CENTERS FOR MEDICARE AND MEDICAID SERVICES

Medicare Carrier Training Conference Call:

2005 Drug Administration Coding Revisions (CR 3631)
and
Chemotherapy Demonstration Project (CR 3670)

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P R O C E E D I N G S

[1:10 p.m.]

THE OPERATOR: [In progress] -- we will conduct a question-and-answer session. At that time, to ask a question, please press star-1.

Today's conference is being recorded and transcribed. If you have any objections, you may disconnect at this time.

Now I will turn the meeting over to Ms. Hazeline Roulac. You may begin.

Opening Remarks

Hazeline Roulac

MS. ROULAC: Thank you.

Good afternoon, everyone. This is Hazeline Roulac, and I am with the Provider Communications Group, Division of Provider Information, Planning, and Development at CMS in Baltimore. I would like to welcome everyone to our Medicare Carrier training on the 2005 Drug Administration Coding Revision, CR 3631, and the Chemotherapy Demonstration Project, CR 3670.

This training will include a presentation by

Steve Phillips on the specific issues covered in CR 3631 and 3670, including an overview of the new codes and a discussion of the demonstration project. In addition, Jim Menas will review some of the most frequently asked questions concerning the subject matter. At the end of the presentation, we will open the call for questions.

A PowerPoint slide presentation has been prepared for today's call and was posted to the Medlearn Contractor Training for CMS Initiatives Web page for you to download prior to the call so that you can follow along with the speakers. The presentation is located at www.cms.hhs.gov/medlearn/cmsinit.asp.

This training session, again, is being recorded and transcribed. A copy of the transcript will be posted to the Contractor Training website within approximately two weeks from today.

Before we begin, I would like everyone here at Central Office to go around the room, introduce yourself, and identify your division or group you're in.

MS. COLEMAN: Hello. I'm Rene Coleman. I am with the Provider Communications Group in the Division of

Contractor Oversight.

MS. KERSELL: Hello. This is Kathy Kersell. I'm in the Division of Practitioner Claims Processing, part of the Provider Billing Group.

MS. MYERS: This is Susan Myers. I'm also in the Division of Practitioner Claims Processing in the Provider Billing Group.

MS. SCALLY: Hi. This is Kit Scally, and I work with the Division of Practitioner Services.

MR. MENAS: Hi. I'm Jim Menas. I work in the Division of Practitioner Services.

MR. PHILLIPS: Hi. I'm Steve Phillips, also in the Division of Practitioner Services, within the Hospital and Ambulatory Policy Group.

MS. ALLEN: Karen Allen, Division of Standard Systems Maintenance.

MR. GIWA: Justin Giwa from the Provider Communications Group.

MS. PHILLIPS: Robin Phillips with the Provider Communications Group.

MS. ROULAC: Okay, great. Thank you.

At this time, we will have Steve Phillips begin the training session.

Presentation: 2005 Drug Administration Coding Revisions and the Chemotherapy Demonstration Project

Steve Phillips and Jim Menas

[PowerPoint presentation.]

MR. PHILLIPS: Thanks, Hazeline. I must start off just thanking the Provider Communications Group for setting this up on short notice, and everyone on the call for being available to discuss this today, again on short notice.

The topic is the changes to the Drug Administration policy. That is an important policy, and we wanted to just take the time today, one, in response to some concerns that we've been hearing from our oncology community but also just to make sure everyone is on the same page as far as going forward and implementing that.

So as Hazeline indicated, basically what I'm going to do is just go through the slides that are posted to the website at the address just given. As far as the

prepared remarks on the slides, I'll really just kind of go through the main points of the instructions that were issued in December, first, with the Drug Administration and then, second, with the Chemotherapy Demonstration Project.

Then we have a couple of questions and answers that Jim Menas will go through based on issues that have come up since publication of the instructions, and then, as indicated earlier, we'll open it up for questions.

You will see, and basically I just wanted to note, that a lot of the information here, the American Society of Clinical Oncology has actually been working and having conferences with its members. We just wanted to acknowledge that they were good enough to share some slides they had already put together which helped to formulate this. Of course, that was all based on our instructions, but we just wanted to acknowledge their input.

So then, moving on to Slide No. 4, Drug Administration Payment Policy and Coding, this just gets at the reasons why all of this is happening. The

Medicare Modernization Act required CMS to promptly evaluate the existing drug administration codes to ensure that they accurately reflect physician resources involved in providing the services.

Of course, that is linked to the change in drug payments from the average wholesale price to the average sales price and the resulting reductions on the drug payment side, which for oncologists have been -- the Inspector General's Office and the Government Accountability Office, I guess it is now, have issued reports in the past basically indicating that oncologists have essentially been really supplementing their drug administration costs through excess payments on the drug side.

So the MMA mandate was in recognition of that fact and recognizing that reductions to the drug payments would necessitate some adjustments on the drug administration side.

The second bullet here is, another part of that requirement was to use existing processes and consult with the physician specialties affected by the provision

that provides drug administration services. So essentially, referencing the existing processes, on the next slide, we referred to the AMA process for updating and creating new CPT codes, but we worked with the AMA, CPT Editorial Panel, and the Drug Administration Workgroup. The workgroup and the panel approved new CPT codes for drug administration in August of last year, and the RUC met in September and approved or assigned new values to those new codes.

Because of the timing of that process, there was not time remaining to have those new codes into the CPT book for 2005. They are targeted to become effective in January of 2006. Nevertheless, in response to the AMA mandate, CMS established new G codes for 2005, and these correspond to the new CPT codes. The new G codes will only be in place for 2005, and then we will switch over to the CPT codes.

The last bullet there on Slide 5 just indicates that at the same time the MMA required a transition payment increase in 2004 of 32 percent for drug administration services, and then that drops down to 3

percent in 2005, and then it goes away in 2006. So kind of a tapering off to some additional revenue source to help ease the transition to the reduced drug payments.

In Slide 6, we just get into the design of the new codes, and I will refer the rest of the way to the G codes. But again, these just reflect the changes to the CPT codes that will be in place next year.

This Slide 6 indicates there are three categories of new codes: first, infusion for hydration; and then the second, non-chemotherapy therapeutic and diagnostic injections and infusions; and then the third is chemotherapy administration.

