# CMS Manual System

## Pub. 100-04 Medicare Claims Processing

**Department of Health & Human Services (DHHS)**
**Centers for Medicare & Medicaid Services (CMS)**

**Transmittal 147** **Date: APRIL 23, 2004**

**CHANGE REQUEST 3192**

**I. SUMMARY OF CHANGES**: This Change Request (CR) incorporates the policy included in CR 3028 (Transmittal 34, dated December 24, 2003) pursuant to section 303 of the Medicare Modernization Act which affects payment for chemotherapy administration and nonchemotherapy drug infusion services furnished on or after January 1, 2004. In section 20.3, the old section D has been deleted and replaced with the old section E.

**NEW/REVISED MATERIAL - EFFECTIVE DATE: January 1, 2004**
***IMPLEMENTATION DATE: May 24, 2004**

***Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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:**
**(R = REVISED, N = NEW, D = DELETED)**

| R/N/D | CHAPTER/SECTION/SUBSECTION/TITLE |
|---|---|
| **R** | 12/20.3/Bundled Services/Supplies |
| **R** | 12/30.5/Chemotherapy Administration (Codes 96400 - 96549) |
| **D** | 12/30.5/Section D |

***III. FUNDING:**

**These instructions shall be implemented within your current operating budget.**

**IV. ATTACHMENTS:**

| | |
|---|---|
| **X** | **Business Requirements** |
| **X** | **Manual Instruction** |
| | **Confidential Requirements** |
| | **One-Time Notification** |
| | **Recurring Update Notification** |

***Medicare contractors only**

# Attachment - Business Requirements

| Pub. 100-04 | Transmittal: 147 | Date: April 24, 2004 | Change Request 3192 |
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**SUBJECT: Payment for Chemotherapy Administration Services, Nonchemotherapy Drug Infusion Services, and Drug Injection Services**

## I. GENERAL INFORMATION

### A. Background:

Chemotherapy administration services (CPT codes 96400, 96408 to 96425, 96520 and 96530) , therapeutic or diagnostic infusions (excluding chemotherapy) (CPT codes 90780 to 90781), and drug injection codes (90782 to 90788) are paid under the Medicare physician fee schedule. These codes have had practice expense relative value units and malpractice relative value units, but zero physician work relative value units.

For chemotherapy administration services furnished prior to January 1, 2004, the carrier allowed CPT code 96408 (Chemotherapy administration, intravenous; push technique) to be reported only once per day, even if the physician administered multiple drugs.

For drug injection codes furnished prior to January 1, 2004, the carrier paid separately for the drug injection code only if no other physician fee schedule service was being paid at the same time. If CPT code 99211 was billed with a drug injection code, the carrier paid only for 99211.

Physicians providing both chemotherapy administration services and evaluation and management services on the same day prior to January 1, 2004 usually billed the evaluation and management service with no modifier.

### B. Policy:

For services furnished on or after January 1, 2004, the carrier shall allow code 96408 to be reported and paid more than once per day. Payment shall be allowed for code 96408 for each drug administered.

Pursuant to section 303 of the Medicare Modernization Act, we established work relative value units for chemotherapy administration services (CPT codes 96400, 96408 to 96425, 96520 and 96530), nonchemotherapy drug infusion services (CPT codes 90780 to 90781), and drug injection codes (90782 to 90788). The work relative value for each code is equal to the work relative value unit for a level 1 office medical visit for an established patient (CPT code 99211). CPT code 99211 is a level 1 established patient office visit with physician work relative values of .17.

For services furnished on or after January 1, 2004, the carrier shall not allow CPT code 99211, with or without modifier 25, to be billed or paid on the same day as a chemotherapy administration service or a nonchemotherapy drug infusion service.

The carrier shall continue the previous policy for drug injection codes. Pay separately for the drug injection code only if no other physician fee schedule service is being paid at the same time. If CPT code 99211 is billed with a drug injection code, pay only for 99211.

Physicians providing chemotherapy drug administration services (or nonchemotherapy drug infusion services) and evaluation and management services, other than CPT code 99211, must bill in accordance with section 30.6.6 of Chapter 12 of the Internet Only Manual (IOM) using modifier "25". Carriers pay for evaluation and management services, other than CPT 99211, provided on the same day as chemotherapy drug administration services (or nonchemotherapy drug infusion services) if the evaluation and management service meets the requirements of section 30.6.6 even though the underlying codes do no have global periods.

