CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 785

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: DECEMBER 16, 2005

Change Request 4258

SUBJECT: January 2006 Update of the Hospital Outpatient Prospective Payment System (OPPS) Manual Instruction: Changes to Coding and Payment for Drug Administration -- MANUALIZATION

I. SUMMARY OF CHANGES:

NEW/REVISED MATERIAL
EFFECTIVE DATE: January 1, 2006
IMPLEMENTATION DATE: January 3, 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/Table of Contents
R	4/230.2/Coding and Payment for Drug Administration
R	4/230.2.1/Administration of Drugs Via Implantable or Portable Pumps
R	4/230.2.2/Chemotherapy Drug Administration
R	4/230.2.3/Non-Chemotherapy Drug Administration
D	4/230.2.4/Administration of Non-Chemotherapy Drugs by Infusion
D	4/230.2.5/Administration of Non-Chemotherapy Drugs by a Route Other Than Infusion
D	4/230.2.6/Use of Modifier 59
D	4/230.2.7/Billing for Infusion Hours

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: 785	Date: December 16, 2005	Change Request 4258

SUBJECT: January 2006 Update of the Hospital Outpatient Prospective Payment System (OPPS) Manual Instruction: Changes to Coding and Payment for Drug Administration -- MANUALIZATION

I. GENERAL INFORMATION

A. Background: This manual section describes changes to coding and payment for drug administration for hospitals paid under the OPPS, to be implemented in the January 2006 OPPS update. The January 2006 OPPS OCE and OPPS PRICER reflect the changes identified in this manual section. The instruction to install the January 2006 OPPS PRICER is provided in Change Request 4250, Transmittal 786, dated December 16, 2005. The instruction to install the January 2006 OPPS OCE is provided in Change Request 4238, Transmittal 784, dated December 16, 2005. Unless otherwise noted, the coding and payment policy addressed in this manual revision are effective for services furnished on or after January 1, 2006.

B. Policy: 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 OPPS 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 OPPS 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 OPPS drug administration services.

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	
4258.1	Contractors shall be in compliance with the manual instruction in Publication 100-4, Chapter 4, Sections 230.1, 230.1.2, 230.1.3, 230.1.4, 230.2, 230.2.1, 230.2.2, 230.2.3	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	
4258.2	Contractors shall post this entire instruction, or a direct link to this instruction, on their Web site and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic.	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:** January 3, 2006 **Pre-Implementation Contact(s):** Chuck Braver at (410) 786-6719 for policy payment issues Antoinette Johnson at (410) 786-9326 for Part B claims processing **Post-Implementation Contact(s):** Chuck Braver at (410) 786-6719 for policy payment issues Antoinette Johnson at (410) 786-9326 for Part B claims processing	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

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(Rev.785, 12-16-05)

Crosswalk to Old Manuals

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230.2.1 –Administration of Drugs Via Implantable or Portable Pumps

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230.2.3 - Non-Chemotherapy Drug Administration

230.2 - Coding and Payment for Drug Administration
(Rev.785, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)

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 OPPS 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 OPPS 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 OPPS 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.

Included Services – *Hospitals are instructed that the following services, when performed to facilitate an infusion or injection, are not separately billable:*

- *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.

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

(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. The drug administration occurs during a distinct encounter on the same date of service of previous drug administration services; and

2. The same HCPCS code has already been billed for services provided during a separate and distinct encounter earlier on that same day.

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, 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

(Rev.785, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)

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.

230.2.1 - Administration of Drugs Via Implantable or Portable Pumps

(Rev.785, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)

Table 2: CY 2006 OPPS Drug Administration Codes for Implantable or Portable Pumps

2005 CPT		Final CY 2006 OPPS			
2005 CPT	2005 Description	Code	Description	SI	APC
n/a	n/a	C8957	Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump	S	0120

2005 CPT		Final CY 2006 OPPS			
2005 CPT	2005 Description	Code	Description	SI	APC
96414	Chemotherapy administration, intravenous; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of portable or implantable pump	S	0117
96425	Chemotherapy administration, infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump)	96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	S	0117
96520	Refilling and maintenance of portable pump	96521	Refilling and maintenance of portable pump	T	0125
96530	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic [e.g. Intravenous, intra-arterial]	96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial)	T	0125
n/a	n/a	96523	Irrigation of implanted venous access device for drug delivery systems	N	-

Hospitals are to report HCPCS code C8957 and CPT codes 96416 and 96425 to indicate the initiation of a prolonged infusion that requires the use of an implantable or portable pump. CPT codes 96521, 92522, and 96523 should be used by hospitals to indicate refilling and maintenance of drug delivery systems or irrigation of implanted venous access devices for such systems, and may be reported for the servicing of devices used for therapeutic drugs other than chemotherapy.

