

**2006 FAQs ON CODING FOR DRUG ADMINISTRATION  
SERVICES AND OTHER CODING CHANGES FROM THE 2006  
PHYSICIAN FEE SCHEDULE**

**1. Have the 2005 Medicare G-codes for drug administration been deleted?**

Yes. The Medicare G-codes for drug administration are no longer valid codes. Providers should report drug administration services using the applicable 2006 CPT codes for services on or after January 1, 2006.

**2. Do the 2006 Current Procedural Terminology (CPT) codes correspond to the Medicare G-codes for drug administration?**

The 2006 CPT code definitions for drug administration services (hydration, therapeutic/diagnostic, chemotherapy) mirror the 2005 Medicare G-codes for drug administration services. A coding cross-reference sheet containing the 2006 CPT codes, the 2005 Medicare G-codes and their definitions is provided at the end of this document. (Attachment A.)

**3. Did CPT keep the terms “initial,” “each additional,” and “additional sequential” that were used with the Medicare G-codes for drug administration?**

Yes. The CPT book includes these same terms and there have been no changes in their definitions.

**4. Will the 2006 CPT codes be recognized by private insurers?**

Private payors should recognize published CPT codes because CPT is the standard coding system recognized under the Health Insurance Portability and Accountability Act (HIPAA).

**5. Can the 2006 CPT codes be reported in the hospital outpatient setting?**

CPT codes are recognized under the hospital outpatient prospective payment system.

**6. Did the CPT make any additional changes to the definition of an intravenous push?**

No. In February 2005 the CPT Editorial Panel defined an intravenous or intra-arterial push as, “an injection in which the healthcare professional who administers

the substance or drug is continuously present to administer the injection and observe the patient, or an infusion of 15 minutes or less.”

The definition specifically recognizes short infusions, so although short infusions are reported using the codes for pushes, they are not considered to be pushes.

**7. Can I bill for a subcutaneous or intramuscular injection (90772) if there is no physician supervision?**

No. A subcutaneous or intramuscular injection requires direct physician supervision. Under Medicare, this means the physician must be present in the office suite and immediately available while the service is being performed. If there is no physician supervision, the service cannot be reported as an incident to service.

However, the service may be billed by a midlevel practitioner with a Medicare billing number. The midlevel practitioner's service would be paid at a reduced rate (85%).

**8. Do I have to use the –59 modifier when reporting a therapeutic/diagnostic subcutaneous or intramuscular injection (90772) on the same day as drug administration services?**

Yes. The National Correct Coding Initiative (NCCI) created edits on code 90772, which requires the use of a modifier. ASCO requested that the edit be deleted; however, CMS disagreed. If the drug or substance is unrelated to an anesthetic, providers should use the -59 modifier to bypass the edit.

**9. Can a level-one office visit be billed on the same day as chemotherapy?**

No. Medicare rules state that a level-one office visit (99211) cannot be billed on the same day as chemotherapy.

When the drug administration codes were revised, physician work was added to reflect the physician's active participation in the patient's treatment. The physician work value is equal to or greater than the work value of a level-one office visit; therefore, Medicare will not allow a level-one office visit to be billed on the same day as chemotherapy.

**10. Can evaluation and management services (E & M) other than a level-one visit be reported with drug administration services? If so, is a different diagnosis needed?**

Level two through five E & M services can be reported on the same day as drug administration services. CPT guidelines require that the –25 modifier be attached to E & M services provided. CPT language also states that a different diagnosis is

not required for E & M services provided on the same day as drug administration services.

Significant, separately identifiable E & M services will be paid if appropriate documentation (outlined in the 1995 or 1997 E & M guidelines) is maintained. Additional documentation beyond what is outlined in the guidelines should not be required by your carrier.

**11. We are still very confused about concurrent infusions. Has there been any clarification or definition of a concurrent infusion?**

The American Medical Association (AMA) defines a concurrent infusion as one in which multiple infusions are provided through the same intravenous line.

**12. If a second drug is added to a bag for intravenous administration, can the administration of the second drug be reported?**

No. More than one substance in a single bag is considered one infusate and one infusion. In this scenario, one administration can be reported. The J-code for each substance or drug, however, would be separately reportable.

**13. If two drugs are infused simultaneously but hung in two separate bags, would it still be a concurrent infusion?**

Yes. Even if multiple drugs are hung separately, the administration is considered to be concurrent because the drugs are running simultaneously. In this situation, you would be able to report an initial or subsequent administration for the first drug and a concurrent administration for the second drug.