### C. Provider Education:

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 one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.

## II. BUSINESS REQUIREMENTS

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

| Requirement # | Requirements | Responsibility |
|---|---|---|
| 3192.1 (Manual ref: Chapter 12 Sec 20.3 B) | The carrier shall pay separately for the drug injection code (code 90782 to 90788) if no other physician fee schedule service is paid at the same time. | Medicare Carriers |
| 3192.2 (Manual ref: Chapter 12 Section 20.3 B) | If code 99211 is billed with a drug injection code (90782 to 90788), the carrier shall pay only code 99211. | Medicare Carriers |
| 3192.3 (Manual ref: Chapter 12 Section 30.5A) | For services furnished on or after January 1, 2004, the carrier shall not allow payment for code 99211, with or without modifier 25, if it is billed with a nonchemotherapy drug infusion code (90780 or 90781). | Medicare Carriers |
| 3192.4 (Manual ref: Chapter 12 Section 30.5A) | For services furnished on or after January 1, 2004, the carrier shall not allow payment for code 99211, with or without modifier 25, if it is billed with the following chemotherapy | Medicare Carriers |

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|---|---|---|
| | administration codes, 96400, 96408 to 96425, 96520, or 96530. | |
| 3192.5 (Manual ref: Chapter 12 Section 30.5 B) | The carrier shall pay for code 96408 if it is furnished more than once per day for each drug administered and the service is furnished on or after January 1, 2004. | Medicare Carriers |
| 3192.6 (Manual re: Chapter 12 Section 30.5 A) | The carrier shall pay for evaluation and management services, other than 99211, provided by the physician on the same day as the chemotherapy administration code, 96400, 96408 to 96425, 96520 or 96530, if the evaluation and management service meets the requirements of section 30.6.6 of Chapter 12 even though the underlying codes do not have global periods. | Medicare Carriers |
| 3192.7 (Manual re: Chapter 12 Section 30.5 A) | The carrier shall pay for evaluation and management services, other than 99211, provided by the physician on the same day as the nonchemotherapy drug infusion service (90780 or 90781), if the evaluation and management service meets the requirements of section 30.6.6 of Chapter 12 even though the underlying codes do not have global periods | Medicare Carriers |
| 3192.8 (Manual ref: Chapter 12, Sections 20.3B, and 30.5) | Carriers shall use the appropriate Medicare Summary Notice (MSN), such as #16.8, when denying a service such as 99211 if billed on the same day as a chemotherapy administration service or a nonchemotherapy drug infusion service. This same message can also be used when denying a drug injection service that is billed with 99211. MSN 16.8 reads, "Payment is included in another service received on the same day." | Medicare Carriers |
| 3192.9 (Manual ref: Chapter 12, Sections 20.3B, And 30.5A) | Carriers shall use the appropriate adjustment reason code, such as 97, when denying a service that is not separately payable. 97 reads, "Payment is included in the allowance for another service/provider." | Medicare Carriers |

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| 3192.10 | Do not go back and adjust claims that have already been processed. However, make adjustments to any claims that are brought to your attention. | Medicare Carriers |

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| | **NOTE:** Carriers shall follow the criteria listed above in Item 1.C., Provider Education, regarding the Medlearn Matters Article. | Medicare Carriers |

## III. 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

## IV. SCHEDULE, CONTACTS, AND FUNDING

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|---|---|
| **Effective Date:** January 1, 2004<br><br>**Implementation Date:** May 24, 2004<br><br>**Post-Implementation Contact(s):** Appropriate Regional Office | **These instructions shall be implemented within your current operating budget.** |

## 20.3 - Bundled Services/Supplies

***(Rev. 147, 04-23-04)***

There are a number of services/supplies that are covered under Medicare and that have HCPCS codes, but they are services for which Medicare bundles payment into the payment for other related services. If carriers receive a claim that is solely for a service or supply that must be mandatorily bundled, the claim for payment should be denied by the carrier.

### A - Routinely Bundled

Separate payment is never made for routinely bundled services and supplies. The CMS has provided RVUs for many of the bundled services/supplies. However, the RVUs are not for Medicare payment use. Carriers may not establish their own relative values for these services.

