

National Coverage Provision

Subject Title

Chemotherapy and Drug Administration

Subject Number

HONC-002

CPT/HCPCS Codes

	Intravenous infusion, Hydration
*90760	initial, 31 minutes to one (1) hour
90761	each additional hour, up to eight (8) hours
	Intravenous infusion, for therapy, prophylaxis or diagnosis;
90765	initial, up to one hour
90766	each additional hour, up to eight (8) hours
90767	additional sequential infusion, up to one hour
90768	concurrent infusion
	Therapeutic, prophylaxis or diagnostic injection;
90772	subcutaneous or intra-muscular
90773	intra-arterial
	Therapeutic, prophylaxis or diagnostic injection; intravenous push,
90774	single or initial substance/drug
90775	each additional sequential intravenous push of a new substance/drug
90779	Unlisted Therapeutic, prophylaxis or diagnostic intravenous or intra-arterial injection or infusion
	Chemotherapy administration intravenous infusion technique;
96413	up to 1 hour, single or initial substance
96415	each additional hour, 1 to 8 hours
96416	initiation of prolonged chemotherapy infusion (more than 8 hours); requiring use of a portable or implantable pump
96417	each additional sequential infusion (different substance/drug), up to one hour
	Chemotherapy intravenous push technique
96409	single or initial substance/drug
96411	each additional substance/drug
	Chemotherapy administration, subcutaneous or intra-muscular;
96401	non-hormonal anti-neoplastic
96402	hormonal anti-neoplastic
	Chemotherapy administration; intralesional
96405	up to and including 7 lesions
96406	intralesional, more than 7 lesions
	Chemotherapy administration, intra-arterial;
96420	push technique
96422	infusion technique, up to one hour
96423	infusion technique, each additional hour, one to eight hours
96425	infusion technique, initiation of prolonged infusion (more than 8 hours), requiring use of a portable or implantable pump
96440	Chemotherapy administration into pleural cavity
96445	Chemotherapy administration into peritoneal cavity
96450	Chemotherapy administration into CNS

96521	Refilling and maintenance of portable pump
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (EG. intravenous, intra-arterial)
96523	Irrigation of implanted venous access device for drug delivery systems
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir single or multiple agents
*36591	Collection of blood specimen from a completely implantable venous access device
*36593	Dec clotting by thrombolytic agent of implanted vascular access device or catheter.

Indications and Limitations:

The drug administration codes are grouped into three categories of codes: hydration; therapeutic or diagnostic injections and intravenous infusions other than hydration; and chemotherapy administration.

*When administering multiple infusions, injections or combinations, only **one “initial”** drug administration service code should be reported per patient per day, unless protocol requires that two separate IV sites must be utilized. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported.*

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.

Physician work related to hydration, injection, and infusion services involves the affirmation of the treatment plan and the supervision (pursuant to incident to requirements) of nonphysician clinical staff.

I. Hydration Services

*Hydration IV infusions (90760, 90761) consist of prepackaged fluid and/or electrolyte solutions (e.g., normal saline, D5-1/2 normal saline +30mEq KCl/liter), but are **not** used to report infusion of drugs or other substances.*

Hydration IV infusion typically requires direct physician supervision for purposes of consent, safety oversight or intra-service supervision of staff. Typically such infusions require little special handling to prepare or dispose of, and staff which administer these do not typically require advanced training. After initial set up, infusion typically entails little patient risk and thus little monitoring.

90760 “Intravenous infusion, **hydration; initial, 31 minutes to one hour”;*

*90761 “Intravenous infusion, **hydration**; each additional hour, up to eight (8) hours (List separately in addition to code for procedure)”.*

Report 90761 for hydration infusions of greater than 30 minutes beyond 1 hour increments, or hydration greater than 30 minutes provided as a secondary or sequential service after a different initial infusion or chemotherapy service is provided.

