96420 to 96520, and 96530 to 96549). The allowances for these codes reflect the application of the 2005 transitional payment adjustment of 3%, which by law is applicable only to drug administration codes.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: January 1, 2005
IMPLEMENTATION DATE: January 17, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

	Business Requirements
	Manual Instruction
	Confidential Requirements
X	**One-Time Notification**
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 129	Date: December 10, 2004	Change Request 3631

SUBJECT: 2005 Drug Administration Coding Revisions

I. GENERAL INFORMATION

A. Background: Section 1848(c)(2)(J) of the Social Security Act (as added by section 303(a) of the Medicare Modernization Act) requires the Secretary to promptly evaluate existing drug administration codes for physicians' services to ensure accurate reporting and billing for those services, taking into account levels of complexity of the administration and resource consumption. The law further provides that the Secretary shall use existing processes for the consideration of coding changes and, to the extent changes are made, shall use those processes to establish values for those services.

The AMA's CPT Editorial Panel established a workgroup, with representatives from affected specialties, that met earlier this year to develop recommendations on drug administration coding. The workgroup presented its recommendations to the CPT Editorial Panel in August. Based on these recommendations, that panel adopted several new drug administration codes and revised several existing codes. Subsequently, the AMA's Relative Value Update Committee (RUC) met at the end of September to make recommendations to CMS on the practice expense resource inputs and work relative values for the new and revised drug administration codes.

The 2005 CPT had already been published prior to the adoption of the new and revised drug administration codes. The new and revised drug administration codes and the CPT coding rules, applicable to them, will appear in the 2006 CPT.

In the physician fee schedule final rule published in the **Federal Register** on November 15, 2004, we announced that we would adopt G-codes for 2005 that correspond to the new CPT codes that will become active in 2006. These new G codes are interim until 2006. While we are adopting the G-codes, we also generally are adopting, in 2005, the CPT coding rules for the new drug administration codes in their current form that will not officially appear until the CPT 2006 is published.

B. Policy: The new G-codes we established in the Federal Register parallel the drug administration codes approved by the CPT Editorial Panel in August. They are effective for services provided on or after January 1, 2005, and before January 1, 2006 and to be used by billers where the carrier pays for these services under the Medicare physician fee schedule.

The CPT drug administration codes approved by the CPT Editorial Panel are grouped into three categories: hydration; therapeutic or diagnostic injections and intravenous (IV) infusions (other than hydration); and chemotherapy administration. The new codes provide for expanded use of the chemotherapy codes. Currently, Medicare allows chemotherapy administration codes to be used only for reporting chemotherapy administration when the drug being used is an anti-neoplastic and the diagnosis is cancer (see Pub. 100-04, Medicare Claims Processing Manual, chapter 12, section 30.5 at http://www.cms.hhs.gov/manuals/104_claims/clm104c12.pdf).

Under the new codes, chemotherapy administration codes apply to parenteral administration of non-radionuclide anti-neoplastic drugs and also to anti-neoplastic agents provided for the treatment of noncancer diagnoses (e.g., cyclophosphamide for autoimmune conditions), or to substances such as monoclonal antibody agents and other biologic response modifiers.

Another important change pertains to the creation of new codes to identify additional sequential infusions. Current CPT codes do not separately identify additional sequential infusions apart from additional hours of infusion. Consistent with the new codes adopted by the CPT Editorial Panel, we implemented new G codes to separately identify additional sequential infusions. There are also new codes to identify additional nonchemotherapy sequential intravenous pushes and intravenous chemotherapy pushes for additional drugs.

"Subsequent" drug administration codes, or codes that state the code is listed separately in addition to the code for the primary procedure, should be used to report these secondary codes. When administering multiple infusions, injections or combinations, only one "initial" drug administration service code should be reported per patient per day, unless protocol requires that two separate IV sites must be utilized. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported. The initial code is the code that best describes the service the patient is receiving and the additional codes are secondary to the initial code.

If the patient has to come back for a separately identifiable service on the same day, or has 2 IV lines per protocol, these services are separately payable and reported with modifier 76.

The new drug administration G-codes and their descriptors for 2005 are described below. The allowances for these codes reflect the application of the 2005 transitional payment adjustment of 3 percent, which, by law (MMA section 303(a)(4)), is applicable only to drug administration codes.