One important aspect of the new codes is the CPT redefines or actually introduces a broader definition of chemotherapy administration. We will get into that a little bit in a later slide.

Slide 7. Well, actually, here it is. As I said, the CPT expanded the definition of chemotherapy, and this slide indicates under the new codes chemotherapy administration is applied to non-radionuclide anti-neoplastic drugs. I will just leave it to you to read

this slide. You can probably read it better than I can as far as the drugs themselves.

This is an issue that I will just say, I know that there is a medical directors' call next Tuesday. I think this is one of the issues on the agenda. So we will get into it more at that point, but, you know, the Change Request 3631 did give a couple of examples of drugs that are now defined as chemotherapy just to establish some guidelines.

Again, we will talk about, you know, how exactly we are approaching this at the call on Tuesday, but, you know, essentially, we are relying on the medical directors for a lot of these determinations at this point, based on the general guidance under the new CPT definition, to designate which drugs are chemotherapy and which are not. So the slides here are really just to try to broaden our definitions we use to make those determinations.

Slide 8, more changes. Infusion of substances such as monoclonal antibody agents or other biologic response modifiers is reported under the chemotherapy

administration code, so these are, again, getting more into the definition of what is chemotherapy. Administration of the anti-anemia drugs and anti-emetics by injection or infusion for cancer patients is not considered chemotherapy.

Slide 9 is some additional changes. There are new codes in both chemotherapy and non-chemotherapy sections for reporting the additional sequential infusion of different substances or drugs. This is a change that is dealt with and is found in Change Request 3631. Basically, the new CPT and G codes provide for one initial infusion to be coded, and then subsequent infusions or injections or courses are coded using the sequential or subsequent codes, which we will get into in a minute.

Another important point here on this Slide 9 is that injection services are now separately paid even if another physician fee schedule service is billed for the same patient that day. This was implemented through a change in the status indicator on the fee schedule database.

Starting on Slide 10, we get into some of the specific new codes, and the left-hand column is the predecessor CPT code. Some of these are one-to-one crosswalks. Some of them, there may be some variation in terms of predecessor codes. They may have more than one predecessor. In some cases the predecessor code may not go to more than one G code, and in some cases there is really no predecessor code at all.

There is a similar table, again, in CR 3631, and this is just to help kind of tie it back to prior practice.

We have been getting a lot of questions, very specific coding questions, and Jim has been handling those. We can maybe get into some of that in the Qs & As, as well as a couple of the prepared questions and responses may deal with some of those issues as well.

Slide 11 deals with more of the new codes, the non-chemotherapy injections and infusions, again showing the prior CPT code and then the new G code and a short descriptor.

Slide 12 shows the new injection and infusion

codes: G0351, -353, and -354. It shows G0354 is actually a new code definition for each additional sequential IV course with no predecessor CPT code. So that is an example of the change CPT made to break out a service separately.

Slide 13 has the chemotherapy administration codes. Here you see G0357, for example, is the code for the initial infusion. It would be coded using that code, and then each additional substance or drug after the initial would be coded. For example, here you can see G0358.

Slide 14, again, are some additional chemotherapy administration services. I think people probably are pretty familiar with the new codes, so I just wanted to go through those quickly.

The next slide, 15, What is Initial Service? This, again, gets back to the change that was made where generally there was just one initial code that is used for the infusion on a particular day. If a combination of chemotherapy drugs, non-chemotherapy drugs, and/or hydration is administered by infusion, the initial code

that best describes the service should always be billed irrespective of the order.

Basically, what that means is if you have -- well, I guess what it says, a combination of infusions, injections, pushes, chemo or non-chemo, that, you know, we would expect the primary service for which the patient came in to receive that day and the ancillary or supplemental services that are also provided, the initial should reflect, really, the primary service provided. As indicated in the second bullet, the additional codes are secondary to the initial code.

As I said, the general rule is that there is only one initial service. However, on the next slide, you see in the first bullet that an exception to that is where a protocol requires two separate IV sites to be utilized. Then two initial codes could be reported.

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

On to Slide 17. This is an issue that we have

had some questions about. Following the definition of CPT, this essentially is the language right out of the CPT instructions. Intravenous or intra-arterial push is defined as an injection or infusion of short duration, i.e., 30 minutes or less, in which the healthcare professional who administers the substance or drug is continuously present to administer the injection and observe the patient. So that is, you know, also carried over into the CR 3631 as far as the definition of how to code that service.

Slide 18. This just gets into some of the new codes that are intended to recognize additional work and practice expense in the provision of multiple drugs. You see here on the third bullet this list of the add-on codes that would be subsequent to initial infusion chemotherapy.

Slide 19. Again, this is just identifying a specific code for additional sequential infusions, up to an hour. For example, if you administer three chemotherapy drugs, you report one initial code and two additional sequential codes. So that is, you know, first

hour, then second hour additional infusion, would result in two additional codes.

Slide 20, Injections and Infusions for non-chemotherapy, other than hydration. Here, G0354 is used to report each additional sequential IV push for non-chemotherapy drugs. It is possible that a non-chemotherapy drug-administered IV push may follow the administration of a chemotherapy drug. In that case, G0357 would be reported as the initial, and G0354. Even though it is a combination of chemo and non-chemo, the non-chemo sequential drug would be here, and the chemo drug would be the initial drug reported.

There are also changes to the Port Flush codes. G0363 now is used to report irrigation of an implanted venous access device. Medicare will pay for this code if it is the only service provided that day. If there is a visit or other drug administration service provided on the same day, the payment is funneled into the payment for the other service.

There are some drug administration codes that are not changing in 2005 or 2006 as well. Listed here on

these pages, 90783, 90788. Also, 96405 and 96406. Basically, CPT will not change those codes.

Slide 23 has a list of additional codes that are not changing. So these will still be accurate. And then Slide 24 also lists some of the codes related to refilling and maintenance of portable pumps.

That is essentially the presentation on the drug administration codes. As I'm sure you all have had as well, we have had questions that have come in for further clarification on issues as people begin to operate under these instructions out in the field. So we will cover some of those in the Qs & As and then in our prepared Qs & As and then open it up for your specific questions.