230.2.2 - Chemotherapy Drug Administration

(Rev.785, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)

A. Overview

AMA chemotherapy administration instructions for CPT codes 96401-96549 additionally apply to HCPCS codes C8954, C8955 and C8953. Therefore, hospitals are to report chemotherapy drug administration HCPCS codes when providing non-radionuclide anti-neoplastic drugs to treat cancer and when administering non-radionuclide anti-neoplastic drugs, anti-neoplastic agents, monoclonal antibody agents, and biologic response modifiers for treatment of noncancer diagnoses.

Medicare's general policy regarding physician supervision within hospital outpatient departments meets the physician supervision requirements for use of CPT codes 96401-96549. (Reference: Medicare Benefit Policy Manual, Pub.100-02, Chapter 6, §20.4.1.)

B. Administration of Chemotherapy Drugs by Intravenous Infusion

(Rev. XXX, Issued: XXX, Effective: 01-01-06, Implementation: 01-01-06)

Effective for services furnished on or after January 1, 2006, hospitals paid under the OPPS (12x and 13x bill types) are to report an appropriate HCPCS code for chemotherapy drug administration by intravenous infusion as listed in Table 3.

Table 3: CY 2006 OPPS Chemotherapy Drug Administration – Intravenous Infusion Technique

2005 CPT		*Final CY 2006 OPPS*			
2005 CPT	*2005 Description*	*HCPCS Code*	*Description*	*SI*	*APC*
96410	*Chemotherapy administration, intravenous; infusion technique, up to one hour*	*C8954*	*Chemotherapy administration, intravenous; infusion technique, up to one hour*	*S*	*0117*
96412	*Chemotherapy administration, intravenous; infusion technique, one to 8 hours, each additional hour (List separately in addition to code for primary procedure)*	*C8955*	*Chemotherapy administration, intravenous; infusion technique, each additional hour (List separately in addition to C8954)*	*N*	*-*
96414	*Chemotherapy administration, intravenous; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump*	*96416*	*Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of portable or implantable pump*	*S*	*0117*

For services furnished in hospital outpatient departments prior to January 1, 2005, chemotherapy drug infusions were reported using HCPCS alphanumeric code Q0084, Administration of Chemotherapy by Infusion only, per visit. Chemotherapy infusion services furnished in hospital outpatient departments during CY 2005 were reported using CPT codes 96410, 96412 and 96414.

Table 3 maps CY 2005 chemotherapy administration via intravenous infusion CPT codes to OPPS drug administration codes effective January 1, 2006.

HCPCS code C8955 is an add-on code. HCPCS code C8955 should be used by hospitals to report the total number of additional infusion hours after the first hour of chemotherapy infusion. Additional hours of chemotherapy infusion beyond 9 hours will no longer need to be reported on separate lines, as there is no hour limit associated with this code.

The OCE logic assumes that all services for chemotherapy infusions billed on the same date of service were provided during the same encounter. In those unusual cases where the beneficiary makes two separate visits to the hospital for chemotherapy infusions in the same day, the hospital reports modifier 59 for chemotherapy infusion codes during the second encounter that were also furnished in the first encounter. The OCE identifies modifier 59 and pays up to a maximum number of units per day, as listed in Table 1.

EXAMPLE 1

A beneficiary receives one injection of non-hormonal anti-neoplastic drugs and an infusion for 2 hours of anti-neoplastic drugs in one encounter. The patient leaves the hospital and later that same day returns to the hospital for two injections of non-hormonal anti-neoplastic drugs. To bill for the first encounter, the hospital reports one unit of 96401 (without modifier 59), one unit of C8954, and one unit of C8955 (without modifier 59). To bill 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 two units of APC 0116 (once for each encounter with 96401 - one unit in the first, two units in the second)) and one unit of APC 0117 (for the one unit of C8954 and the one unit of C8955). (NOTE: See §230.1 for drug billing instructions.)