*Separate payment is made for hydration therapy provided **sequentially** (but not concurrently) to the chemotherapy infusion.*

II. Therapeutic, Prophylaxis or Diagnostic Injections and IV Infusions (other than Hydration)

A. Therapeutic, Prophylaxis or Diagnostic Infusions

A therapeutic, prophylactic, or diagnostic IV infusion or injection, other than hydration, is for the administration of substances/drugs. The fluid used to administer the drug(s) is incidental hydration and is not separately payable.

90765 “Intravenous infusion, for therapy. Prophylaxis, or diagnosis (specify substance or drug); initial, up to one hour”;

90766 “Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); **each additional hour**, up to eight (8) hours (List separately in addition to code for primary procedure)”.

90767 Intravenous infusion, for therapy, prophylaxis or diagnosis; **additional sequential infusion, up to one hour, (List separately in addition to code for primary procedure)”**, **used to report the first hour of a sequential infusion of a second nonchemotherapy drug**;

90766 is used to report additional hour(s), beyond the first hour, of sequential infusion as well as the second and subsequent hours of the initial drug. Report 90766 for infusion intervals of greater than 30 minutes beyond 1 hour increments.

90768 “Intravenous infusion, for therapy, prophylaxis or diagnosis (specify substance or drug); **concurrent** infusion (List separately in addition to code for primary procedure) (**report only once per substance/drug, regardless of duration**).

*The carrier shall allow payment for only **one** concurrent infusion per patient per encounter. The carrier shall not allow payment for 90768 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.*

B. Therapeutic, Prophylaxis or Diagnostic Injections

90772 “Therapeutic, prophylaxis or diagnostic injection (specify substance or drug); subcutaneous or intramuscular”

*Report 90772 for **non-antineoplastic** hormonal therapy injections.*

90773 Therapeutic, Prophylaxis or Diagnostic Injection; Intra-arterial

90774 Therapeutic, prophylaxis or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug”;

90775 Therapeutic, prophylaxis or diagnostic injection (specify substance or drug); each additional sequential intravenous push (List separately in addition to code for primary procedure)”

Report 90775 for an intravenous push subsequent to another drug administration service, if appropriate.

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.

Do not report 90760-90775 or 90779 with codes (including injections and intravenous chemotherapy, intra-arterial chemotherapy, and other chemotherapy) for which IV push or infusion is an inherent part of the primary procedure (e.g., administration of contrast material for a diagnostic imaging study).

The CPT 2006 includes a parenthetical remark immediately following CPT code 90772 (Therapeutic, prophylactic or diagnostic injection; (specify substance or drug); subcutaneous or intramuscular.) It states, “Do not report 90772 for injections given without direct supervision. To report, use 99211.”

*This coding guideline **does not** apply to Medicare patients. If the RN, LPN or other auxiliary personnel furnishes the injection in the office and the physician is not present in the office to meet the supervision requirement, which is one of the requirements for coverage of an incident to service, then the injection is not covered. The physician would also not report 99211 as this would not be covered as an incident to service.*

III. Chemotherapy Administration

For services furnished on or after January 1, 2005, chemotherapy administration codes apply to parenteral administration of nonradionuclide anti-neoplastic drugs and also to anti-neoplastic agents provided for the treatment of noncancer diagnoses (e.g., cyclophosphamide for autoimmune conditions) or to substances such as monoclonal antibody agents and other biologic response modifiers. The following drugs are commonly considered to fall under the category of monoclonal antibodies: Infliximab (Remicade®), Rituximab (Rituxan®), Alemtuzumab (Campath®), Gemtuzumab (Mylotarg®) and Trastuzumab (Herceptin®).

*The administration of **anti-anemia drugs and anti-emetic drugs** by injection or infusion for cancer patients is **not** considered chemotherapy administration. Such services are reported using codes from the range 90765-90775.*

Report separate codes for each parenteral method of administration employed when chemotherapy is administered by different techniques. Medications (e.g., antibiotics, steroidal agents, antiemetics, narcotics analgesics) administered independently or sequentially as supportive management of chemotherapy administration should be separately reported using 90761, 90766, 90767, 90768, 90775, 90773 or 90779 as appropriate. Report the specific service as well as code(s) for the specific substance or drug(s) provided.

