

MLN Matters Number: MM4388

Related Change Request (CR) #: 4388

Related CR Release Date: April 7, 2006

Effective Date: January 1, 2006

Related CR Transmittal #: R902CP

Implementation Date: May 8, 2006

Note: This article was updated on November 1, 2012, to reflect current Web addresses. All other information remains unchanged.

Hospital Outpatient Prospective Payment System (OPPS) Manual Revision: Clarification of Coding and Payment for Drug Administration

Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) for drug administration services under the Hospital OPPS

Provider Action Needed

This article is based on Change Request (CR) 4388, which clarifies the revision to the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 4, Section 230.2) regarding the coding and payment for drug administration under the Hospital Outpatient Prospective Payment System (OPPS).

Background

The Centers for Medicare & Medicaid Services (CMS) previously revised the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 4, Section 230) in Change Request (CR) 4258 (Transmittal R785CP, at <http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R785CP.pdf> on the CMS website).

That manual revision updated payment policies for drug administration services furnished under the OPPS effective January 1, 2006. CMS wants to clarify the new manual language.

To assist hospitals in ensuring continued correct drug administration services coding concepts, CR4388 adds clarifying language to the existing policies in the *Medicare Claims Processing Manual* (Chapter 4, Section 230.2).

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Following is a key excerpt from the revised portion of Section 230.2 that highlights (bolded and italicized) these clarifications:

Medicare Claims Processing Manual

Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS)
Section 230.2 (Coding and Payment for Drug Administration) (Rev.785,
Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)

B. Billing for Infusions and Injections

Intravenous or Intra-Arterial Push - Hospitals are to bill push codes (e.g. C8952, C8953, 96420) for services that meet either of the following criteria:

- A healthcare professional administering an injection is continuously present to administer and observe the patient; or
- An infusion lasting 15 minutes or less.

Hospitals are to bill for additional IV pushes of different substances or drugs using multiple units of the appropriate push code. ***Additional IV pushes of the same substance or drug are not separately reported with multiple units of a push code because the number of units reported with the IV push code is to indicate the number of separate substances or drugs administered by IV push.***

Included Services – Hospitals are instructed that the following ***items and*** services, when performed to facilitate an infusion or injection, are not separately billable. ***However, hospitals have one of two choices: (1) continue to report separate charges so long as the charges are reported without a CPT/HCPCS code but, rather are reported with an appropriate packaged revenue code or (2) do not report any separate charges but include the charges for the items/services as part of the charge for the procedure in which the items/services are supplied.***

- 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)

Fluid used to administer drug(s) is considered incidental hydration and a separate non-chemotherapy infusion service should not be reported.

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EXAMPLE 1

A non-chemotherapy infusion lasts 3 hours and 7 minutes. The hospital bills one unit of C8950 (for the first hour) and two units of C8951 (for the second and third hour). Hospitals cannot bill push codes for carryover infusion services not otherwise eligible for billing of a subsequent infusion hour. Payment will be one unit of APC 0120. (NOTE: See §230.1 for drug billing instructions.)

C. Use of Modifier 59**(Rev.)**

With respect to chemotherapy administration and non-chemotherapy drug infusion, the use of Modifier 59 indicates a distinct encounter on the same date of service. In the case of chemotherapy administration or non-chemotherapy infusion, Modifier 59 is appended to drug administration HCPCS codes that meet the following criteria:

1. **a.** The drug administration occurs during a distinct encounter on the same date of service of previous drug administration services; and
- b.** The same HCPCS code has already been billed for services provided during a separate and distinct encounter earlier on that same day.

OR

2. A distinct and separate drug administration service is provided on the same day as a procedure when there is an OPPS National Correct Coding Initiative edit for the drug administration service and procedure code pair that may be bypassed with a modifier, and the use of the modifier is clinically appropriate.

The CPT modifier 59 is NOT to be used when a beneficiary receives infusion therapy at more than one vascular access site of the same type (intravenous or intra-arterial) in the same encounter or when an infusion is stopped and then started again in the same encounter.

In the instance where infusions of the same type (e.g. chemotherapy, non-chemotherapy, intra-arterial) are provided through two vascular access sites of the same type in one encounter, hospitals may report two units of the appropriate first hour infusion code for the initial infusion hours without modifier 59.

The Outpatient Code Editor (OCE) will pay one unit of the corresponding APC for each separate encounter ***of an appropriately billed drug administration service***, up to the daily maximum listed in Table 1. Units of service exceeding daily maximum allowances will be packaged and no additional payment will be made.

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Additional Information

Transmittal 896, Change Request 5011, issued on March 24, 2006, instructed FIS to implement Version 12.0 of the Correct Coding Initiative (CCI) edits for drug administration services paid under the OPPS and furnished on or after April 1, 2006.

When an OPPS claim triggers a CCI edit, the entire claim is not rejected or returned. Rather, only one line item is rejected. That is, the CCI edits identify pairs of codes that are not appropriately reported together unless an edit permits use of a modifier to signal that the codes represent separate and distinct services/procedures.

Hospitals have expressed concerns about the impact of CCI edits on coding for drug administration services under the OPPS.

Therefore, CMS instructed fiscal intermediaries on May 8, 2006, to enable claims with dates of service on or after April 1, 2006, through June 30, 2006, to process to payment without triggering a line item rejection and CCI edit when the following code pairs are reported on the same claim with the same date of service, but without modifier -59:

Column 1	Column 2
C8950	C8952
C8953	C8950
C8953	C8952
C8954	C8950
C8954	C8952
C8954	C8953

Providers may submit adjustment bills to receive payment if one of the codes in any of the above code pairs has been rejected for payment.

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed at

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R902CP.pdf> on the CMS website.

For complete details of CR5011, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed at

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R896CP.pdf> on the CMS website.

If you have any questions, please contact your intermediary 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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