**14. What if two drugs are mixed in the same bag and administered for fifteen minutes?**

If an infusion is 15 minutes or less, it would meet the definition of a push and the appropriate push code (initial or subsequent) should be reported. In this situation, the infusion would be reported as one push; however, each substance or drug would be separately reported.

**15. Can more than one concurrent administration code be reported?**

A concurrent infusion can be billed once per patient encounter.

**16. Is there a code for concurrent chemotherapy?**

No. There is no code to report concurrent chemotherapy administrations. If a concurrent chemotherapy administration occurs, only one chemotherapy

administration code can be reported. However, each drug can be separately reported.

**17. Are there guidelines for reporting the duration of an infusion?**

Yes. After the first hour of infusion, round infusion times to the nearest 30 minutes. For infusions of 30 minutes or less, round down. For infusions greater than 30 minutes, round up. For example, if you conduct a chemotherapy infusion (for one drug) for 1 hour and 45 minutes, you would report the following:

96413	Chemotherapy IV infusion, initial hour
96415	Chemotherapy IV infusion, each additional hour

Start timing over when you switch to a different drug.

**18. When reporting infusion times, does the infusion time start when the drug/substance is being mixed or when the actual infusion starts?**

The infusion time begins when the infusion starts. Infusion time reflects the time the drug/substance is actually being administered.

**19. Do we need to use the –59 modifier to bill for hydration provided on the same day as chemotherapy?**

Yes. The –59 modifier should be used to indicate that hydration was provided prior to or following chemotherapy. Hydration provided at the same time as chemotherapy to facilitate drug delivery is not separately reportable.

**20. Can we bill separately for starting an IV or accessing a port when providing drug administration services?**

Starting an IV or accessing an IV or port are considered integral to the drug administration and are therefore not separately reportable. In addition, use of local anesthesia, flushing at the conclusion of infusion, and standard tubing, syringes, and supplies associated with infusions are considered to be included in the service.

**21. Is there a CPT code for flushing a port?**

Yes. CPT code 96523 is for the irrigation of an implanted venous access device. This code should not be reported when an injection or infusion occurs on the same date of service.

Under Medicare rules, 96523 is payable if it is the only physician fee schedule service provided that day. If another fee schedule service is reported on the same day, payment for the port flush code will be bundled into the payment for the other fee schedule service(s).

**22. Is it true that CMS created a G-code to be reported with IVIG to supplement the price of the drug?**

CMS created a temporary G-code, G0332, to reflect additional resources associated with locating and obtaining IVIG products. The description of code G0332 is preadministration-related services for intravenous infusion of immunoglobulin, per infusion encounter. Code G0332 will be effective from January 1, 2006 through December 31, 2006.

G0332 can be reported when an IVIG infusion occurs during a patient encounter. The code can be billed once per day and should be reported with the appropriate drug administration service(s).

**23. Can we bill the IVIG G-code with other drugs that we are unable to obtain at Medicare's reimbursement amount?**

Code G0332 is to be reported on a day a patient receives an IVIG administration. It should not be reported in conjunction with other drugs.

**24. Can the new G-code for IVIG be reported in the hospital setting?**

Code G0332 can be reported in the office and hospital outpatient settings.

**25. What happened to HCPCS codes J0880, Q0136, and Q0137 for darbepoetin alfa? What code(s) should we use when reporting darbepoetin alfa?**

HCPCS codes J0880 (injection, darbepoetin alfa, 5 mcg) and Q0137 {injection, darbepoetin alfa, 1 mcg (non-ESRD use)} have been deleted. Code Q0136 {injection, epoetin alfa (for non-ESRD use), per 1,000 units} has also been deleted. CMS announced the deletion of these codes in the 2006 physician fee schedule final rule.

Codes J0881 {injection, darbepoetin alfa, 1 microgram (non-ESRD use)} and J0885 {injection, epoetin alfa (for non-ESRD use), 1000 units} are the new HCPCS codes to use when reporting epoetin alfa/darbepoetin alfa for non-ESRD use.

**26. Has code J7051 been deleted, and has a new code been established to replace it? If so, will it be covered by the Medicare program?**

Code J7051 (sterile saline or water, up to 5 cc) has been deleted. Medicare reclassified the item as a supply under code A4218 (sterile saline or water, metered dose dispenser, 10 ml). The Medicare program does not cover supplies, and, therefore, code A4218 will likely not be covered by Medicare.