A. Chemotherapy Injections (subcutaneous (SQ) or intramuscular (IM))

Hormonal and non-hormonal anti-neoplastics:

96401 “Chemotherapy administration, subcutaneous or intramuscular; **nonhormonal** anti-neoplastic”,

96402 “Chemotherapy administration, subcutaneous or intramuscular; **hormonal** anti-neoplastic”.

Drugs commonly considered to fall under the category of hormonal antineoplastics include Leuprolide Acetate and Goserelin Acetate.

B. Chemotherapy Infusions

96413 Chemotherapy administration, intravenous infusion technique; up to one hour, **single or initial substance/drug**”;

96415 Chemotherapy administration, intravenous infusion technique, each additional hour, **one to eight (8) hours** (List separately in addition to code for primary procedure)”; Report 96415 for infusion intervals of greater than 30 minutes beyond 1 hour increments. Report 96415 for additional hour(s) of sequential infusion.

96416 Chemotherapy administration, intravenous initiation of **prolonged** chemotherapy infusion (more than eight hours) requiring the use of a portable or implantable pump

96417 Chemotherapy administration, intravenous infusion technique; each additional **sequential infusion, (different substance/drug)** up to one hour (List separately in addition to code for primary procedure).

Report 96417 only once per sequential infusion. Use 96417 in conjunction with 96413, if appropriate.

96523 Irrigation of implanted venous access device for drug delivery systems

Irrigation of implanted venous access device for drug delivery systems (96523) will be paid if it is the only service provided that day. If there is a visit or other drug administration service provided on the same day, payment for 96523 is included in the payment for the other service.

IV Intra-Arterial Chemotherapy

CPT codes 96420, 96422, 96423, and 96425. Report CPT code 96423 for infusion intervals of greater than 30 minutes beyond 1 hour increments.

V. Evaluation and Management Services

CPT 99211 is not to be billed on the same day as a drug administration code that has a work relative value unit. If a significant separately identifiable evaluation and management (E & M) service is performed, the appropriate E & M service code should be reported utilizing modifier 25 in addition to codes 90760-90779, 96401, 96402, 96405, 96406, 96409, 96411, 96413-96523, 96542. For an E & M service provided on the same day, a different diagnosis is not required.

VI. Services included in chemotherapy and drug administration

If performed to facilitate the infusion or injection or hydration, the following services and items are included and are not separately billable:

- Use of local anesthesia
- IV start
- Access to indwelling IV, subcutaneous catheter or port
- Flush at conclusion of infusion, and
- Standard tubing, syringes and supplies.
- Preparation of chemotherapy agent (s)

Payment for the above is included in the payment for the chemotherapy administration or nonchemotherapy injection and infusion service.

VII. Catheter Declotting

For declotting a catheter or port, use 36550 declotting by thrombolytic agent of implanted vascular access device or catheter.

VIII. Edits

Medicare policies including, but not limited to, correct coding edits for the services described by codes 90772, 90774, 90775 may apply.

IX. Coding instructions and billing examples

A. Hydration and chemotherapy services: *Separate payment is made for hydration therapy provided sequentially (but not concurrently) to the chemotherapy infusion.*

- To indicate hydration was administered **sequentially**, that is, before or after chemotherapy report 90761 to identify hydration was **not** furnished concurrent with chemotherapy 96413.

B. *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. If a combination of chemotherapy drugs, non-chemotherapy drugs, and/or hydration is administered by infusion, the **initial code** that best describes the service should always be billed irrespective of the order in which the infusions occur.*

*Only **one “initial”** drug administration service code should be reported per patient per day, unless protocol requires that two separate IV sites must be utilized. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported.*

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 59.

