

CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 968

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: MAY 26, 2006

Change Request 5028

SUBJECT: Chemotherapy Administration and Nonchemotherapy Injection and Infusion Coding and Payment Policy - Update to Pub. 100-04 Medicare Claims Processing Manual

I. SUMMARY OF CHANGES: The purpose of this instruction is to incorporate in the Medicare Claims Processing Manual the payment policy and claims processing instructions in Transmittal 129, Change Request 3631, 2005 Drug Administration Coding Revisions, issued on December 10, 2004, and Transmittal 148, Change Request 3818, Revised Coding Guidelines for Drug Administration Codes issued on April 15, 2005.

NEW/REVISED MATERIAL

EFFECTIVE DATE: June 26, 2006

IMPLEMENTATION DATE: June 26, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. 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 is not updated)

R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
R	12/30.5/Payment for Codes for Chemotherapy Administration and Nonchemotherapy Injections and Infusions

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 968	Date: May 26, 2006	Change Request 5028
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SUBJECT: Chemotherapy Administration and Nonchemotherapy Injection and Infusion Coding and Payment Policy - Update to Pub. 100-04 Medicare Claims Processing Manual

I. GENERAL INFORMATION

A. Background: Transmittal 129, Change Request (CR) 3631 (2005 Drug Administration Coding Revisions) issued on December 10, 2004, and Transmittal 148, Change Request (CR) 3818 (Revised Coding Guidelines for Drug Administration Codes) issued on April 15, 2005, provided the carriers with information on 2005 coding guidelines and payment policies for drug administration codes. Under the Medicare Modernization Act (MMA), drug administration codes included three categories of codes for which there were no work relative value units as of October 1, 2003: 1.) hydration; 2.) therapeutic or diagnostic injections and intravenous infusions other than hydration; and 3.) chemotherapy administration. The MMA established work relative value units for these codes and provided for transitional payment adjustments in 2004 and 2005.

Chemotherapy administration and nonchemotherapy injection and infusion codes include the drug administration codes, specified in the MMA, as well as five codes that represent complex chemotherapy administration but which were not considered drug administration codes under the MMA. These complex chemotherapy codes include: 96405, 96406, 96440, 96445, 96450, and 96542. The coding and payment policy that applies to drug administration codes applies to these codes.

This transmittal incorporates material from these transmittals into the Medicare Claims Processing Manual.

B. Policy: 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 drug administration services for 2005. These codes correspond to the new CPT codes, which would not become active until 2006. (The 2005 CPT had already been published prior to the adoption of the new and revised drug administration codes.)

In addition to adopting the G codes, we also adopted, in 2005, the CPT coding rules (which remain unpublished until the 2006 CPT book is published) for the new drug administration codes.

These new G codes are interim until 2006; in 2006, the G codes are replaced by the 2006 CPT drug administration codes. Thus, beginning in 2006, the physicians will follow the CPT coding guidelines and select the CPT code(s) that best represents the underlying service.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement

"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
5028.1	The carriers shall pay for chemotherapy administration and nonchemotherapy injection and infusion codes under the physician fee schedule. These 2006 CPT codes include: Hydration (codes 90760 and 90761), Therapeutic, prophylactic and diagnostic injections and infusions (codes 90765 to 90779), and Chemotherapy administration (codes 96401 to 96417, 96420 to 96425, and 96440 to 96549)			X						
5028.2	The carriers shall be in compliance with the instructions in Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.5.			X						

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
5028.3	A 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			X						

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
	education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. 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.									

IV. 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

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: June 26, 2006 Implementation Date: June 26, 2006 Pre-Implementation Contact(s): James Menas 410-786-4507 James.Menas@cms.hhs.gov	No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.
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Post-Implementation Contact(s): Appropriate Regional Office Staff	
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***Unless otherwise specified, the effective date is the date of service.**

Medicare Claims Processing Manual

Chapter 12 - Physicians/Nonphysician Practitioners

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(Rev. 968, 05-26-06)

*30.5-Payment for Codes for Chemotherapy Administration and
Nonchemotherapy Injections and Infusions*

30.5- Payment for Codes for Chemotherapy Administration and Nonchemotherapy Injections and Infusions

(Rev. 968. Issued: 05-26-06; Effective/Implementation Dates: 06-26-06)

A. General

Codes for Chemotherapy administration and nonchemotherapy injections and infusions include the following three categories of codes in the American Medical Association's Current Procedural Terminology (CPT):

- 1. Hydration;*
- 2. Therapeutic, prophylactic, and diagnostic injections and infusions (excluding chemotherapy); and*
- 3. Chemotherapy administration.*

Physician work related to hydration, injection, and infusion services involves the affirmation of the treatment plan and the supervision (pursuant to incident to requirements) of nonphysician clinical staff.

B. Hydration

The hydration codes are used to report a hydration IV infusion which consists of a pre-packaged fluid and /or electrolytes (e.g. normal saline, D5-1/2 normal saline +30 mg EqKCl/liter) but are not used to report infusion of drugs or other substances.

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

A therapeutic, prophylactic, or diagnostic IV infusion or injection, other than hydration, is for the administration of substances/drugs. The fluid used to administer the drug (s) is incidental hydration and is not separately payable.