### B - Injection Services

Injection services (codes 90782, 90783, 90784, 90788, and 90799) included in the fee schedule are not paid for separately if the physician is paid for any other physician fee schedule service rendered at the same time. Carriers must pay separately for those injection services only if no other physician fee schedule service is being paid. In either case, the drug is separately payable. *If, for example, code 99211 is billed with an injection service, pay only for code 99211 and the separately payable drug. (See section 30.6.7.D.)* Injection services that are immunizations with hepatitis B, pneumococcal, and influenza vaccines are not included in the fee schedule and are paid under the drug pricing methodology as described in Chapter 17.

### C - Global Surgical Packages

The MPFSDB lists the global charge period applicable to surgical procedures.

### D - Intra-Operative and/or Duplicate Procedures

Chapter 23 and §30 of this chapter describe the correct coding initiative (CCI) and policies to detect improper coding and duplicate procedures.

### E - EKG Interpretations

For services provided between January 1, 1992, and December 31, 1993, carriers must not make separate payment for EKG interpretations performed or ordered as part of, or in conjunction with, visit or consultation services. The EKG interpretation codes that are bundled in this way are 93000, 93010, 93040, and 93042. Virtually, all EKGs are performed as part of or ordered in conjunction with a visit, including a hospital visit.
If the global code is billed for, i.e., codes 93000 or 93040, carriers should assume that the EKG interpretation was performed or ordered as part of a visit or consultation. Therefore, they make separate payment for the tracing only portion of the service, i.e., code 93005 for 93000 and code 93041 for 93040. When the carrier makes this assumption in processing a claim, they include a message to that effect on the Medicare Summary Notice (MSN).
For services provided on or after January 1, 1994, carriers make separate payment for an EKG interpretation.

## 30.5 - Chemotherapy Administration (Codes 96400 - 96549) *And Non Chemotherapy Drug Infusions (Codes 90780-90781)*

***(Rev. 147, 04-23-04)***

A - General Use of Codes

Chemotherapy administration codes, 96400 through 96450, 96542, 96545, and 96549, are only to be used when reporting chemotherapy administration when the drug being used is an anti-neoplastic **and** the diagnosis is cancer. The administration of other drugs, such as growth factors, saline, and diuretics, to patients with cancer, or the administration of anti-neoplastics to patients with a diagnosis other than cancer, are reported with codes 90780 through 90784 as appropriate. *For services furnished on or after January, 1, 2004, do not allow payment for CPT code 99211, with or without modifier 25, if it is billed with a nonchemotherapy drug infusion code, 90780 or 90781, or a chemotherapy administration code, 96400, 96408 to 96425, 96520, or 96530.*

*Physicians providing chemotherapy drug administration services (or nonchemotherapy drug infusion services) and evaluation and management services, other than CPT code 99211, on the same day must bill in accordance with section 30.6.6 using modifier "25". Carriers pay for evaluation and management services provided on the same day as the chemotherapy drug administration (or nonchemotherapy drug infusion services) if the evaluation and management service meets the requirements of section 30.6.6 even though the underlying codes do not have global periods.*

**B - Chemotherapy Administration by Push and Infusion on Same Day**

Separate payment is allowed for chemotherapy administration by push and by infusion technique on the same day. Only one push administration is paid on a single day. *For services furnished on or after January 1, 2004, allow code 96408 to be reported and paid once per day for each drug administered.*

**C - Chemotherapy Infusion and Hydration Therapy Infusion on Same Day**

Separate payment is not allowed for the infusion of saline, an anti-emetic, or any other nonchemotherapy drug under CPT codes 90780 and 90781 when administered at the same time as chemotherapy infusion (CPT codes 96410, 96412, or 96414). Separate payment is allowed for these two services on the same day when they are provided sequentially, rather than at the same time. Physicians use the modifier "-59" to indicate when CPT codes 90780 and 90781 are provided sequentially with CPT codes 96410, 96412, and 96414.

***D - Flushing of Vascular Access Port***

Flushing of a vascular access port prior to administration of chemotherapy is integral to the chemotherapy administration and is not separately billable. If a special visit is made to a physician's office just for the port flushing, code 99211, brief office visit, should be used. Code 96530, refilling and maintenance of implantable pump or reservoir, while a payable service, should not be used to report port flushing.