I wanted to then go through Slide 25. It begins with the discussion of the Chemotherapy Demonstration Project. This project is designed to identify and assess certain oncology services in an office-based oncology practice having a positive effect on the outcomes in the Medicare population. It is a one-year demonstration project for 2005.

While we encourage optimal care of cancer patients, and all patients, based on input from cancer patients and meetings that we have had with organizations of cancer patients here at Central Office, working with our Office of Clinical Standards and Quality, we have identified three areas of concern that are most often cited by patients. The first is pain control management, second is minimization of nausea and vomiting, and the third is the reduction of fatigue.

So the demonstration project is designed to conceptually collect data on patients' data or symptom levels for those three areas and the data selected through the claims processing system, as you will see in a minute.

What do practitioners need to do to participate? They must provide and document specified measurements related to pain control management, minimization of nausea and vomiting, and reduction of fatigue. Basically, those are reported and measured using the specified G codes.

The assessment may be taken either by the

practitioner or by a qualified employee of the office under the supervision of the practitioner. If the assessment is performed by an employee, the expectation by CMS is that the practitioner will review the data as part of the patient assessment.

The responses of the patient should be recorded and included as part of the medical records.

Slide 27, How is the Assessment Performed? Patients will basically assess their symptoms using four standard patient assessment responses for each of the three symptom areas.

Although the answers seem somewhat simplistic, they are actually based on a scale that is out there and being used in the clinical world, the Rotterdam scale. It was chosen just, really, for the reason that they are easily understood by the patient and don't require, you know, a burdensome process for the practitioner to determine the appropriate level to report.

As was indicated, they should be documented in the medical report and submitted on the claim.

In order to bill for the encounter under the

demonstration project, a patient must have received chemotherapy through intravenous infusion or push, and billing under the demonstration is limited to once per day.

Participation is open to any office-based physician or non-physician practitioner operating within the State scope of the practice. They must be providing chemotherapy to oncology patients in an office setting. The CR 3670 that was issued December 30th indicated that payment under the demonstration is limited to chemotherapy care that is provided and billed under the physician fee schedule, effectively precluding outpatient department chemotherapy within a hospital outpatient department.

By billing the designated G codes, the practitioner self-enrolls in the project and agrees to all the terms and conditions of the demonstration project.

Slide 29 just graphically displays the 12 new G codes. As you see here, for example, in the second column, Nausea and/or Vomiting, G codes G9021 through

G9024 are used to report symptom levels of nausea and/or vomiting ranging from "not at all" for G9021 to "very much" for G9024, and similarly for pain and fatigue.

In the demonstration project, for each encounter reported with the chemotherapy administration where each of the patient status codes are reported on the claim, an additional $130 per encounter. The payment requires that one code from each symptom category -- that is, one code reported on the level for pain, nausea and vomiting, and fatigue -- must be included on the claim or else the demonstration payment will be denied.

The CR basically just established the allowances for the various codes, which you see on Slide 31. So since all three codes are required, they just split the $130 payment among the three sets of codes.

Services are paid on an assignment basis, and the usual Part B coinsurance and deductibles apply under this MO.

This is just going into detail. The codes should be recorded on the same claim and for the same date of service as either chemotherapy infusion or

chemotherapy push. The patient must have a cancer diagnosis; it is limited to those patients. And the place of service is Code 11 for an office. Only beneficiaries not enrolled in a Medicare managed care plan are included within the demonstration project.

Slide 33, then. We get some of the questions that Jim Menas will take you through. So that concludes the sort of run-through of 3631 and 3670. So these kind of follow up on issues that have come up. These questions and Jim's responses follow up on issues that have arisen since we put out those instructions.

Presentation by Jim Menas

[PowerPoint presentation.]

MR. MENAS: Thanks, Steve.

As Steve mentioned, the remaining slides are a hodgepodge of different questions somewhat from the perspective of the carriers or somewhat from the perspective of the oncologist. There is a range of issues in there, from specific codes that are selected, the policies for chemotherapy for last year or for this year, whether they continue to apply or not.

Also, not in this package as far as this presentation, but we have worked with ASCO. They have conducted a number of seminars for folks and they have submitted a number or series of different questions for us. We reviewed those and probably got two RAM of responses back to them.

What we intend to do in the next week or two is to compile those questions and those responses and put them on the CMS website, as well as, I guess, any questions that come up today. If they need clarification, we'll put those on the website, also.

Anyway, the first slide, the question there has to deal more with the coding structure. It is, "How are the 'each additional hour' and the 'additional sequential codes' different?"

As was mentioned earlier, you can see that there has been a pretty fundamental change in the coding structure for drug administration codes in 2005. There are three different levels of codes for chemotherapy and non-chemotherapy services.

What is the same as before is there is the

initial infusion code up to one hour. What is also the same as before is there is an add-on code for each additional hour that follows that first hour.

What is the difference in 2005 for both chemo and non-chemo is there are new codes for additional sequential drugs, the codes for the drugs that follow the first drug. In the past, sequential drugs would have been recorded using the additional hour codes. Now we have new codes that really reflect the additional work and the practice expenses that are associated with these kinds of services. Then there are the additional sequential codes to use for each drug provided after the first drug.

At the bottom of that slide, you will see a little there about how the "each additional hour" code is reported. It is used if a particular drug is infused for more than one hour and 30 minutes. An example of the way it works is, if you have an infusion of one drug that goes for an hour and 45 minutes, the provider would bill G0350, which would be the initial code for up to the first hour, and then G0360 would be the additional hour

add-on.

The next slide is use of the -25 modifier with E & M visits. This is from the perspective of the oncologist and whether they need to use the -25 modifier with E & M services conducted on the same day as chemotherapy. Of course, the -25 modifier is used for designated significant, separately identified evaluation and management service by the same physician on the same day of service of the procedure.

Last year, we addressed this in the follow-up physician fee schedule in the transmittal in the spring of 2004. Basically, the policy is that the -25 modifier has to be attached to the E & M service that actually is billed by the oncologist on the same day that chemotherapy is provided. This policy is Exception 30.5, Chapter 12 of Publication [inaudible.]

