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Information for Medicare Fee-For-Service Health Care Professionals

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Related CR Transmittal #: 148

Implementation Date: May 16, 2005

## Revised Coding Guidelines for Drug Administration Codes

**Note:** This article was updated on February 7, 2013, to reflect current Web addresses. All other information remains unchanged.

### Provider Types Affected

Physicians and providers billing carriers for drug administration procedures

### Provider Action Needed

This article and related CR3818 provide information on revisions to the 2005 drug administration coding guidelines. Implementation of these revised coding guidelines will help Medicare make prompt and correct payments for drug administration services.

### Background

Since the release of Transmittal 129 (CR3631, on the subject of 2005 Drug Administration Coding Revisions) on December 10, 2004, the Centers for Medicare & Medicaid Services (CMS) has received a number of questions pertaining to the G codes and the rules for the revised drug administration codes. CR3631 may be accessed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1290TN.pdf> on the CMS website.

In addition, a MLN Matters article (MM3631) is available on this issue at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3631.pdf> on the CMS website.

In accordance with Section 303 of the Medicare Modernization Act (MMA), which requires the Secretary to promptly evaluate existing drug administration codes to ensure accurate reporting and billing, the Common Procedural Terminology (CPT)

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Editorial Panel was asked to address these questions and consider appropriate revisions to the drug administration coding guidelines. That panel approved revised drug administration coding guidelines.

As a result, CMS has approved revisions to the drug administration coding guidelines to resolve implementation issues associated with Transmittal 129. A summary of changes to the drug administration coding guidelines, which are effective as of March 15, 2005, is provided in the following chart.

Change	Coding Guideline
<b>Short duration infusion</b>	An intravenous or intra-arterial push is now defined as an injection in which the healthcare professional who administers the substance/drug is continuously present to administer the injection and observe the patient; or an infusion of 15 minutes or less. The previous guideline stated 30 minutes or less for infusions.
<b>Concurrent infusions</b>	Beginning March 15, 2005, Medicare carriers will allow payment for only one concurrent infusion (code G0350) per patient per encounter. If more than one concurrent infusion is billed for the same encounter, the carrier will deny the subsequent encounter and a remittance advice remark code of N20 will be returned to denote the service is not payable with other service rendered on the same date. Also, the Medicare carrier will not pay for G0350 (Intravenous infusion, for therapy/diagnosis; concurrent infusion) if it is billed with modifier 59 unless this procedure is provided during a second encounter on the same day with the patient and accompanied by supporting medical documentation.
<b>Initial code</b>	The definition of "initial code" is amended to state that the initial code best describes the key or primary reason for the encounter and should always be reported irrespective of the order in which the infusions or injections occur. This is a clarification of the Transmittal 129 definition that the initial code is "the code that best describes the service the patient is receiving and the additional codes are secondary to the initial code." If more than one initial service code is billed, the carrier will deny the second initial service code using remittance advice remark code of M86 to show that it is not payable unless the patient has to return for a separately identifiable service on the same day or has two IV lines per protocol.
<b>Hydration therapy</b>	Transmittal 129 incorrectly stated: "Report G0346 to identify hydration furnished concurrent with G0359." To be consistent with section 30.5 C, Chapter 12 of the Medicare Claims Processing Manual, this statement should read, "Report G0346 to identify hydration not furnished concurrent with G0359." Separate payment is allowed for hydration therapy and chemotherapy infusion if they are provided sequentially on the same day, but not at the same time.
<b>Separately identifiable services</b>	Transmittal 129 stated, "If the patient has to come back for a separately identifiable service on the same day, or has 2 IV lines per protocol, these services are separately payable and reported with modifier 76." CMS has revised this statement to show that it is more appropriate to use modifier 59 in this situation.

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Your Medicare Carrier will not implement these changes in the system until May 16, 2005. They will not make any adjustments to claims that were processed and paid under the previous guidelines unless you call their attention to such claims. These guidelines are effective for dates of services on or after March 15, 2005.

To see the official instruction regarding revisions to the 2005 drug administration coding guidelines, go to <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1480TN.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.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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