EXAMPLE 2

A beneficiary receives an infusion of anti-neoplastic drugs for 2 hours using a hydrating solution to which the anti-neoplastic drug has been added, without a specific medically necessary order for hydration. The hospital reports one unit of C8954 and one unit of C8955. The OCE will pay one unit of APC 0117 (for the one unit each of C8954 and C8955). (NOTE: See §230.1 for drug billing instructions.)

C. Administration of Chemotherapy Drugs by a Route Other Than Intravenous Infusion

(Rev.785, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)

Effective for services furnished on or after January 1, 2006, hospitals paid under the OPPS (12x and 13x bill types) are to report an appropriate HCPCS code for chemotherapy drug administration by route other than infusion as listed in Table 4.

Table 4: CY 2006 OPPS Chemotherapy Drug Administration – Route Other Than Intravenous Infusion

2005 CPT		*Final CY 2006 OPPS*			
2005 CPT	*2005 Description*	*HCPCS Code*	*Description*	*SI*	*APC*
96408	*Chemotherapy administration, intravenous; push technique*	*C8953*	*Chemotherapy administration, intravenous; push technique*	*S*	*0116*
96400	*Chemotherapy administration, subcutaneous or intramuscular, with or without local anesthesia*	*96401*	*Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic*	*S*	*0116*
96400	*Chemotherapy administration, subcutaneous or intramuscular, with or without local anesthesia*	*96402*	*Chemotherapy administration, subcutaneous or intramuscular; hormonal anti neoplastic*	*S*	*0116*
96405	*Chemotherapy administration, intralesional; up to and including 7 lesions*	*96405*	*Chemotherapy administration; intralesional, up to and including 7 lesions*	*S*	*0116*
96406	*Chemotherapy administration, intralesional; more than 7 lesions*	*96406*	*Chemotherapy administration; intralesional, more than 7 lesions*	*S*	*0116*
96420	*Chemotherapy administration, intra-arterial; push technique*	*96420*	*Chemotherapy administration, intra-arterial; push technique*	*S*	*0116*

2005 CPT		Final CY 2006 OPPS			
2005 CPT	2005 Description	HCPCS Code	Description	SI	APC
96422	Chemotherapy administration, infusion technique up to one hour	96422	Chemotherapy administration, intra-arterial; infusion technique, up to one hour	S	0117
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	S	0116
96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis	96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis	S	0116
96450	Chemotherapy administration, into CNS (e.g. Intrathecal) requiring and including spinal puncture	96450	Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture	S	0116
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	S	0116
96549	Unlisted chemotherapy procedure	96549	Unlisted chemotherapy procedure	S	0116
96423	Chemotherapy administration, infusion technique, one to 8 hours, each additional hour (List separately in addition to code for primary procedure)	96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour up to 8 hours (List separately in addition to code for primary procedure)	N	-

Chemotherapy drug administration services other than intravenous infusion that were furnished in hospital outpatient departments during CY 2005 were reported using CPT codes 96420-96549.

Table 4 maps CY 2005 chemotherapy administration via routes other than intravenous infusion CPT codes to OPPS drug administration HCPCS codes effective January 1, 2006.

CPT code 96423 is an add-on code to indicate the total number of hours of intra-arterial infusion that are provided in addition to the first hour of administration. CPT code 96423 should be used by hospitals to report the total number of additional infusion hours. Additional hours of infusion beyond 8 should be reported on another separate line with CPT code 96423 and the appropriate number of hours.

OCE logic assumes that all services for chemotherapy drug administration by a route other than infusion that are billed on the same date of service were provided during the same encounter. In those unusual cases where the beneficiary makes two separate visits to the hospital for chemotherapy treatment in the same day, hospitals are instructed to report modifier 59 for chemotherapy drug administration (by a route other than infusion) codes during the second encounter that were also furnished in the first encounter. The OCE identifies modifier 59 and pays up to a maximum number of units per day, as listed in Table 1.