New G-Codes for Hydration Services

For services furnished prior to January 1, 2005, CPT did not include distinct codes for hydration infusion services. Infusions involving hydration or nonchemotherapy drugs were billed using CPT codes 90780 and 90781. For services furnished in 2005, CPT codes 90780 and 90781 will not be recognized under the Medicare physician fee schedule. The following new G-codes should be used instead: codes G0345, "*Intravenous infusion, hydration; initial, up to one hour*"; and G0346, "*Intravenous infusion, hydration; each additional hour, up to eight (8) hours (List separately in addition to code for procedure*").

Codes G0345 and G0346 are intended to report a hydration IV infusion to consist of a prepackaged fluid and/or electrolyte solutions (e.g., normal saline, D5-1/2 normal saline +30mEq KC1/liter), but are not used to report infusion of drugs or other substances. Hydration IV infusion typically requires direct physician supervision for purposes of consent, safety oversight or intra-service supervision of staff. Typically such infusions require little special handling to prepare or dispose of, and staff which administer these do not typically require advanced training. After initial set up, infusion typically entails little patient risk and thus little monitoring.

Report G0346 for hydration infusions of greater than 30 minutes beyond 1 hour increments, or hydration greater than 30 minutes provided as a secondary or sequential service after a different initial infusion or chemotherapy service is provided.

The current policy in section 30.5 C of chapter 12 of Pub.100-04 that permits separate payment of hydration therapy provided sequentially (but not concurrently) to the chemotherapy infusion applies to services furnished in 2005. We intend to seek public input on this policy.

New G-Codes for Nonchemotherapy Therapeutic or Diagnostic Injections and IV Infusions (other than Hydration)

IV Infusions

For services furnished prior to January 1, 2005, chemotherapy administration codes could only be used when the drug being administered was an anti-neoplastic and the diagnosis was cancer. Nonchemotherapy infusions were billed using codes 90780 and 90781. As described above, however, the new drug administration codes approved by the CPT Editorial Panel incorporate an expanded definition of chemotherapy drugs.

For services furnished in 2005, nonchemotherapy infusions for therapy or diagnosis are reported using new G-codes: G0347, "*Intravenous infusion, for therapy/diagnosis (specify substance or drug); initial, up to one hour*"; and G0348, "*Intravenous infusion, for therapy diagnosis (specify substance or drug); each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)*".

G0348 is used to report additional hour(s), beyond the first hour, of sequential infusion as well as the second and subsequent hours of the initial drug. Report G0348 for infusion intervals of greater than 30 minutes beyond 1 hour increments.

Also, prior to January 1, 2005, there were not distinct codes to report concurrent and/or sequential nonchemotherapy infusions involving a different drug. For 2005, there are new G codes that distinctly describe these services: G0349, "*Intravenous infusion, for therapy/diagnosis (specify substance or drug); additional sequential infusion, up to one hour (List separately in addition to code for primary procedure*)"**,** used to report the first hour of a sequential infusion of a second nonchemotherapy drug; and G0350, "*Intravenous infusion, for therapy/diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure) (report only once per substance/drug, regardless of duration)*".

If a significant separately identifiable evaluation and management (E & M) service is performed, the appropriate E & M service code should be reported utilizing modifier 25 in addition to codes G0347-G0354. For an E & M service provided on the same day, a different diagnosis is not required.

If performed to facilitate a therapeutic/diagnostic infusion or injection, the following are included and are not reported separately:

- Use of local anesthesia
- IV start

- Access to indwelling IV, subcutaneous catheter or port
- Flush at conclusion of infusion, and
- Standard tubing, syringes and supplies.

Intravenous or intra-arterial push is defined as an injection/infusion of short duration (i.e., 30 minutes or less) in which the healthcare professional who administers the substance/drug is continuously present to administer the injection and observe the patient.

Nonchemotherapy Injections

Current CPT codes 90782-90788 are used for therapeutic, prophylactic, or diagnostic injections. After January 1, 2005, codes 90782 and 90784 will not be recognized under the Medicare physician fee schedule. CPT codes 90783 and 90788 remain in effect.