The next slide involves, "Can a level one office visit be billed on the same day as chemotherapy?" This is a policy that was put into effect last year. Basically, what happened last year was work was added to the drug administrations codes where some of those codes

had a zero work value. The [inaudible] was added with the work that was associated with 99211. So, in regards to that shift, the policy was to not recognize 99211 if it was billed the same day as the chemotherapy service. That policy stays in effect this year.

Also, there is a change [inaudible] that policy to the diagnostic or therapeutic injection codes. That comes about largely because the status indicator, the physician fee schedule for the diagnostic or therapeutic injection codes used to be [inaudible] now those codes have an eight [inaudible] level. So those codes are treated just like any other code under that fee schedule.

Slide 36 has to deal with reporting times for infusion codes. I believe that in the past CPT did not have a specific guideline in terms of the amount of time that had to be met to report the first hour or additional hour code. Beginning in 2005, there is a coding guideline for the amount of time that has to be associated with the subsequent hour code.

The instruction in Transmittal 129 is that it has to be basically later than 30 minutes beyond the one

hour increment. So the way that would work in that example -- this is one that I mentioned before -- you have an hour and 45 minutes of chemotherapy. You would be able to bill the additional hour code. Since you're more than 30 minutes beyond the hour, you are allowed to bill the additional hour code, G0360.

The next slide takes you through receiving hydration before, concurrent, and after chemotherapy. We are continuing the same policy this year as we have had for many years previously. Hydration can be paid before and after chemotherapy but not concurrent to chemotherapy. I believe in Transmittal 129 there was a mistake. There is an indication in there that potentially you could pay hydration that was concurrent to chemotherapy. So this is a clarification to make sure that you are aware that the same policy carries over from last year and that we pay for hydration both before and after chemotherapy.

The next slide deals with the appropriate modifiers to be used with hydration when it is provided with chemotherapy. Again, this is just a reminder that

we are continuing the same policy that we have always had and that is currently in Section [inaudible] of Chapter 12, Publication [inaudible], that you would append a -59 to the hydration code with chemotherapy.

The next slide deals with injections provided on the same day as other services. As I mentioned, in the past the diagnostic injection codes had a key status which indicated that they are payable [inaudible] billed and provided the service on that day. Those status indicators have been changed from T to A. There are new G codes that replace two of the diagnostic exemption codes. Beginning in 2005, the G replacement codes are going to be G0351 to G0354. They will be eligible for separate payment.

The next question is whether the new G codes for drug administration services, whether these are available for outpatient hospital services. It may not be pertinent to this audience, but the question has come up quite a bit. As you know, the G codes have a [inaudible.] These codes are not payable if provided in a hospital outpatient was used. The CPT code in 2005

[inaudible] would be billed to [inaudible] and those services would be paid on an outpatient system.

Moving on to the last slide, as I mentioned, the G codes parallel the CPT codes. They will be in effect for this year, and in 2006, they will be replaced with the new CPT codes.

That pretty much completes the frequently asked questions.

MS. ROULAC: Thank you very much, Jim. We appreciate the explanation that you've just shared with us.

We are going to prepare now to open the call for your questions. Because the call is being transcribed and recorded, when you ask your question, please identify yourself and your organization that you are with. We will allow plenty of opportunity to take as many questions as we can. We do ask that you limit your questions to one at a time.

We do have subject matter experts in the room who can answer your questions concerning coding, payment policy, claims processing, and systems.

If for some reason we are not able to answer your question at this particular point in time, maybe because we need to do a little more research, we ask that you would forward your question to the following mailbox. It is contractortraining@cms.hhs.gov. We will get your question to the correct expert and we will get it answered for you.

At this time, Operator, you may go ahead and open the phone up to questions.

Question-and-Answer Session

THE OPERATOR: Thank you.

We will now begin the question-and-answer session. If you would like to ask a question, please press star-1. You will be prompted to record your name. To withdraw your request, you may press star-2.

Our first question comes from Christina Stelavides [ph]. Your line is open.

[No response.]

THE OPERATOR: Christina Stelavides, your line is open. Please check your mute button.

MS. STELAVIDES: Actually, that was answered.

I apologize.

MS. ROULAC: You can go to the next call.

THE OPERATOR: Our next question comes from Richard Whitten [ph].

MR. WHITTEN: Thank you. This is Dick Whitten, medical director for Noridian for Washington, Alaska, and Hawaii. I have a couple closely related questions.

You have made it clear that the difference between an infusion and an injection is the 30-minute timetable. I assume that what you mean by that is the protocol requirement of less than 30 minutes. Just the fact that the injection happens to go beyond 30 minutes does not turn an injection into an infusion. Is that correct?

CMS PARTICIPANT: You're saying that the injection itself is going more than 30 minutes?

MR. WHITTEN: Correct. [Inaudible] that protocol is given for less than 30 minutes but borderline. If it happens during the course of its administration to extend beyond 30 minutes, this does not change the nature of what we would call it. It would

still be intended to be and would remain an injection, is that correct?

CMS PARTICIPANT: That's my reading of it, yes. I mean, yes.

MR. WHITTEN: That was ours, too. Thank you.

Related to that, a push in the past was defined as something for which someone is continuously present. Since we are now allowing IV push to go out to 30 minutes and sometimes these things are hung for brief periods of time, and the only requirement typically for hung medicines was that someone was immediately available but didn't have to be continuously present, we would now accept that things up to 30 minutes may not necessarily have someone continuously present. Is that correct?

MR. PHILLIPS: Yes. This is Steve Phillips. That is correct. Short infusions where the -- our understanding is that this is an issue ASCO particularly has raised a lot of questions about and has indicated to us that they intend to raise this with the CPT Editorial Panel next week. You know, we recognized as well that because the definition of the code includes that it is a

push and that personnel is continuously present, it has created a lot of confusion.

So we are anxious to hear and to participate, since we are represented on the CPT panel, in that discussion for further clarification on that. But at this point, based on our understanding of the coding instructions, you're right. An infusion of 30 minutes would be coded as a push even if the personnel was not at the bedside the entire time.

MR. WHITTEN: Thank you.

If I could, with the push, you have been discussing separate medications have their own code now. For instance, a sequential IV or a sequential IV push or infusion. Those separate medications would apply only if they had separate hanging set-ups, would they not? You would not bill separately for Menital [ph], Benadryl, Lasix, et cetera, that were placed in the same bag, is that correct?