230.2.3 – Non-Chemotherapy Drug Administration

A. Administration of Non-Chemotherapy Drugs by Intravenous Infusion

(Rev.785, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)

Table 5: CY 2006 OPPS Non-Chemotherapy Drug Administration –Intravenous Infusion Technique

2005 CPT		*Final CY 2006 OPPS*			
2005 CPT	***2005 Description***	***Code***	***Description***	***SI***	***APC***
90780	*Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour*	*C8950*	*Intravenous infusion for therapy/diagnosis; up to 1 hour*	*S*	*0120*
90781	*Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; each additional hour, up to eight (8) hours (List separately in addition to code for primary procedure)*	*C8951*	*Intravenous infusion for therapy/diagnosis; each additional hour (List separately in addition to C8950)*	*N*	*-*
n/a	*n/a*	*C8957*	*Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump*	*S*	*0120*

Hospitals are to report HCPCS code C8950 to indicate an infusion of drugs other than anti-neoplastic drugs furnished on or after January 1, 2006 (except as noted at 230.2.2(A) above). HCPCS code C8951 should be used to report all additional infusion hours, with no limit on the number of hours billed per line. Medically necessary separate therapeutic or diagnostic hydration services should be reported with C8950 and C8951, as these are considered intravenous infusions for therapy/diagnosis.

HCPCS codes C8950 and C8951 should not be reported when the infusion is a necessary and integral part of a separately payable OPPS procedure.

When more than one nonchemotherapy drug is infused, hospitals are to code HCPCS codes C8950 and C8951 (if necessary) to report the total duration of an infusion, regardless of the number of substances or drugs infused. Hospitals are reminded to bill separately for each drug infused, in addition to the drug administration services.

The OCE pays one APC for each encounter reported by HCPCS code C8950, and only pays one APC for C8950 per day (unless Modifier 59 is used). Payment for additional hours of infusion reported by HCPCS code C8951 is packaged into the payment for the initial infusion. While no separate payment will be made for units of HCPCS code C8951, hospitals are instructed to report all codes that appropriately describe the

services provided and the corresponding charges so that CMS may capture specific historical hospital cost data for future payment rate setting activities.

OCE logic assumes that all services for non-chemotherapy infusions billed on the same date of service were provided during the same encounter. Where a beneficiary makes two separate visits to the hospital for non-chemotherapy infusions in the same day, hospitals are to report modifier 59 for non-chemotherapy infusion codes during the second encounter that were also furnished in the first encounter. The OCE identifies modifier 59 and pays up to a maximum number of units per day, as listed in Table 1.

EXAMPLE 1

A beneficiary receives infused drugs that are not anti-neoplastic drugs (including hydrating solutions) for 2 hours. The hospital reports one unit of HCPCS code C8950 and one unit of HCPCS code C8951. The OCE will pay one unit of APC 0120. Payment for the unit of HCPCS code C8951 is packaged into the payment for one unit of APC 0120. (NOTE: See §230.1 for drug billing instructions.)

EXAMPLE 2

A beneficiary receives infused drugs that are not anti-neoplastic drugs (including hydrating solutions) for 12 hours. The hospital reports one unit of HCPCS code C8950 and eleven units of HCPCS code C8951. The OCE will pay one unit of APC 0120. Payment for the 11 units of HCPCS code C8951 is packaged into the payment for one unit of APC 0120. (NOTE: See §230.1 for drug billing instructions.)

EXAMPLE 3

A beneficiary experiences multiple attempts to initiate an intravenous infusion before a successful infusion is started 20 minutes after the first attempt. Once started, the infusion lasts one hour. The hospital reports one unit of HCPCS code C8950 to identify the 1 hour of infusion time. The 20 minutes spent prior to the infusion attempting to establish an IV line are not separately billable in the OPPS. The OCE pays one unit of APC 0120. (NOTE: See §230.1 for drug billing instructions.)

B. Administration of Non-Chemotherapy Drugs by a Route Other Than Intravenous Infusion

(Rev.785, Issued: 12-16-05, Effective: 01-01-06, Implementation: 01-03-06)

Table 6: CY 2006 OPPS Non-Chemotherapy Drug Administration –Route Other Than Intravenous Infusion

2005 CPT		Final CY 2006 OPPS			
2005 CPT	2005 Description	Code	Description	SI	APC
90784	Therapeutic, prophylactic or diagnostic injection (specify material injected); intravenous	C8952	Therapeutic, prophylactic or diagnostic injection; intravenous push	X	0359
90782	Therapeutic, prophylactic or diagnostic injection (specify material injected); subcutaneous or intramuscular	90772	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	X	0353
90783	Therapeutic, prophylactic or diagnostic injection (specify material injected); intra-arterial	90773	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial	X	0359
90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial, injection or infusion	90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion	X	0352