For 2005, 90782 is replaced by G0351, "*Therapeutic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular*". Code 90784, currently used for IV push of nonchemotherapy drugs, is replaced in 2005 by the following two codes that separately identify the initial and additional nonchemotherapy IV push: G0353, "*Therapeutic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug*"; and G0354, "*Therapeutic or diagnostic injection (specify substance or drug); each additional sequential intravenous push (List separately in addition to code for primary procedure)*".

For services furnished prior to 2005, codes 90782 to 90788 were only payable under the Medicare physician fee schedule if there were no other services billed on the same date by the same provider (status indicator "T"). Otherwise, these services were bundled into the other service(s) for which payment was made. For services furnished on or after January 1, 2005, services described by codes G0351, G0353, G0354, and CPT codes 90783 and 90788, may be paid in addition to other physician fee schedule services billed by the same provider on the same day of service (the status indicator of "T" is removed and replaced with the "A" status indicator). **Note**: Certain Medicare policies, including but not limited to, correct coding edits for the services described by codes G0351, G0353, G0354, and CPT codes 90783 and 90788 may apply.

Report G0351 for non-antineoplastic hormonal therapy injections. Report G0356 for anti-neoplastic hormonal injection therapy.

Use G0354 to report an intravenous push subsequent to another drug administration service, if appropriate.

Do not report G0345-G0354 with codes (including injections and intravenous chemotherapy, intra-arterial chemotherapy, and other chemotherapy) for which IV push or infusion is an inherent part of the primary procedure (e.g., administration of contrast material for a diagnostic imaging study).

New G-Codes for Chemotherapy Administration

As described previously, the definition of the codes to report chemotherapy has been expanded. For services furnished prior to January 1, 2005, chemotherapy was limited to the injection or infusion of an anti-neoplastic drug used to treat cancer patients.

For services furnished on or after January 1, 2005, chemotherapy administration codes apply to parenteral administration of nonradionuclide anti-neoplastic drugs and also to anti-neoplastic agents provided for the treatment of noncancer diagnoses (e.g., cyclophosphamide for auto-immune conditions) or to substances such as monoclonal antibody agents and other biologic response modifiers. Administration of anti-anemia drugs and anti-emetic drugs by injection or infusion for cancer patients is not considered chemotherapy administration. Such services are reported using codes from the range G0347 to G0354.

Currently, CPT has one code for subcutaneous or intramuscular chemotherapy administration, 96400. For services in 2005, there are new G-codes that uniquely describe the administration of hormonal and non-hormonal anti-neoplastics: G0355, "*Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic*", and G0356, "*Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic*". CPT code 96400 is not recognized under the Medicare physician fee schedule in 2005.

The following two CPT codes are still recognized for Medicare purposes in 2005: 96405, "*Chemotherapy administration, intralesional; up to and including 7 lesions*"; and 96406, "*Chemotherapy administration, intralesional; more than 7 lesions*". The expanded definition of chemotherapy as described above will apply to these codes beginning January 1, 2005.

Currently, CPT has one code for chemotherapy administration with IV push technique, 96408. For services in 2005, there are two new G-codes to report the initial push and additional pushes: G0357, "*Chemotherapy administration, intravenous; push technique, single or initial substance/drug*", and G0358, "*Chemotherapy administration, intravenous; push technique, each additional substance/drug (List separately in addition to code for primary procedure)"*. CPT code 96408 is not recognized under the Medicare physician fee schedule in 2005.

For services furnished prior to January 1, 2005, chemotherapy intravenous infusions (other than prolonged infusions, as discussed below) were billed using CPT code 96410 for the first hour and code 96412 for each additional hour. There was not a distinct code to report a sequential chemotherapy infusion involving a different drug. For services furnished in 2005, chemotherapy intravenous infusions are reported using the following new G-codes, which include a separate code for additional drugs infused: G0359, "*Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug*"; G0360, "*Chemotherapy administration, intravenous infusion technique, each additional hour, one to eight (8) hours (List separately in addition to code for primary procedure)*"; and G0362, "*Chemotherapy administration, intravenous infusion technique; each additional sequential infusion, (different substance/drug) up to one hour (List separately in addition to code for primary procedure*.

Prolonged chemotherapy infusions requiring the use of a portable or implantable pump are currently reported using CPT code 96414. Beginning January 1, 2005, under the Medicare physician fee schedule, code G0361, "*Chemotherapy administration, intravenous initiation of prolonged chemotherapy infusion*

(more than eight hours), requiring the use of a portable or implantable pump" should be used instead of code 96414.