If performed to facilitate the infusion or injection or hydration, the following services and items are included and are not separately billable:

- 1. Use of local anesthesia;*
- 2. IV start;*
- 3. Access to indwelling IV, subcutaneous catheter or port;*
- 4. Flush at conclusion of infusion; and*
- 5. Standard tubing, syringes and supplies.*

Payment for the above is included in the payment for the chemotherapy administration or nonchemotherapy injection and infusion service.

If a significant separately identifiable evaluation and management service is performed, the appropriate E & M code should be reported utilizing modifier 25 in addition to the chemotherapy administration or nonchemotherapy injection and infusion service. For an evaluation and management service provided on the same day, a different diagnosis is not required.

The CPT 2006 includes a parenthetical remark immediately following CPT code 90772 (Therapeutic, prophylactic or diagnostic injection; (specify substance or drug); subcutaneous or intramuscular.) It states, “Do not report 90772 for injections given without direct supervision. To report, use 99211.”

This coding guideline does not apply to Medicare patients. If the RN, LPN or other auxiliary personnel furnishes the injection in the office and the physician is not present in the office to meet the supervision requirement, which is one of the requirements for coverage of an incident to service, then the injection is not covered. The physician would also not report 99211 as this would not be covered as an incident to service.

D. Chemotherapy Administration

Chemotherapy administration codes apply to parenteral administration of non-radionuclide anti-neoplastic drugs; and also to anti-neoplastic agents provided for 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, alemtuzumb, 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.

The administration of anti-anemia drugs and anti-emetic drugs by injection or infusion for cancer patients is not considered chemotherapy administration.

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

- 1. Use of local anesthesia;*
- 2. IV access;*
- 3. Access to indwelling IV, subcutaneous catheter or port;*
- 4. Flush at conclusion of infusion;*
- 5. Standard tubing, syringes and supplies; and*
- 6. Preparation of chemotherapy agent(s).*

Payment for the above is included in the payment for the chemotherapy administration service.

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

E. Coding Rules for Chemotherapy Administration and Nonchemotherapy Injections and Infusion Services

Instruct physicians to follow the CPT coding instructions to report chemotherapy administration and nonchemotherapy injections and infusion services with the exception listed in subsection C for CPT code 90772. The physician should be aware of the following specific rules.

When administering multiple infusions, injections or combinations, the physician should report only one “initial” service code unless protocol requires that two separate IV sites must be used. The initial code is the code that best describes the key or primary reason for the encounter and should always be reported irrespective of the order in which the infusions or injections occur. 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 should be reported. For example, the first IV push given subsequent to an initial one-hour infusion is reported using a subsequent IV push code.

If more than one “initial” service code is billed per day, the carrier shall deny the second initial service code 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 physician to report with modifier 59.

The CPT includes a code for a concurrent infusion in addition to an intravenous infusion for therapy, prophylaxis or diagnosis. Allow only one concurrent infusion per patient per encounter. Do not allow payment for the concurrent infusion billed with modifier 59 unless it is provided during a second encounter on the same day with the patient and is documented in the medical record.

For chemotherapy administration and therapeutic, prophylactic and diagnostic injections and infusions, an intravenous or intra-arterial push is defined as: 1.) an injection in which the healthcare professional is continuously present to administer the substance/drug and observe the patient; or 2.) an infusion of 15 minutes or less.

The physician may report the infusion code for “each additional hour” only if the infusion interval is greater than 30 minutes beyond the 1 hour increment. For example if the patient receives an infusion of a single drug that lasts 1 hour and 45 minutes, the physician would report the “initial” code up to 1 hour and the add-on code for the additional 45 minutes.

Several chemotherapy administration and nonchemotherapy injection and infusion service codes have the following parenthetical descriptor included as a part of the CPT code, “List separately in addition to code for primary procedure.” Each of these codes has a physician fee schedule indicator of “ZZZ” meaning this service is allowed if billed with another chemotherapy administration or nonchemotherapy injection and infusion service code.

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 90761 will be ordinarily billed with code 90760. However, there may be instances when only the add-on code, 90761, is billed because an “initial” code from another section in the drug administration codes, instead of 90760, is billed as the primary code.

Pay for code 96523, "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 chemotherapy administration or nonchemotherapy injection or infusion service provided on the same day, payment for 96523 is included in the payment for the other service.

F. Chemotherapy Administration (or Nonchemotherapy Injection and Infusion) and Evaluation and Management Services Furnished on the Same Day

For services furnished on or after January 1, 2004, do not allow payment for CPT code 99211, with or without modifier 25, if it is billed with a nonchemotherapy drug infusion code or a chemotherapy administration code. Apply this policy to code 99211 when it is billed with a diagnostic or therapeutic injection code on or after January 1, 2005.

Physicians providing a chemotherapy administration service or a nonchemotherapy drug infusion service and evaluation and management services, other than CPT code 99211, on the same day must bill in accordance with §30.6.6 using modifier 25. The carriers pay for evaluation and management services provided on the same day as the chemotherapy administration services or a nonchemotherapy injection or infusion service if the evaluation and management service meets the requirements of section §30.6.6 even though the underlying codes do not have global periods. If a chemotherapy service and a significant separately identifiable evaluation and management service are provided on the same day, a different diagnosis is not required.

In 2005, the Medicare physician fee schedule status database indicators for therapeutic and diagnostic injections were changed from T to A. Thus, beginning in 2005, the policy on evaluation and management services, other than 99211, that is applicable to a chemotherapy or a nonchemotherapy injection or infusion service applies equally to these codes.