



MLN Matters



Information for Medicare Fee-for-Service Health Care Professionals

Related Change Request (CR) #: 3631

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Related CR Transmittal #: 129

Effective Date: January 1, 2005

Implementation Date: January 17, 2005

MMA - 2005 Drug Administration Coding Revisions

Provider Types Affected

Physicians billing Medicare carriers for drug administration.

Provider Action Needed

Physicians should note that this article is based on Change Request (CR) 3631; it clarifies the 2005 drug administration coding revisions. In the final physician fee schedule rule published in the Federal Register on November 15, 2004, the Centers for Medicare & Medicaid Services (CMS) announced that it would adopt G-codes for 2005 that correspond to the new Current Procedural Terminology (CPT) drug administration codes that will become effective in 2006.

The new G-codes will apply on an interim basis until 2006. As CMS is adopting the G-codes, CMS is also adopting, in 2005, the CPT coding rules that will not officially appear until the CPT 2006 is published.

The relevant CPT drug administration codes approved by the CPT Editorial Panel are grouped into three categories:

- 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).

Note: The allowances for these codes reflect the application of the 2005 transitional payment adjustment of 3 percent, which by law is applicable only to drug administration codes.

Background

The Social Security Act (Section 1848c(2)(J)), as modified by the Medicare Modernization Act (MMA) (Section 303a)), requires CMS to promptly evaluate existing drug administration codes for physicians' services to ensure accurate reporting and billing for those services, taking into account the levels of

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complexity of the administration and resource consumption. The law further provides that CMS must use existing processes for the consideration of coding changes and, to the extent changes occur, use those processes to establish values for those services.

The American Medical Association's (AMA's) CPT Editorial Panel established a workgroup, with members from affected specialties, who met earlier in 2004 to develop recommendations on drug administration coding. The workgroup presented its recommendations to the CPT Editorial Panel in August, 2004. Based on those recommendations, the CPT Editorial 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 2004 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 was already published prior to the adoption of the new and revised drug administration CPT codes. Therefore, 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, CMS announced that it would adopt G-codes for 2005 that correspond to the new CPT codes that will become active in 2006. These new G codes are considered interim until 2006.

As CMS adopts the G-codes, CMS is also 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.

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 the *Medicare Claims Processing Manual*, Chapter 12, Section 30.5 at <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf> on the CMS website.)

Under the new codes, chemotherapy administration codes will apply to parenteral administration of non-radionuclide anti-neoplastic drugs and also 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.

At this time, CMS is not developing a national list of approved chemotherapy drugs. CMS will allow each Medicare carrier to develop such a list.

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, CMS 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.

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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 used.

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 primary service the patient is receiving and the additional codes are secondary to the primary procedure.

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 three 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:

- **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 consisting 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 who administer these do not typically require advanced training. After initial setup, infusion typically entails little patient risk and thus little monitoring.

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

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

IV Infusions

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

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- **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 thirty minutes beyond one-hour increments.

Also, prior to January 1, 2005, distinct codes did not exist 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
- Standard tubing, syringes and supplies.

What is Intravenous/Intra-Arterial Push?

Intravenous or intra-arterial push is defined as an injection/infusion of short duration (i.e., thirty 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

After January 1, 2005, Codes 90782 and 90784 will not be recognized under the Medicare physician fee schedule, and 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."*

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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.

Use code G0351 for non-anti-neoplastic hormonal therapy injections and use 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

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:

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- CPT Code 96405, *"Chemotherapy administration, intralesional; up to and including 7 lesions;"* and
- CPT Code 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)."*

Beginning January 1, 2005, under the Medicare physician fee schedule, the following G code should be used instead of code 96414:

- **G0361**, *"Chemotherapy administration, intravenous initiation of prolonged chemotherapy infusion (more than eight hours), requiring the use of a portable or implantable pump"*

Report **G0360** for infusion intervals of greater than thirty minutes beyond one-hour increments.

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.

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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, anti-emetics, 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.

Intra-Arterial Chemotherapy

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

Other Chemotherapy

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

Medicare will 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 status 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.

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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.

Table 1: 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); concurrent infusion (List separately in addition to code for procedure) | Yes |
| 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 | |

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

- CPT code 90783 and 90788;
- CPT codes 96405 to 96406; and
- CPT codes 96420 to 96520 and 96530 to 96549.

Partial List of Drugs Commonly Considered to Be Monoclonal Antibodies and Hormonal Anti neoplastics

As noted above, chemotherapy administration codes apply to:

- Parenteral administration of nonradionuclide anti-neoplastic drugs; and
- 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
- Trastuzumab.

Drugs commonly considered to fall under the category of hormonal anti-neoplastics 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.

Implementation

The implementation date for this instruction is January 17, 2005.

Additional Information

To see the official instruction issued to your carrier regarding this change, go to <http://www.cms.hhs.gov/transmittals/Downloads/R1290TN.pdf> on the CMS website.

If you have any questions, please contact your carrier at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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