Report G0360 for infusion intervals of greater than 30 minutes beyond 1 hour increments.

Report G0346 to identify hydration furnished concurrent with G0359.

Use G0362 in conjunction with G0359, if appropriate. Report G0362 only once per sequential infusion. Report G0360 for additional hour(s) of sequential infusion.

If a significant separately identifiable E & M service is performed, the appropriate E & M CPT code should be reported utilizing modifier 25 in addition to codes G0355-G0363, 96405-96406, 96420-96520, 96530-96549. For an E & M service provided on the same day, a different diagnosis is not required.

Pay for G0363 if it is the only service provided that day.

If performed to facilitate the chemotherapy infusion or injection, the following are included and are not reported separately:

- Use of local anesthesia
- IV start
- Access to indwelling IV, subcutaneous catheter or port
- Flush at conclusion of infusion
- Standard tubing, syringes and supplies
- Preparation of chemotherapy agent(s)

For declotting a catheter or port, see CPT code 36550.

Report separate codes for each parenteral method of administration employed when chemotherapy is administered by different techniques. Medications (e.g., antibiotics, steroidal agents, antiemetics, narcotics analgesics) administered independently or sequentially as supportive management of chemotherapy administration should be separately reported using G0346, G0348, G0350, G0354, or CPT codes 90783 or 90799 as appropriate.

Report the specific service as well as code(s) for the specific substance or drug(s) provided.

<u>Intra-Arterial Chemotherapy</u>

CPT codes 96420, 96422, 96423, and 96425 are recognized for Medicare purposes in 2005. Report CPT code 96423 for infusion intervals of greater than 30 minutes beyond 1 hour increments.

<u>Other Chemotherapy</u>

CPT codes 96440, 96445, 96450, and 96520 are recognized for Medicare purposes in 2005.

Pay for G0363, Irrigation of implanted venous access device for drug delivery systems, if it is the only service provided that day. If there is a visit or other drug administration service provided on the same day, payment for G0363 is included in the payment for the other service.

CPT codes 96530 and 96542 are recognized for Medicare purposes in 2005.

Add-On Codes

Eight of the new drug administration G codes have the following parenthetical descriptor included as a part of the code, "List separately in addition to code for primary procedure". These eight codes are: G0346, G0348, G0349, G0350, G0354, G0358, G0360, and G0362. Each of these codes has a physician fee schedule data base indicator of "ZZZ" meaning this service is allowed if billed with another drug administration service.

Do not interpret this parenthetical descriptor to mean that the add-on code can be billed only if it is listed with another drug administration primary code. For example, code G0346 ordinarily will be billed with code G0345. However, there may be instances where only the add-on code, G0346, is billed because an "initial" code from another section in the drug administration, instead of G0345, is billed as the primary code.

The coding instructions in this one time notification supersede the coding descriptors that may be included in the HCPCS tape for the drug administration G codes.

Billing of Code 99211

Continue to implement the policy in section 30.5 of chapter 12 of Pub 100-04 with respect to the billing of code 99211 with a nonchemotherapy or chemotherapy drug infusion code. Also apply this policy to 99211 when billed with a diagnostic or therapeutic injection code furnished in 2005.

2005 Drug Administration G Codes

Old Code	New Code	Descriptor	Add-On Code
90780	G0345	Intravenous infusion, hydration; initial, up to one hour	
90781	G0346	Intravenous infusion, hydration; each additional hour, up to eight (8) hours (List separately in addition to code for procedure	Yes
90780	G0347	Intravenous infusion, for therapy/diagnosis (specify substance or drug); initial, up to one hour	
90781	G0348	Intravenous infusion, for therapy diagnosis (specify substance or drug); each additional hour, up to eight hours (List separately in addition to code for procedure)	Yes
90781	G0349	Intravenous infusion, for therapy/diagnosis (specify substance or drug); additional sequential infusion, up to one hour (List separately in addition to code for procedure)	Yes
N/A	G0350	Intravenous infusion, for therapy/diagnosis (specify substance or drug);	Yes

