

CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 902

Department of Health &
Human Services (DHHS)

Centers for Medicare &
Medicaid Services (CMS)

Date: APRIL 7, 2006

Change Request 4388

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

I. SUMMARY OF CHANGES: Clarifying revisions to Chapter 4 of the Medicare Claims Processing Manual on Coding and Payment for Drug Administration under the Hospital Outpatient Prospective Payment System (OPPS)

NEW/REVISED MATERIAL

EFFECTIVE DATE: January 1, 2006

IMPLEMENTATION DATE: May 8, 2006

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 |
|-------|--|
| R | 4/230.2/Coding and Payment for Drug Administration |

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

| | | | |
|-------------|------------------|---------------------|---------------------|
| Pub. 100-04 | Transmittal: 902 | Date: April 7, 2006 | Change Request 4388 |
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SUBJECT: Hospital Outpatient Prospective Payment System (OPPS) Manual Revision: Clarification of Coding and Payment for Drug Administration

I. GENERAL INFORMATION

A. Background: In Transmittal R785CP (Change Request 4258), we revised Pub. 100-04, Chapter 4, §230 of the Medicare Claims Processing Manual. The manual revision updated payment policies for drug administration services furnished under the Hospital Outpatient Prospective Payment System (OPPS) effective January 1, 2006. The payment policies contained in the manual revision have generated requests to clarify the new manual language.

B. Policy: In order to support continued hospital implementation efforts of correct coding concepts for drug administration services, we are adding clarifying language to existing policies in Pub. 100-04 Medicare Claims Processing Manual, Chapter 4, §230.

II. BUSINESS REQUIREMENTS

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

| Requirement Number | Requirements | Responsibility (“X” indicates the columns that apply) | | | | | | | | |
|--------------------|--|---|-------------|---------------------------------|-----------------------|---------------------------|-------------|-------------|-------------|-------|
| | | F I | R H I | C a r r i e r | D M E R C | Shared System Maintainers | | | | Other |
| | | | | | | F I S S | M C S | V M S | C W F | |
| 4388.1 | Contractors shall be in compliance with the manual instruction in Publication 100-04, Chapter 4, §230. | X | | | | | | | | |

III. PROVIDER EDUCATION

| Requirement Number | Requirements | Responsibility (“X” indicates the columns that apply) | | | | | | | |
|--------------------|---|---|-------------|---------------------------------|-----------------------|---------------------------|-------------|--|--|
| | | F I | R H I | C a r r i e r | D M E R C | Shared System Maintainers | | | |
| F I S S | M C S | | | | | V M S | C W F | | |
| 4388.2 | <p>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 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 Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.</p> | X | | | | | | | |

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*: January 1, 2006 Implementation Date: May 8, 2006 Pre-Implementation Contact(s): Rebecca Kane, (410)786-0378, rebecca.kane@cms.hhs.gov Post-Implementation Contact(s): Appropriate RO | No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets. |
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***Unless otherwise specified, the effective date is the date of service.**

230.2 - Coding and Payment for Drug Administration

(Rev.902, Issued: 04-07-06, Effective: 01-01-06, Implementation: 05-08-06)

A. Overview

Certain drug administration services furnished under the Hospital Outpatient Prospective Payment System (OPPS) prior to January 1, 2005 were reported using HCPCS alphanumeric codes: Q0081, Infusion therapy other than chemotherapy, per visit; Q0083, Administration of chemotherapy by any route other than infusion, per visit; and Q0084, Administration of chemotherapy by infusion only, per visit) in combination with applicable CPT codes for administration of non-infused, non-chemotherapy drugs. (NOTE: HCPCS code Q0085, administration of anti-neoplastic drugs by both infusion and a route other than infusion, per visit, was discontinued in 2004.)

These same drug administration services furnished by hospital outpatient departments to Medicare beneficiaries during CY 2005 were reported using CPT codes 90780, 90781, and 96400-96459. Payments for these drug administration services in 2005 continued to be made on a per visit basis (rather than a per-service basis) due to the per-day 2003 cost data available to set CY 2005 payment rates.