CMS PARTICIPANT: Are you talking about sequential or concurrent infusions?

MR. WHITTEN: In that case they would be

concurrent. There would only be one administration, correct? Even if they were placed in the same administration set, it would be one administration, is that correct?

CMS PARTICIPANT: We are getting questions in terms of -- I mean, there is this -- before, CPT never had a code for a concurrent infusion. This year there is a concurrent infusion code that is for maximum therapy. CPT guidelines, which were adopted by instruction, do not contain any type of additional guide to what constitutes a concurrent infusion.

We are pretty much [inaudible] those questions. It is the coders and the medical folks that decide how you want to code those because we [inaudible] providing more guidance.

MR. WHITTEN: We are hoping to get some further guidance next week. But basically, you're saying if it's in one bag, it's one infusion, right?

CMS PARTICIPANT: I think [inaudible] you know, when [inaudible] code from CPT [inaudible] we can see, you know, what the net for the typical patient is and

also for practice expense codes are assigned to that code in terms of the clinical labor, the medical supplies, and the medical equipment.

So my take on it would be the [inaudible] being billed for is consistent with the underlying practice expenses that are associated with that [inaudible.] I think that is the only kind of guidance that we would be able to provide.

MR. WHITTEN: Okay, thank you.

Heparin used to maintain the line is not a separate drug, correct?

CMS PARTICIPANT: [Inaudible.]

MR. WHITTEN: Correct. [Inaudible] yes.

CMS PARTICIPANT: You know, I would toss the question back, would you think that the new code, the G0363, does that describe that service?

MR. WHITTEN: It does when you apply a venous device, but it doesn't for just [inaudible] or something that is closed temporarily [inaudible.] So something used in the process of administering a drug or something of that nature which does not meet the criteria for G0363

would not be separately billable, correct?

CMS PARTICIPANT: Is that something [inaudible] policy on, or is that something -- I don't believe that's open to [inaudible.]

MR. WHITTEN: [Inaudible.] Okay. So we don't have a clear answer on that, but we'll see if we can get that from CPT.

One last thing. You've mentioned several times that normally we would have only one initial code, the exceptions being the protocol requires a separate one or that the patient returns later in the day. The return would be the return later in the day and at that time requiring a new line, correct? Someone who really returned an hour later but [inaudible] would not require a separate initial code. Is that correct or not?

CMS PARTICIPANT: Sir, we [inaudible] clinical folks here really [inaudible] particular guidance [inaudible] outside our group of expertise. So we will defer responding to that for now.

MR. WHITTEN: Okay, thank you. I just wondered if there was. Thank you very much.

MS. ROULAC: Thank you.

Next call.

THE OPERATOR: Linda Greenberg, your line is open.

MS. URES: This is actually Tammy Ures [ph] from Noridian. I had a question in regards to the G codes and not for hospitals. But does that apply also to critical access hospitals? Those are non-OPPS hospitals, and they were told that they could use the G codes because the 9 code -- none of them was deleted off of their outline. I was under the impression that a hospital outpatient was a hospital outpatient regardless of the type of hospital.

CMS PARTICIPANT: You say they were told to use the G codes?

MS. URES: Yes. It was going to be something that they could use. Not the demonstration codes but the administration codes.

CMS PARTICIPANT: Do you know who told them that?

MS. URES: They didn't tell us. We asked for

clarification from CMS and got a response back that critical access hospitals, non-OPPS hospitals -- using the G codes, and I just wanted to make sure -- I question that because the CR didn't seem to indicate that.

CMS PARTICIPANT: Right. Well, I know that critical access hospitals have different methods that they can bill for Part B services. I think, maybe, before we answer definitively on that, we should check with the people who deal directly with billing under CAHs. For example, they use Method 2 for the professional services that, you know, in fact would be a situation where they could use the G codes. I think that is one where we will have to follow up.

MS. URES: [Inaudible] Method 1 and Method 2, because Method 1 they bill out on a 1500 Form. They would get out all of the physician components. Maybe that was what the confusion was.

CMS PARTICIPANT: Right.

MS. URES: Method 2 would be all-inclusive on a UB92 [inaudible] physician component on the original claim. But if they are Method 1, then it would be a

separate physician service, that it would be done in an outpatient hospital setting.

CMS PARTICIPANT: Okay. Maybe, yes, Method 1 could be the situation. But let us check on that and get clarification.

MS. URES: Thank you very much.

MS. ROULAC: Can you put that question in the Contractor Training e-mailbox?

MS. URES: Sure. I'd love to.

MS. ROULAC: Okay. Great. That would ease our responding to you.

Next question.

THE OPERATOR: Michelle Kelly, your line is open.

MS. KELLY: Thank you.

We received a question, or we have a lot of issues coming up on the demonstration codes where the providers are not referencing the cancer diagnosis. They are putting the cancer diagnosis on the claim but they are just not pointing to it. The requirements say that they must reference it. Would you consider changing that

so that they just have the diagnosis on the claim?

MS. ROULAC: Michelle, what organization are you with?

MS. KELLY: National Heritage.

MS. ROULAC: Thank you.

CMS PARTICIPANT: When you say that they are not pointing to it, they are referencing it, I guess, could you describe a little bit more, you know, what you mean?

MS. KELLY: From the 1500 Claim Form perspective, they put four diagnoses in Item 21. Then each line points to a diagnosis. In most cases, they are pointing to the nausea or the vomiting; they are not pointing to the cancer, so they are not actually referencing the cancer as the primary reason for these codes. And we have it set up to deny if they don't reference the cancer diagnosis, which causes a lot of reworks and a lot of questions because they do have the cancer diagnosis on the claim.

MS. MYERS: This is Susan Myers. We suggest that maybe you put that in writing and send that in to

Hazeline, and we'll have to do a bit more research on that.

MS. KELLY: Okay.

MS. ROULAC: Thank you, Michelle.

Next question.

THE OPERATOR: Carol Manilow [ph], you may ask your question.

[No response.]

THE OPERATOR: Carol Manilow from Medicare Arkansas, your line is open.