## 2006 CODING CHANGES FOR DRUG ADMINISTRATION SERVICES

A cross reference between 2006 CPT codes, Medicare's 2005 G-codes, and 2005 CPT codes

2006 CPT Codes	2006 CPT Code Descriptions	2005 Medicare G-code	2005 Medicare G-code Descriptions (No G-codes in some cases.)	2005 CPT Codes (*denotes deleted code)
<b>Hydration Administration Codes</b>				
<b>90760</b>	Intravenous infusion, hydration; <b>initial</b> , up to 1 hour	G0345	Intravenous infusion, hydration; initial, up to one hour	90780*
90761 (add-on code)	each additional hour, up to 8 hours	G0346	Each additional hour, up to eight (8)hours	90781*
<b>Therapeutic, Diagnostic, Prophylactic Administration Codes</b>				
<b>90765</b>	Intravenous infusion, for therapy, prophylaxis, or diagnosis, (specify substance or drug); <b>initial</b> , up to 1 hour	G0347	Intravenous infusion, for therapeutic/diagnostic; initial, up to one hour	90780*
90766 (add-on code)	each additional hour, up to 8 hours	G0348	Each additional hour, up to eight (8) hours	90781*
90767 (add-on code)	additional sequential infusion, up to 1 hour	G0349	Additional sequential infusion, up to one hour	90781*
90768 (add-on code)	concurrent infusion	G0350	Concurrent infusion	N/A
90772	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	G0351	Therapeutic or diagnostic injection; subcutaneous or intramuscular	90782*
90773	intra-arterial	**	**	90783*
<b>90774</b>	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or <b>initial</b> substance/drug	G0353	Intravenous push, single or initial substance/drug	90784*
90775 (add-on code)	each additional sequential intravenous push of a new substance/drug	G0354	Each additional sequential intravenous push	N/A
90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion	**	**	90799*
<b>Chemotherapy Administration Codes</b>				
96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	G0355	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal antineoplastic	96400*

2006 CPT Codes	2006 CPT Code Descriptions	2005 Medicare G-code	2005 Medicare G-code Descriptions (No G-codes in some cases.)	2005 CPT Codes (*denotes deleted code)
96402	hormonal anti-neoplastic	G0356	Hormonal antineoplastic	96400*
96405	Chemotherapy administration; intralesional, up to and including 7 lesions	**	**	96405
96406	intralesional, more than 7 lesions	**	**	96406
<b>96409</b>	Chemotherapy administration; intravenous, push technique, single or <b>initial</b> substance/drug	G0357	Intravenous; push technique, single or initial substance/drug	96408*
96411 (add-on code)	each additional substance/drug	G0358	Intravenous, push technique, each additional substance/drug	N/A
<b>96413</b>	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or <b>initial</b> substance/drug	G0359	Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug	96410*
96415 (add-on code)	each additional hour, 1 to 8 hours	G0360	Each additional hour, one to eight (8) hours	96412*
96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump	G0361	Initiation of prolonged chemotherapy infusion (more than 8 hrs), requiring use of a portable or implantable pump	96414*
96417 (add-on code)	each additional sequential infusion (different substance/drug), up to 1 hour	G0362	Each additional sequential infusion (different substance/drug), up to one hour	96412*
96420	Chemotherapy administration, intra-arterial; push technique	**	**	96420
96422	infusion technique, up to one hour	**	**	96422
96423 (add-on code)	infusion technique, each additional hour up to 8 hours	**	**	96423
96425	infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	**	**	96425
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	**	**	96440
96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis	**	**	96445
96450	Chemotherapy administration, into CNS (e.g. intrathecal), requiring and including spinal puncture	**	**	96450

2006 CPT Codes	2006 CPT Code Descriptions	2005 Medicare G-code	2005 Medicare G-code Descriptions (No G-codes in some cases.)	2005 CPT Codes (*denotes deleted code)
96521	Refilling and maintenance of portable pump	**	**	96520*
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)	**	**	96530*
96523	Irrigation of implanted venous access device for drug delivery systems	G0363	Irrigation of implanted venous access device for drug delivery systems	N/A
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	**	**	96542
96549	Unlisted chemotherapy procedure	**	**	96549

- \*\* Indicates no Medicare G-code or description.
- Bolded codes reflect “initial” service codes. “Initial” codes best describe the primary reason for the patient encounter, and only one initial code can be billed.
- Code 90768 (concurrent infusion) can be billed only once per patient encounter.
- No concurrent code for chemotherapy administration(s).
- Services such as the use of local anesthesia, IV start, access to indwelling IV (a subcutaneous catheter or port), a flush at conclusion of an infusion, standard tubing, syringes and supplies are included in the payment for the drug administration service. These services should not be billed separately.