Effective January 1, 2006, some of the CPT codes that were used for drug administration services under the OPSS throughout CY 2005 are replaced with more detailed CPT codes incorporating specific procedural concepts, as defined and described by the CPT manual, such as “initial,” “concurrent,” and “sequential.”

In order to facilitate the transition to more specific CPT codes within the hospital environment and to assist hospitals in ensuring continued correct coding concepts, drug administration services provided in CY 2006 under the OPSS will be billed using a combination of CPT codes and C-codes that were created to be consistent with some aspects of the CY 2005 CPT coding structure.

Hospitals are reminded to bill a separate Evaluation and Management code (with modifier 25) only if a significant, separately identifiable E/M service is performed in the same encounter with OPSS drug administration services.

B. Billing for Infusions and Injections

First Hour of Infusion - Hospitals are to report first hour infusion codes (e.g., C8950, C8954, 96422) after 15 minutes of infusion. Infusions lasting 15 minutes or less should be billed as intravenous (or intra-arterial) pushes and must be coded accordingly. If hospitals provide different types of infusions (1) that could be reported with separate first hour infusion codes (e.g. chemotherapy and non-chemotherapy intravenous infusions, or intra-arterial and intravenous chemotherapy infusions) in the same encounter and (2) that also meet the time requirements for billing an hour of each type of infusion, then hospitals may report a first hour for each different type of infusion provided.

Subsequent Infusion Hours - Hospitals are to report additional hours of infusion (e.g., C8951, C8955, 96423), either a continuing infusion of the same substance or drug or a sequential infusion of a different substance or drug, beyond the first hour, in accordance with §230.2.2 and §230.2.3, and only after more than 30 minutes have passed from the end of the previously billed hour. Therefore, to bill an additional hour of infusion after the first hour, more than 90 minutes of infusion services must be provided. One unit of the appropriate code is to be reported for each additional hour of infusion.

Concurrent Infusions – Concurrent infusions through the same vascular access site of the same type are not separately reportable under the OPPS. Hospitals are to include the charges associated with concurrent infusions in their charges for the infusion service billed.

Infusion Time – Hospitals are to report HCPCS codes that describe the actual time over which the infusion is administered to the beneficiary for time-specific drug administration codes (e.g., C8950, C8951, C8954, C8955, 96422, 96423). Hospitals should not include in their reporting the time that may elapse between establishment of vascular access and initiation of the infusion.

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 and 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; and
- 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.

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 can not 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

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:

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

OR

- *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, nonchemotherapy, 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.

EXAMPLE 1

A beneficiary receives infused non anti-neoplastic drugs for 2 hours. The hospital reports one unit of HCPCS code C8950 and one unit of HCPCS code C8951 for the services in the encounter. The beneficiary leaves the hospital and returns for a second encounter in which the beneficiary again receives infused non anti-neoplastic drugs for 2 hours. For the second encounter on the same date of service, the hospital reports one unit of HCPCS code C8950 with modifier 59 and one unit of HCPCS code C8951 with modifier 59. The OCE will pay 2 units of APC 0120 (i.e., one unit for each encounter). (NOTE: See §230.1 for drug billing instructions.)

EXAMPLE 2

A beneficiary receives one injection of non-hormonal anti-neoplastic drugs and 2 hours of an infusion of anti-neoplastic drugs in the first encounter. The hospital reports one unit of 96401 and one unit each of C8954 and C8955. The OCE will pay one unit of APC 0116 (for one unit of 96401) and one unit of APC 0117 (for the one unit each of C8954 and C8955). Later on the same date of service, the beneficiary returns to the hospital and receives two injections of non-hormonal anti-neoplastic drugs. For the second encounter, the hospital reports one unit of 96401 with modifier 59, and one unit of 96401 without modifier 59. The hospital will be paid one unit of APC 0116 for two units of 96401 (as the second unit of 96401 provided during the second encounter is bundled with the first unit of 96401 provided during the second encounter). (NOTE: See §230.1 for drug billing instructions.)