MS. LEDGE: This is Cheryl Ledge [ph] from Oklahoma and New Mexico Medicare. On the G0350, we are having some confusion on that concurrent administration. We need some clarification on that. Even our medical directors here are unable to agree on how we should use that code.

MR. MENAS: This is Jim Menas. I'm not sure we can give you a lot of guidance right now. We will probably have to, you know, work more at that. As I mentioned, that is a new code that CPT adopted. It doesn't crosswalk to any prior code.

MS. LEDGE: Okay. Would you be able to bill that with sequential infusion?

MR. MENAS: I'm not sure I understand, but I mean, "concurrent" means, in my mind, you have, you know, maybe another cancer patient or part of the chemotherapy you may mix together two different types of drugs that are combined, or non-cancer drugs for therapy and diagnosis.

MS. LEDGE: Right. You may be giving Doprin [ph] and you may also be giving them Decadron. We are wondering if we could use that concurrent administration code.

MR. MENAS: Well, again, the code was created for other than chemotherapy. It seems to me that I guess the kind of response we would have to put out would be something that describes what CPT looked at when they provided that code in terms of work and practice expense inputs, or whether the clinical circumstance that you have described is consistent with how they looked at the service.

MR. PHILLIPS: This is Steve Phillips. I just

wanted to add, I mean, Jim indicated earlier that we don't have our medical officers here today. Basically, what we were intending to do is at the CMT call next Tuesday to have them available and, you know, if need be, we can have some subsequent discussions as well on some of these issues.

MS. LEDGE: So, if we could e-mail this question to you, could you address it to your medical staff there?

MR. PHILLIPS: Yes.

MS. LEDGE: Okay.

MR. PHILLIPS: Sure.

MS. LEDGE: Thank you.

MR. PHILLIPS: Okay.

MS. ROULAC: Thank you.

Next question.

THE OPERATOR: [Name], you may ask your question.

QUESTION: I'm back on Slide 16 on if the patient has come in for a separate identifiable service on the same day or they have two separate IV lines per

protocol. It says to tell them to use the -76 modifier.

Now, I can understand that if they are getting the same initial drug administration, but if they have two different IV lines and they're doing G0359 for the one IV line and then they do a G0347 for the other line, that is going to get denied for CCI. The -76 modifier is not recognized by CCI.

So, should we clarify to our providers that [inaudible] and their records support it, they need to use a CCI modifier?

MR. MENAS: This is Jim Menas. What modifier would you need there to [inaudible]?

QUESTION: -59. -76 is only for internal [inaudible] products, glycogen. So if they were doing the same code, I could see the -76. It's when they're doing two different procedure codes.

CMS PARTICIPANT: -76 would be identical to [inaudible.]

CMS PARTICIPANT: -76 is identical to [inaudible] service.

CMS PARTICIPANT: We'll have to go back and

look at that [inaudible.]

MS. ROULAC: Thanks, Elaine. What organization are you with?

QUESTION: BlueCross BlueShield of Montana.

MS. ROULAC: Thank you very much.

QUESTION: You're welcome.

Next question.

THE OPERATOR: Harold Graham [ph] -- actually, it's Paul Goatch [ph] of [inaudible], you may ask your question.

DR. GOATCH: Thank you. First, thank you very much. This was very helpful, the PowerPoint.

First, and the real question, can we release this PowerPoint to providers or put it up on the website, or is CMS going to have it available on their website?

MS. ROULAC: We may need to make some revisions to it, and we'll indicate on the Medicare Contractor website the date that it has been revised.

DR. GOATCH: Okay. Thank you.

The second question is, in both the administration and the demonstration, we keep referring

that this is for place of service "office," 11. Under Part B, we also have independent clinics, place of service 49, which for all intents and purposes is identical to an office and in fact was cross-walked from 11 to 49, and last year we were allowed. So I'm wondering, for both issues, should we be billing 49 and take that literally from both CRs?

The other point is, when you're discussing the OPPS, on the administration codes, again in these independent clinics, what happens in the other settings, like the SNFs, which is a non-Part A stay? Normally, these services could be paid under Part B. Then there is no OPPS issue.

CMS PARTICIPANT: With respect to the place of service code, we need to consult with the Operations folks here. But I understand your concern. I thought the place of service code "office" was more far-reaching than just the physician office and that it would encompass clinics.

CMS PARTICIPANT: [Inaudible.]

DR. GOATCH: Yes. You said that in Slide 11

specifically, and then on the OPPS, you really get to the whole issue of non-Part A stays in SNFs.

CMS PARTICIPANT: We're going to have to look at that. I don't know; I mean, are there any other place of service codes that should be included, too? [Inaudible.]

CMS PARTICIPANT: You might wind up, actually -- and again, it goes to the intent of some of these things again. If there are people who are getting some of these things at home or in skilled nursing facilities and [inaudible] facilities, even.

CMS PARTICIPANT: Yes. I mean, the policy as they described it in the CR was, I mean, there was a limitation. I mean, we said office-based, but then, you know, sort of [inaudible] participate. We didn't really look at it more than that. I think what we will have to do is try to look at the issue based, you know, as far as the different sites of service where it could be provided and billed under the fee schedule and issue some clarification on that. So this is helpful.

DR. GOATCH: I just have two additional things.

One question is, on the chemo demonstration, the question of frequency. At one of our major academic hospitals here in New York, the question was raised, what happens if a patient gets an IV chemo multiple days in a row; can the physicians bill for the symptom codes?

It seems if you have two days in a row and the symptom codes say, "Have you had these symptoms within the prior week?", they have the chemo administration two days in a row. If they bill the symptom code that second day, essentially they're asking, "Have you had any symptoms in the past one day?" Otherwise, they are asking for essentially the same period of time. It means that we would have duplicate payments, all right, if we do multiple sequential days.

CMS PARTICIPANT: Yes. I think what you are referring to in the CR, we indicated that the assessment was, ask the patient, as you say, in the past week the degree to which they have been involved in this experiencing these symptoms. But the design of the demonstration really is that there is not a limit on billing other than once per day. I think the reference

to asking the patient about their symptoms during the past week comes from, you know, the material out there on the Rotterdam scale.

I think in response to your question that it needs to be modified in terms of this demo that since it is available on a daily basis, if the patient is coming in more frequently than once per week, that it would just essentially reflect since the last visit as far as the assessment of the patient's symptoms.