C. Add-On Codes

Several chemotherapy administration and nonchemotherapy injection and infusion service codes have the following parenthetical descriptor included as a part of the CPT code, “List separately in addition to code for primary procedure.” Each of these codes has a physician fee schedule indicator of “ZZZ” meaning this service is allowed if billed with another chemotherapy administration or nonchemotherapy injection and infusion service code.

Do not interpret this parenthetical descriptor to mean that the add-on code can be billed only if it is listed with another drug administration primary code. For example, code 90761 ordinarily will be billed with code 90760. However, there may be instances where only the add-on code, 90761, is billed because an “initial” code from another section in the drug administration, instead of 90760, is billed as the primary code.

D. Reporting times for infusion codes:

After the first hour of an infusion, round infusion times to the nearest 30 minutes. For 30 minutes or less, round down; for greater than 30 minutes, round up.

F. **Billing Examples:**

1. **Example:** Benadryl and Cimetidine have been added to one bag of normal saline by our Sterile Products Pharmacy. Is it appropriate to bill an administration code for each drug?

Response: No, it is not appropriate to bill an infusion administration code for each drug that is contained within an IV bag. Only one IV bag is being administered and should be billed as one infusion service.

2. **Example:** Leucovorin IV runs for 2 hours (0900-1100). During that time, Irinotecan runs for 95 minutes (0900-1035). We understand that we would bill the initial chemo IV infusion (96413 and 96415) for the Irinotecan infusion. How would we bill for Leucovorin infusion? Would it be billed as concurrent (90768) for the first hour and the last 30 minutes be sequential non-chemo (90767)?

Response: Irinotecan is a chemotherapy drug that was infused from 0900-1035 and would be billed as 96413 and 96415. Leucovorin was also initiated at 0900 and ran until 1100. Leucovorin would be billed as a concurrent non-chemotherapy infusion (90768). A concurrent infusion (90768) can only be reported once per substance/ drug regardless of the duration. A concurrent infusion code can only be reported once per patient encounter.

If the infusions are not administered concurrently, Leucovorin would be billed with a **non-chemotherapy** infusion administration code.

3. **Example:** What if the drug was magnesium sulfate administered 35 minutes IV in the morning, and the patient returns for another 35 minute IV administration of magnesium sulfate in the afternoon. Would both be billed as initial non-chemo infusion because one is administered in the morning and one in the afternoon? Or would one be billed as an initial non-chemo infusion and the second as an additional non-chemo infusion regardless of the time of day? Would both be combined to bill initial non-chemo infusion, up to one hour?

Response: Since there were two separate encounters, both of the non-chemo infusions could be billed. Both the morning and afternoon infusion would be billed with (90765). Modifier 59 would need to be appended to indicate the patient came back for a separately identifiable service.

- *4. **Example:** We cannot bill CPT *36591 for a blood draw from a partially implanted VAD. Can we bill 96523 for the flush done to maintain the partially implanted VAD after the blood draw?

Response: Irrigation of implanted venous access device for drug delivery systems (96523) will be paid if it is the only service provided that day. If there is

a visit or other drug administration service provided on the same day, payment for 96523 is included in the payment for the other service.

5. **Example:** A loading dose of Fluorouracil 936 mg IV is given prior to initiation of the ambulatory infusion pump containing Fluorouracil at a less concentrated dose for overnight infusion. Clinical trials show that a loading dose prior to prolonged infusion of Fluorouracil results in greater efficacy in treatment. Therefore, we believe it is appropriate to bill for the chemo IV infusion and the ambulatory infusion pump for the Fluorouracil. Is this correct?

Response: You do not mention the time it takes for the loading dose to infuse. So you may be able to bill an infusion or a push code. Your example appears to be the infusion of a separate bag of Fluorouracil was given so it would be appropriate to bill for the loading dose and the actual chemo prolonged infusion of 8 hours or greater code. If the loading dose is a bolus that is taken from the syringe/bag that is in the pump, then it would not be appropriate to bill for the loading dose infusion code.

