CMS Manual System

Pub 100-20 One-Time Notification Transmittal Sheet

Transmittal 148

Department of Health & Human Services
Center for Medicare and & Medicaid Services
Date: APRIL 15, 2005
Change Request # 3818

SUBJECT: Revised Coding Guidelines for Drug Administration Codes

I. SUMMARY OF CHANGES: This one time notification incorporates revisions to the coding guidelines for drug administration services adopted by the Current Procedural Terminology (CPT) Editorial Panel in February 2005. These revisions pertain to the short duration infusion, the allowable number of concurrent infusions per patient per encounter, and clarification of the term "initial" service for drug administration services. We are also providing corrections to two issues presented in Transmittal 129, released on December 10, 2004, which addressed the 2005 drug administration coding revisions. These corrections relate to the use of modifier 59, instead of modifier 76, for the patient who has to come back for a separately identifiable service on the same day, or has 2 IV lines per protocol and that hydration services are billable only if they are performed sequentially, but not concurrently, to a drug infusion service.

NEW/REVISED MATERIAL :
EFFECTIVE DATE : March 15, 2005
IMPLEMENTATION DATE : May 16, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-04	Transmittal: 148	Date: April 15, 2005	Change Request 3818

SUBJECT: Revised Coding Guidelines for Drug Administration Codes

I. GENERAL INFORMATION

A. Background: CMS issued Transmittal 129 (2005 Drug Administration Coding Revisions) on December 10, 2004. This transmittal implemented the drug administration policy in the physician fee schedule final rule published in the **Federal Register** on November 15, 2004. In that final rule, we announced that we would adopt G codes for 2005 for drug administration services that correspond to the new CPT drug administration codes that will become effective in 2006. (The 2005 CPT had already been published prior to the adoption of the new and revised drug administration codes.)

In addition to adopting the G codes, we also adopted, in 2005, the CPT coding rules (which remain unpublished until the 2006 CPT book is published) for the new drug administration codes.

We have received a number of questions from our carriers and the oncology community since the issuance of Transmittal 129. When the CPT Editorial Panel met in February 2005, we asked them to consider revised drug administration coding guidelines to address these questions. The Panel approved revised drug administration coding guidelines at this meeting and communicated this information to CMS in a letter dated March 3, 2005.

We are adopting these guidelines now to make for an easier transition next year.

B. Policy: Transmittal 129 incorporates coding guidelines adopted by CPT in September 2004 for drug administration codes. One of these guidelines defines an intravenous or intra-arterial push as an injection/infusion of short duration (i.e., 30 minutes or less) in which the healthcare professional who administers the substance/drug is continuously present to administer the injection and observe the patient.

We have received a number of questions from the carriers and the oncology community on this guideline. The most notable question is whether the professional administering the infusion must be continuously present to administer the infusion and observe the patient or whether this requirement only applies to the push itself. Concerns have also been raised from the medical community that an infusion is not a push and should not be coded as such.

In February 2005, the CPT Editorial Panel met and discussed revisions to the coding guidelines for drug administration codes for 2006. The CPT sent a letter to CMS on March 3, 2005 noting that it would be desirable from the perspective of the American Medical Association and the CPT Editorial Panel to resolve implementation issues associated with the earlier drug administration guidelines. For the short duration infusion, the CPT Editorial Panel Meeting adopted the following coding guideline (which will appear in the 2006 book):

Intravenous or intra-arterial push is 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.

Concurrent Infusions

For 2005, there is a new drug administration code for a concurrent infusion. The specific G code is: G0350 *Intravenous infusion, for therapy/diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for procedure)*

Transmittal 129 did not limit the billing of concurrent infusions.

At its February meeting, the CPT Editorial Panel Meeting adopted the coding guideline that the concurrent infusion code is reported only once per encounter.

We are adopting this guideline effective with the implementation date of this transmittal. The carrier shall allow payment for only one concurrent infusion per patient per encounter. The carrier shall not allow payment for G0350 if it is billed with modifier 59 unless this is provided during a second encounter on the same day with the patient and is accompanied by supporting medical documentation.

Initial Code

Transmittal 129 stated 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".

At its February 2005 meeting, the CPT clarified 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.

Implementation of Revised Coding Guidelines

We are adopting these guidelines in 2005 and not waiting to implement these guidelines until the 2006 CPT book is published. The carriers shall implement these revised guidelines effective with the implementation date of this transmittal. The carriers shall make no adjustments to claims that were processed and paid under the previous guidelines unless brought to their attention.

Corrections

Transmittal 129 stated the policy in section 30.5 C of Chapter 12 of Pub. 100-04 that permits separate payment of hydration therapy sequentially (but not concurrently) to the chemotherapy applies to services furnished in 2005. However, later in Transmittal 129, it incorrectly stated that: "Report G0346 to identify hydration furnished concurrent with G0359". To be consistent with section 30.5C, this statement should read, "Report G0346 to identify hydration **not** furnished concurrent with G0359" (emphasis added).

Transmittal 129 included the statement, “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”. We understand that the use of modifier 59, instead of 76, is more appropriate for this arrangement. We are including a revised business requirement to reflect this revision.

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3818.1	Effective for dates of service on and after March 15, 2005, contractors shall use the revised CPT coding guidelines for drug administration codes listed above in section I., B., Policy, of this CR.			X						
3818.2	Effective for dates of service on and after March 15, 2005, contractors shall allow payment for only one concurrent infusion code per patient per encounter. The concurrent infusion code is G0350.			X						
3818.3	Effective for dates of service on and after March 15, 2005, if more than one concurrent infusion is billed per patient per encounter, contractors shall deny the second concurrent infusion code and generate the appropriate message(s), such as: MSN 15.1 (The information provided does not support the need for this many services or items.); Claims Adjustment Reason Code 151 (Payment adjusted because the payer deems the information submitted does not support this many services.); Remittance Advice Code N20 (Service not payable with other service rendered on the same date.).			X						
3818.4	The contractors shall not allow payment of G0350 if it is billed with modifier 59 unless this is a service provided for the same patient for a second encounter on the same day and is			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	accompanied by medical documentation									
3818.5	If more than one "initial" service code is billed per day, contractors shall deny the second "initial" service code and generate MSN messages 18.16 and 16.45 and Remittance Advice remark code M86 (unless the patient has to come back for a separately identifiable service on the same day or has two IV lines per protocol). For these separately identifiable services, instruct the biller to report with modifier 59.			X						
3818.6	Contractors shall not reopen or adjust claims already processed unless brought to their attention.			X						

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3818.7	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matter articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly. Contractors shall educate the physician community via Medlearn Matters article about the new coding guidelines adopted by CMS.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: March 15, 2005 **Implementation Date:** May 16, 2005	**No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating**

Pre-Implementation Contact(s): James Menas, 410-786-4507 JMenas@cms.hhs.gov; Kathleen Kersell 410-786-2033, KKersell@cms.hhs.gov **Post-Implementation Contact(s):**	**budgets.**

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