DR. GOATCH: Thank you.

My last question: if somebody gets multiple infusions, and say they have two infusions -- the question was raised to us, what if you have two IV pushes in 31 minutes or more? It seems like you could be spending an hour and two minutes and be billing two hours' worth of infusions.

There seems to be a problem. If you look at the corollary physical therapy services, the instructions on physical therapy services is when you get multiple physical therapy services, add them all up and divide by 15 minutes to find out the number of billable services.

It looks like here every drug is a new infusion, a new push, or a new service. So we're going to be winding up maybe doing two hours' work in one hour -- excuse me, getting paid for two hours when you're only doing one hour's work.

CMS PARTICIPANT: What was the scenario again? You have two --

DR. GOATCH: The question that came in from one of our hospitals was, what are the guidelines for billing multiple chemo drugs 31 minutes or more? So, you could wind up with, say, a provider giving two 31-minute infusions and working just over an hour, but they are really going to get paid for two hours' work.

That's going to apply in any combination of infusions. If you take your hour and 30 minutes or hour and 40 minutes, you know, and you take two of those in a row, that gets you up to a little over three hours, when a single infusion wouldn't take three hours. Now it would pay them four hours because of the different drugs.

CMS PARTICIPANT: I think that problem permeates this coding structure, because just looking at

the one hour code, at the low end, as you mentioned, it could be 31 minutes, whereas at the high end, if you work an hour and 29 minutes, you still only get to bill that one hour code. You can't jump into the additional hour code.

So it is almost an averaging game to the extent that the practice [inaudible] both kinds of services, you're okay. To the extent that the practice happens to do more short-term infusions, they tend to benefit.

DR. GOATCH: It's the average game.

CMS PARTICIPANT: Well, if you look at the corollary of the physical therapy services or the physical therapy, they tend to add up the total time and divide by those 15-minute intervals so you can't get paid for more than the actual time. Here it's a little different. I understand about whether it's going to average out or not. Somehow it always averages out on one side, though.

DR. GOATCH: Okay. Thank you very much.

CMS PARTICIPANT: [Inaudible] the codes, although I think that this is another issue that, you

know, I'd like to come up with CPT next week just to try to get, you know, some further clarification on how to interpret those situations: subsequent codes, where do you kick over into the next code, depending on how long it is. But, you know, at this point, Jim just stated our interpretation of it.

MS. ROULAC: Did you have another question, Dr. Goatch?

DR. GOATCH: No. Thank you.

MS. ROULAC: Okay. Thank you.

Next question.

THE OPERATOR: [Name], you may ask your question.

QUESTION: Yes. Our question was addressed with BlueCross BlueShield of Montana.

MS. ROULAC: Okay.

QUESTION: That's the same issue we had, so we'll wait until something is out there on the other Q & A.

MS. ROULAC: All right. Thank you so much.

QUESTION: Okay.

MS. ROULAC: Next question.

THE OPERATOR: Janet [Name], you may ask your question.

[No response.]

THE OPERATOR: Janet [Name], your line is open.

QUESTION: Yes. My question has also been answered. I was seeking clarification on the IV push versus the infusion. I have a lot of very upset nurses down here who are taking this very literally. But I think you answered my question for right now. Thank you.

MS. ROULAC: Thank you.

Next question.

THE OPERATOR: [Name], you may ask a question.

QUESTION: This is [Name], the medical director for WPS [ph.] Looking at the PowerPoint slides, Slide No. 15 says that the initial code that best describes the service should always be billed irrespective of the order in which the infusions occur. If you look at Slide 33, it says, the initial code refers to the first drug infusion administered.

There seems to be a contradiction in your

definition of "initial."

CMS PARTICIPANT: Actually, I think Slide 33 actually needs to be clarified to comport with that "initial." So, thank you for pointing that out.

QUESTION: Second question: going back to the infusion/IV push of 30 minutes or less, if you can bill that when the person administering the dose of the drug is not constantly in attendance, we're actually going against the definition in the OPS. Is that going to be changed or clarified?

Because if we start telling this to our providers, it looks like we are giving them advice that directly contradicts the description of a push in the OPS. I realize, you know, what your answer was, but that is not the description in the OPS that we have to follow.

CMS PARTICIPANT: I'm looking here at Transmittal 129 [inaudible] pages on mine. Okay.

Four pages in, just before the Non-Chemotherapy Injection heading, "Intravenous intra-arterial push is defined as an injection/infusion of short duration, i.e., 30 minutes or less, in which the healthcare professional

administering the substance or drug is continuously present to administer the injection and observe the patient." That is the language out of the CPT guidance that we are relying on for the instructions.

Again, we recognize the reference to the "healthcare professional continuously present," but, you're right, there are some conflicting issues there.

CMS PARTICIPANT: Our interpretation of the CPT guidance is that, you know, it says injection or infusion of short duration is coded as a push.

QUESTION: But we can still advise providers that they can use push even if they're not continuously present, which, by the way, was the COD edit for Part B News, the January 1st edition. Your answer was the same that the COD put in that article, which surprised us.

CMS PARTICIPANT: Right. Yes. I mean, that is basically where we are on it now, pending further clarification, you know, at least from CPT.

QUESTION: Okay. Thank you.

CMS PARTICIPANT: Thanks.

MS. ROULAC: Thank you.

Next question.

THE OPERATOR: Frank [Name], your line is open.

QUESTION: Thank you. Can you hear me?

MS. ROULAC: Yes. If you can identify yourself and your organization?

QUESTION: Sure. Frank [Name], Carrier Medical Directors in Connecticut. I have several questions in regards to the IV push once again. In looking at the input that went into the work value and the practice expense, are we saying that if a drug is pushed via a syringe as an IV push into an existing tubing, is that the same as hanging a sequential IV for less than 30 minutes?

CMS PARTICIPANT: This issue, you know, may be an issue that we should defer until we have our clerical staff -- I know that this was not the specific issue that was scheduled for the CMT call next week, so I don't know if we'll be able to get into it there. But, you know, we have two -- well, Dr. Simon is on the Development CPT Editorial Panel, as well as the direct panel and, you know, is directly involved. And [Name], you know, is

there as well. So maybe before we get too much farther into this, we can bring them into the discussion.