EXAMPLE 3

A beneficiary receives three injections of non-hormonal anti-neoplastic drugs and 2 hours of infusion of anti-neoplastic drugs in one encounter. The beneficiary returns to the hospital in a separate encounter on the same date for administration of hydrating solution provided via infusion over 2 hours to treat dehydration and vomiting. For services in the first encounter, the hospital reports CPT codes as three units of 96401, one unit of C8954, and one unit of C8955 (all without modifier 59). For services in the second encounter, the hospital reports one unit of HCPCS code C8950 and one unit of HCPCS code C8951. The OCE pays one unit of APC 0116 (for the 3 units of 96401), one unit of APC 0117 (for the one unit of C8954 and C8955) and one unit of APC 0120 (for the one unit of C8950 and the one unit of C8951). No modifiers are needed when billing for services in the second encounter as these services were not provided during the first encounter on that day. (NOTE: See §230.1 for drug billing instructions.)

EXAMPLE 4

A beneficiary receives three injections of anti-neoplastic drugs and 2 hours of infusion of anti-neoplastic drugs in one encounter. The beneficiary has a second encounter on the same date of service in which the beneficiary receives three injections of non-hormonal anti-neoplastic drugs and one hour of infusion of drugs other than anti-neoplastic drugs (includes hydrating solution). For the first encounter the hospital reports the following: Three units of 96401, one unit of C8954, and one unit of C8955 (without modifier 59). For the second encounter, the hospital bills three units of CPT code 96401 (one unit with modifier 59, two units without modifier 59), and one unit of CPT code C8950 (without modifier 59). The OCE pays two units of APC 0116 (one for each encounter - 3 units of 96401 during the first encounter and 3 units during the second), one unit of APC 0117 (for the one unit each of C8954 and C8955 during the first encounter) and one unit of APC 0120 (for the one unit of C8950 during the second encounter). (NOTE: See §230.1 for drug billing instructions.)

D. Payments For Drug Administration Services

Payment for drug administration services in CY 2006 will again be based on a per-visit basis due to the per-visit claims data available with which to set CY 2006 payment rates. The OCE includes claims processing logic that assesses each OPPS claim and assigns APC payments to HCPCS codes as appropriate. OCE logic allows for drug administration APC payments as noted in Table 1 below.

Table 1: OCE Parameters for Drug Administration APC Payments

| APC | Maximum Number of Units Without Modifier -59 | Maximum Number of Units With Modifier -59 |
|------|--|---|
| 0116 | 1 | 2 |
| 0117 | 1 | 2 |
| 0120 | 1 | 4 |

The OCE groups each HCPCS code appearing on a claim into one of these three APCs based on their APC assignment in Addendum B of the OPPS final rule with comment period. If none of the reported drug administration HCPCS codes contain modifier -59, the OCE will provide a single per-encounter APC payment for each APC that has a corresponding HCPCS code billed on the claim. If modifier-59 does appear on the claim, the OCE can assign one additional payment per incidence of the modifier, with an upper limit of APC payments listed above in Table 1.

For CY 2006 APC payment rates, refer to Addendum B on the CMS Web site at www.cms.hhs.gov/providers/hopps.asp.

E. Infusions Started Outside the Hospital

Hospitals may receive Medicare beneficiaries for outpatient services who are in the process of receiving an infusion at their time of arrival at the hospital (e.g. a patient who arrives via ambulance with an ongoing intravenous infusion initiated by paramedics during transport). Hospitals are reminded to bill for all services provided using the HCPCS code(s) that most accurately describe the service(s) they provided. This includes hospitals billing C8950 or C8954 for the first hour of intravenous infusion that the patient receives while at the hospital, even if the hospital did not initiate the infusion, and HCPCS codes for additional hours of infusion if needed.