		concurrent infusion (List separately in addition to code for procedure)	
90782	G0351	Therapeutic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	
90784	G0353	Therapeutic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	
N/A	G0354	Therapeutic or diagnostic injection (specify substance or drug); each additional sequential intravenous push (List separately in addition to code for primary procedure)	Yes
96400	G0355	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	
96400	G0356	Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic	
96408	G0357	Chemotherapy administration, intravenous; push technique, single or initial substance/drug	
96408	G0358	Chemotherapy administration, intravenous; push technique, each additional substance/drug (List separately in addition to code for primary procedure)	Yes
96410	G0359	Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug	
96412	G0360	Chemotherapy administration, intravenous infusion technique, each additional hour, one to eight (8) hours) (List separately in addition to code for primary procedure)	Yes
96414	G0361	Chemotherapy administration, intravenous initiation of prolonged chemotherapy infusion (more than eight hours), requiring the use of a portable or implantable pump	
96412	G0362	Chemotherapy administration, intravenous infusion technique; each additional sequential infusion, (different substance/drug) up to one hour (List separately in addition to code for primary procedure)	Yes
N/A	G0363	Irrigation of implanted venous access device for drug delivery systems	

The following codes represent active CPT drug administration codes under the Medicare physician fee schedule in 2005:

CPT codes 90783 and 90788
CPT codes 96405 to 96406
CPT codes 96420 to 96520 and 96530 to 96549

Partial List of Drug Commonly Considered to be Monoclonal Antibodies and Hormonal Antineoplastics

As noted above, chemotherapy administration codes apply to parenteral administration of nonradionuclide anti-neoplastic drugs; and also to anti-neoplastic agents provided for the treatment of noncancer 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, alemtuzumab, gemtuzumab, and trastuzumab. Drugs commonly considered to fall under the category of hormonal antineoplastics include leuprolide acetate and goserelin acetate. The drugs cited are not intended to be a complete list of drugs that may be administered using the chemotherapy administration codes. Local carriers may provide additional guidance as to which drugs may be considered to be chemotherapy drugs under Medicare.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3631.1	Contractors shall make payment for G0351, G0353, G0354, and CPT codes 90783 and 90788. These codes have a status indicator of A under the Medicare physician fee schedule database. Contractors shall pay for these services in addition to other physician fee schedule services furnished to a patient on the same day by the same provider.			X						
3631.2	Contractors shall pay for drug administration codes under the physician fee schedule. Drug administration codes include: -Hydration (codes G0345 and G0346), -Therapeutic or diagnostic injections and IV infusions other than hydration (G0347 to G0354, and CPT codes 90783, 90788), and -Chemotherapy administration (codes G0355 to G0363, CPT codes 96405-96406, 96420 to 96520, and 96530 to 96549).			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3631.3	Contractors shall allow only one "initial" service code, per patient, per day. The "initial" codes are: G0345, G0347, G0353, G0357, and G0359 (unless the patient has to come back for a separately identifiable service on the same day or has two IV lines per protocol).			X						
3631.3.1	If more than one "initial" service code is billed per day, contractors shall deny the second "initial" service code and generate MSN messages 18.16 and 16.45 and Remittance Advice remark code M86 (unless the patient has to come back for a separately identifiable service on the same day or has two IV lines per protocol). For these separately identifiable services, instruct the biller to report with modifier 76.			X						
3631.4	Eight G-codes (G0346, G0348, G0349, G0350, G0354, G0358, G0360 and G0362) are add-on codes and are assigned a ZZZ indicator under the physician fee schedule database. Contractors shall pay for these add-on codes when provided to the patient on the same day as a drug administration code listed in requirement 3631.2 above.			X						
3631.5	Contractors shall pay for G0363 when it is the only service provided to the patient on that service date. Code G 0363 has a status indicator of T under the Medicare physician fee schedule database.			X						
3631.5.1	If billed with a visit or other drug administration service provided on the same day, contractors shall deny payment for G0363 and generate MSN message 16.8 and Remittance Advice reason code 97 and line item remark code N20.			X						

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2005 **Implementation Date:** January 17, 2005 **Pre-Implementation Contact(s):** Jim Menas (410)-7864507; Jmenas@cms.hhs.gov and William Stojak about carrier claims processing issues (410)-786-6984; WStojak@cms.hhs.gov **Post-Implementation Contact(s):** Appropriate Regional Office	**Medicare contractors shall implement these instructions within their current operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**