QUESTION: Should I e-mail that question to the same website?

CMS PARTICIPANT: Sure.

QUESTION: Okay. Great. Thank you.

MS. ROULAC: Thank you.

Next question.

THE OPERATOR: Jill Schaeffer [ph], you may ask your question.

MS. SCHAEFFER: Thank you. Our question was the same question for Slide 16 regarding the -59 modifier. We did address that question to CMS in writing in early January, so a response would be appreciated. Thank you.

MS. ROULAC: You're welcome to send that back to us to the Contractor Training mailbox.

CMS PARTICIPANT: Who was that again? I'm sorry.

MS. SCHAEFFER: [Inaudible.]

MS. ROULAC: Thank you.

Next question.

THE OPERATOR: Theresa Wyland [ph], you may ask your question.

[No response.]

MS. ROULAC: Hello?

THE OPERATOR: Theresa Wyland, your line is open.

MS. WYLAND: This is Theresa Wyland. Our question was already addressed. It had to do with the [inaudible] assessment and whether there needed to be a detail line or header information.

MS. ROULAC: Thank you.

Next question.

THE OPERATOR: [Name], your line is open.

QUESTION: Barb [Name], from Noridian Administrative Services. We've received a lot of questions about the Code G0351, the therapeutic or diagnostic injections. Providers would like to know if they're going to be giving several injections, say maybe three, it would be appropriate to use a -76 modifier with this code, or should they use their quantity value of

three? We would like to know how you feel about this.

MS. ROULAC: Barb, could you put that question and send it to us in the Contractor Training mailbox?

QUESTION: Okay. I'd be glad to. Could I just ask one more quick one?

MS. ROULAC: Certainly.

QUESTION: Okay. The second question is, we've received several inquiries as to whether or not the E & M is coded with the hydration code. We can bill a separate E & M with chemotherapy or infusions, but there was nothing addressed as far as the hydration.

CMS PARTICIPANT: Can you repeat the question again? I didn't catch all of it.

QUESTION: That's okay. The chemotherapy and the infusion codes, we're allowing evaluation and management codes to be billed in addition with a quantified modifier. Providers were asking us if they can bill an E & M with a quantified modifier when they're doing hydration, or would that be bundled?

CMS PARTICIPANT: What level of E & M service are they billing?

QUESTION: They didn't ask.

CMS PARTICIPANT: Beyond level one.

QUESTION: I would assume maybe most of the time hydration is being done with something else, but [inaudible.]

CMS PARTICIPANT: I don't see anything to preclude that as long as it is a separate and related service.

QUESTION: Thank you.

MS. ROULAC: Thank you.

Next question.

THE OPERATOR: Linda [Name], you may ask your question.

QUESTION: Hi. This is Linda [Name] at Noridian Administrative Services. This is regarding the chemo demonstration. If Medicare is a secondary payer and this is a demonstration only for a Medicare population, should the claims processing system bypass the MSP edits and allow the claim for payment?

CMS PARTICIPANT: Yes, presuming your primary payer is not recognizing the demonstration G codes,

which, if that was the case, you know, Medicare would -- my understanding is that, you know, that Medicare, in that situation, would be just paying -- when you say you bypass the edits, I guess I'm not exactly sure what the edits are, but I'm going to answer as far as what the policy would be.

You know, Medicare would be paying for the demonstration. So if it is a matter of how do you pass those costs through --

QUESTION: They may not be recognizing the G codes is kind of what we're thinking.

CMS PARTICIPANT: Right.

QUESTION: So they would be billing -- I don't know -- I guess, the old code or something, so.

CMS PARTICIPANT: Right. Then, I mean, one thing that we have told folks is that it may require, you know, submitting a separate bill with the G codes to Medicare.

MS. ROULAC: If you'd like further clarification on that question, please send it to the Contractor Training mailbox.

QUESTION: Okay. Thank you.

MS. ROULAC: You're welcome.

THE OPERATOR: Sandy Victor [ph], your line is open.

MS. VICTOR: Thank you. My name is Sandy Victor. I'm from Empire Medicare Services, New Jersey. Providers have asked us in relation to the demonstration project why the G0355 and G0356 are not included and only mentioned with G0357 and G0359.

CMS PARTICIPANT: [Inaudible] just for chemotherapy.

MS. VICTOR: G0355 and G0356 are chemotherapy administration except that they're intramuscular and not --

CMS PARTICIPANT: Oh, right. In designing the demonstration, you know, the decision was made to limit it to chemotherapy either infused or administered through a push.

MS. VICTOR: Okay, fine. [Inaudible] the 20 percent [inaudible] providers are getting upset about that. They feel that the CMS [inaudible] and therefore

it is the patient's responsibility for the 20 percent since they [inaudible] patients won't comply with the demonstration project per se. I mean, why did CMS decide to do an 80/20 split?

CMS PARTICIPANT: Well, you know, the decision, you know, was made to include coinsurance under the demonstration just based on the feeling that, you know, that with the design of the demonstration that it wasn't necessary to waive the coinsurance and deductible but that the providers do have the option to waive it on an individual basis and take the financial mean as well as that the participation in the demonstration is voluntary both for the providers and the beneficiaries.

However, certainly, I have been hearing here as well dissatisfaction with the fact that the coinsurance is included, but, you know, it is just a decision that was made in the design of the program. But, you know, we just note that it is voluntary and that it can be waived in individual situations.

MS. VICTOR: Thank you.

MS. ROULAC: Operator, at this time, how many

callers do we have in the queue?

THE OPERATOR: Actually, that was our last one.

MS. ROULAC: Okay. All right. At this point, we won't take any more questions. If you do have additional questions following this training session, please send them to contractortraining@cms.hhs.gov, and if you could get your questions in to us by Friday, February the 11th.

In your e-mail, if you would refer to today's date. We get a lot of questions from different training sessions, so that would be very helpful.

We want to thank everyone for participating in this call. We want to thank our presenters and our subject matter experts here in the room in Central Office for providing answers to your questions.

This ends the training session for today. Thank you so much.

[Whereupon, at 2:30 p.m., the conference call was concluded.]

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