CY 2006 OPPS Drug Administration
Questions Related to Pub 100-04, Medicare Claims Processing
Chapter 4, Section 230.2

Q1. In CY 2005, hospitals were instructed to bill CPT codes 90781, 96412, and 96423 in 8 unit increments for additional hours of infusion on a separate line on the bill. Should we continue to do this in CY 2006?

A1. In CY 2005, CPT codes 90781 and 96412 included a limit of 8 hours in their code descriptors. Therefore, there were a maximum of 8 units that could be billed on a single line and hospitals were instructed to include additional hours on a separate line (again, maximum of 8 units).

For CY 2006 OPPS, CPT code 90781 has been replaced with HCPCS code C8951 and CPT code 96412 has been replaced with HCPCS code C8955. Neither C8951 nor C8955 include the unit restrictions that were inherent in the CY 2005 CPT code descriptors. Therefore, hospitals may bill the total number of additional hours of infusion with C8951 and C8955 on the same line.

CPT code 96423 continues to be active for CY 2006 OPPS. Therefore, CPT code 96423 should continue to be billed with a maximum of 8 units per line.

Q2. Are hospitals allowed to bill more than one "initial hour" drug administration infusion code under OPPS for CY 2006?

A2. The CY 2006 OPPS drug administration C-codes were created because many hospitals expressed great concern about their ability to implement the CPT drug administration coding concepts of "initial," "sequential," and "concurrent." In CY 2006 OPPS, the concepts included in the C-codes are structured in the same way as CY 2005 CPT codes – that is, the C-codes identify a first hour and additional hours of a category of infusion therapy. Therefore, there is a first hour/additional hour combination of codes for chemotherapy IV infusion, non-chemotherapy IV infusion, and intra-arterial chemotherapy infusion. Hospitals should bill an appropriate first hour HCPCS code for the first hour of therapy provided in the corresponding category. For example, if a hospital provides one hour of chemotherapy via IV infusion, and then provides one hour of non-chemotherapy IV infusion, the hospital would bill one unit of C8954 (for the one hour of chemotherapy IV infusion) and C8950 (for the one hour of non-chemotherapy IV infusion).

Q3. HCPCS code C8952 (Therapeutic, prophylactic or diagnostic injection; intravenous push) is included in Transmittal 785 as being billable for each different drug/ substance. How should hospitals bill for multiple pushes of the same drug?

A3. HCPCS code C8952 was created in the context of CY 2005 CPT code 90784 (Therapeutic, prophylactic or diagnostic injection (specify material injected); intravenous) and CY 2006 CPT codes 90774 (Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug) and 90775 (Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure).

Transmittal 785, Section 230.2 B. updates Chapter 4 of the Medicare Claims Processing Manual and includes the following instruction:

> "Hospitals are to bill for additional IV pushes of different substances or drugs using multiple units of the appropriate push code."

This means that hospitals are to bill multiple units of C8952 ***only*** when different substances or drugs are provided via intravenous push in the same encounter.

CY 2006 CPT codes do not provide for separately reporting additional pushes of the same substance or drug, and we stated in the CY 2006 OPPS final rule with comment period: "…we expect that all drug administration codes used in the CY 2006 OPPS, including the new C-codes, will conform to CPT guidance…" (70 FR 68680, November 10, 2005). Therefore, to ensure collection of consistent data, CMS instructs hospitals to report only one unit of C8952 to bill all pushes for a single substance or drug provided to the patient in one hospital encounter. For example, if a patient receives two IV pushes for a single pain medication in the same encounter, the hospital would only bill a total of one unit of C8952.

Multiple units of HCPCS code C8952 without modifier -59 on a claim identify multiple substances or drugs administered in the same hospital encounter, and provide a data set for future reference when setting rates for the drug administration CPT codes. For example, if a patient receives one push of a pain medication and one push of an antiemetic in the same encounter, the hospital would bill a total of two units of C8952 without modifier -59. Administration of the same substance or drug via intravenous push in a separate hospital encounter on the same day may be reported with the appropriate HCPCS code for the push category, with modifier -59 appended.

Q4. How should hospitals bill the administration of pain management medication for beneficiaries placed in observation after an outpatient procedure?

A4. In general, payment for the outpatient procedure includes both post-procedure recovery services and associated pain management treatments. Contact your local FI for specific billing guidance.

Q5. In Transmittal 784, "January 2006 Outpatient Prospective Payment System Outpatient Code Editor (OPPS OCE) Specifications Version 7.0," CMS states that Correct Coding Initiative (CCI) edits for certain drug administration codes are not incorporated in the OCE. CCI edits for most other HCPCS codes billed for hospital outpatient services have already been incorporated in the OCE. Does CMS plan to re-incorporate the CCI edits for drug administration codes into the OCE? If so, when would they be implemented?

A5. Response to this question is under development.

- A file with the most current list of CCI edits applicable to Medicare Part B services paid by FIs under the OPPS is available at: http://www.cms.hhspo.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp#TopOfPage.
- The current CCI coding Manual for Medicare Services is available at http://www.cms.hhs.gov/NationalCorrectCodInitEd/Downloads/manual.zip.
- **Note** that quarterly CCI updates used by Medicare FIs are one calendar quarter behind CCI updates used by Medicare carriers. Therefore, hospitals may refer to the current Carrier CCI edits at http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp#TopOfPage for examples of the types of CCI edits for drug administration services that may be included in the next OPPS CCI update. CCI edits in the OCE may differ from edits used by carriers, both with respect to whether a modifier is allowed with a specific code pair and to whether certain edits are actually incorporated in the OCE.

Q6. In section 230.2.B.of Chapter 4 of the Medicare Claims Processing Manual under the heading "Included Services," as revised by Transmittal 785, hospitals are instructed that certain specified services, such as use of local anesthesia, IV starts, etc., when performed to facilitate an infusion or injection, are not separately "billable". Does this mean that hospitals cannot report charges for the services that are listed?

A6. Hospitals should either package charges for the items listed as "Included Services" into the charge for the service with which the items are associated or report charges for these items under revenue code lines without HCPCS codes. This instruction just means that the charges for the "Included Services" are not reported separately using other HCPCS codes on the claim. For example, when initiating an intravenous drug infusion and then billing for the total hours of infusion, a hospital should not also bill CPT code 36000 for the insertion of the intravenous catheter necessary for the intravenous infusion.

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