6. **Example:** The infusion of Calcium and Magnesium is necessary before and after Oxaliplatin to prevent neuro-toxicity associated with this chemo drug. Calcium and magnesium are combined with D5W IV bag. Should we code each of the 20- minute infusions as 90775, non-chemo IV push, rather than totaling the infusion time for this medication and billing 90767? Also, would it be appropriate to bill separately for the administration of each agent (calcium and magnesium)?

Response: Intravenous or intra-arterial **push** is defined as an injection/infusion of short duration in which the healthcare professional who administers the substance/drug is continuously present to administer the injection **or** an infusion of 15 minutes or less. The infusion of Calcium and magnesium in a bag of D5W would be billed as **one** sequential infusion, up to one-hour (90767). The **2 twenty minute** infusions of calcium /magnesium would be added together for a total of a 40 minute infusion which would be billed as 90767. It is not appropriate to bill an administration code for each of these agents.

7. **Example:** Which administration code (90772 or 96401) should be used when billing for the administration of EPO™, Neulasta™ and Leukine™?

Response: EPO™, Neulasta™ and Leukine™ are **not** chemotherapy agents. They should be billed with the 90772-Therapeutic, prophylaxis or diagnostic subcutaneous or intra-muscular injection code. It is not appropriate to bill these with CPT code 96401.

CPT 96401 is for the administration of antineoplastic chemotherapeutic agents and biologic response modifiers. Traditional antineoplastic chemotherapy agents and the newer biologic response modifiers have a higher patient risk, requiring special knowledge for use and requires longer patient monitoring.

8. **Example:** Is J1642 injection, Heparin sodium, (heparin lock flush) per 10 units payable when I administer it to flush an IV line?

Response: No, it is not separately payable. A flush is included in an infusion service or an evaluation and management service that is performed on the same day.

Documentation Requirements

Documentation supporting the medical necessity of this item, such as ICD-9 codes, must be submitted with each claim. Claims submitted without such evidence will be denied as being not medically necessary

Documentation requirement for Modifier 59 and concurrent infusions:

This can only be billed when a concurrent infusion is provided in a **second encounter** on the same day with the patient. Electronic submissions should indicate they have additional documentation which Medicare requires, by indicating “DOCUMENTATION AVAILABLE UPON REQUEST” in the electronic equivalent of item 19. A development letter will be sent requesting the information. If you do not indicate the availability of the additional documentation, or the information is not returned timely, the claim will be returned as unprocessable.

CMS National Coverage Policy

PUB 100-04 CR 5028 (CP-REV-968), 2006 CPT update; PUB.100-20 OTN (CR 3818, CR 3631, CR 3028)

Dates

Revision Effective Date:	*01/01/2008; 01/01/2007; 03/15/2005
Date Published:	*Article 01/01/08; Article 09/01/07; Article 04/01/2007; Article 07/01/2006; 01/01/2006; 10/02/2002; OTN-34; Article 01/01/2004, Article 04/01/2004; 03/01/2005; 05/01/2005 Article 07/01/2002,
Revision # & Date:	*01/01/2008-08 code update-90760 description change, added 36591, 36593 deleted 36540, 36550; 09/01/2007 –clarification of regulations #8 J1642 denied as included in administrative services or E&M same day (nine); 04/01/2007- added example 7: billing for the administration of EPO, Neulasta and Leukine (eight); 07/01/2006-manual update of previous instructions (seven)- effective date unchanged as rules effective with new 06-codes; 01/01/2006-06 CPT code update added 90760, 90761, 90765-90768, 90772-90775, 96401, 96402, 96409, 96411, 96413, 96415, 96416, 96417, 96521-96523(six), Deleted G0345-G0363 (five); 05/01/2005 change in the definition of an IV push, change in modifier from 76 to 59; limitation on concurrent billing (four); 01/01/2005 Renamed/reformatted and added G-code information from CR 3631; (three); 01/01/2004-updated info on 96048 & 99211 (two); 10/01/2002 - removed V58.1 (one)